Building capacity and bridging the gaps:

Strand 2: Alcohol and other drugs in qualifying social work education

Final Report – June 2013

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Glossary

AOD	Alcohol and other drugs
AS	Adults' Social Care Services
CS	Children's Social Care Services
QSWP	Qualifying Social Work Programme
KE	Knowledge Exchange
LA	Local Authority
NTA	National Treatment Agency
PAG	Project Advisory Group
PG	Post graduate
PLO	Practice Learning Opportunity (formerly known as Placements)
UG	Under graduate

Project Advisory Group

The research presented in this report is one part of a three part project exploring alcohol and other drugs in social care practice, education and employment-based training. In order to support its development, a small project advisory group (PAG) was established at the start of the project. The advantages of establishing a PAG include bringing additional relevant expertise to complement the project team, ensuring the research reflects, wherever possible, the views of a range of professional/personal perspectives, and ensuring the research remains grounded in the experience of those being researched. The group also act as critical 'friends' and can advise on dissemination of projects in their various fields of practice. Two physical meetings were held in April 2012 and October 2012 with further

contact as required throughout the project. The PAG also read and commented on the findings and draft reports in February and March 2013. The PAG comprised:

- Liz Allison, Social Worker (Children)
- Rosie Buckland, Social Worker (Adults)
- Lucy Jordan, PQ Course Leader and Lecturer, Southampton University
- Wulf Livingston, Senior Lecturer, Glyndwr University
- Ian Paylor, Head of Social Work and Senior Lecturer, Lancaster University
- Marcus Roberts, Director of Policy and Membership, DrugScope

Knowledge Exchange Event

Before completing the project's analysis and report writing the research team committed to holding a Knowledge Exchange (KE) event with a selection of participants from each of the three strands of the project. The purpose of this KE event was to ensure that the outputs of a study reflected the perspectives of all potential beneficiaries of the research. It took place at a point in the research which allowed the responses and participation of the beneficiaries could be reflected in the project outputs, and the event was conducted in the spirit of discussion and debate about the data (and sometimes the methodology. It was held on 24th January 2013 in central London. Further details of the programme and attendance at the KE event can be found in the Summary report for the three strands (Galvani et al. 2013).

Strand 2 – Qualifying Social Work Education Survey

Key findings

- 40% of qualifying social work programmes in England (n=63/157) responded to the survey.
- Of these, 94% of respondents (n=59/63) reported some teaching on alcohol and other drugs (AODs) on their social work qualifying programmes.
- AOD education remains an inconsistent and variable element of qualifying social work education.
- The priority given to AOD teaching was considered to be too low by almost three quarters of the respondents. No respondents thought it was too high.
- Among the QSWPs that include AOD education in their curricula, there are a number of approaches to delivering it.
- Integrating AOD teaching into other modules is by far the most common approach adopted. However it is important to state that there is a considerable lack of clarity about what is being taught and in what depth raising questions about the reliability of the data.
- There were few specialist AOD modules (n=13) but a higher number of specialist sessions (n=53). However, all but two programmes with specialist modules or specialist sessions also integrated AOD into other modules and teaching suggesting a greater degree of programme commitment to the topic
- On average students taking specialist AOD 'modules' received 20 hours of AOD education; for those taking specialist AOD 'sessions' the average was four hours only.
- The AOD-related topics most commonly included in teaching were the impact of AODs on physical/mental health, attitudes and values and risk assessment.
- Gender and ethnic differences in AOD use, prescribed drug use and identifying problematic drug use were the AOD-related topics least covered.
- As with Harrison's (1992) research, there was a concerning degree of mismatch between the reported topic coverage and the hours in which it was taught. In a significant minority of specialist AOD modules and in half of all AOD specialist sessions far too many topics were reported as being covered in the time available. This suggests minimal coverage or inaccurate reporting.
- Few respondents formally assessed student learning on AOD-related issues.
- Programme leads were often not aware of whether or not colleagues included AOD content in their teaching.
- It was not possible to establish the quality of AOD education being delivered and this needs further research. More AOD education does not necessarily equate to better quality teaching.
- Current social work education reforms offer opportunities for greater inclusion of AOD education on qualifying social work programmes.

2.1 Introduction

In 1989 Larry Harrison at the University of Hull conducted the first UK survey of teaching and learning on AOD use in qualifying social work education (Harrison 1992). This followed concerns about the "inadequate" level of education social workers received in working with people with alcohol problems in particular. As a result of this research, and with the backing of the Department of Health and an Inter-Ministerial Group on Alcohol Misuse, a working group was set up to develop guidance on integrating AOD use into what was then the 'new' Diploma in Social Work curriculum (CCETSW 1992).

At that time Harrison noted the increasing number of people with AOD problems on social workers' caseloads although his research found inadequate levels of AOD use education in qualifying social work programmes. Since 1989 there has been a further major restructuring of social work education leading to the introduction of the under-graduate and post-graduate routes into social work in 2003. At the time of writing another restructure is underway and 'new' improved social work courses need to be in place in 2013.

Evidence from social work practitioners suggests that little has changed within qualifying social work programmes in relation to AOD education in the intervening years (Galvani *et al*. 2011). However, there has been no further research since 1989 to verify this. It is possible that practitioner recall of AOD teaching and learning has waned in the years since they undertook their social work qualification. This strand of the research set out to update Harrison's work and to determine the nature and extent of AOD education on current qualifying social work programmes.

2.2 Aims and research questions

This report presents the findings of a survey exploring education on alcohol and other drugs within qualifying social work programmes in England. It is part of a larger, three strand project whose primary aims were to:

1) establish the particular challenges faced by practitioners working with the following service user groups; older people, people with learning disabilities and physically disabled people,
2) determine the nature and extent of education on alcohol and other drugs on social work qualifying programmes in England,
3) explore the nature and extent of training on alcohol and other drugs provided by employers for those working in children's and adults' services in England.

These three broad aims formed the three strands of this research project – each strand numbered according to the aims set out above:

- Strand 1 – Existing dataset analysis (PI: Cherilyn Dance)
- Strand 2 – Qualifying social work education survey (PI: Sarah Galvani)
- Strand 3 – Local authority workforce learning and development survey (PI: Aisha Hutchinson)

Initially the survey reported here (Strand 2) included alcohol and other drug education within post qualifying (PQ) as well as qualifying social work programmes. Formal PQ education has traditionally been run by universities to meet requirements set by the governing body of social work (until recently the General Social Care Council). However, recent years have seen major changes within PQ frameworks. While some formal PQ courses have been retained, employers and social care practitioners are increasingly accessing a wide range of post graduate training and qualification opportunities including those not specifically targeting social workers. Such courses range from one day conferences to full time degree level courses in a huge range of subjects from management and leadership to substance use. Following discussion with the Project Advisory Group and agreement that it was not possible to survey all such PQ training and education opportunities given the scale of this study, PQ education was dropped from the research.

Thus the focus of this survey was on establishing the nature and extent of education on alcohol and other drugs on qualifying social work programmes (QSWPs). As QSWPs are offered at under-graduate (UG) and post-graduate (PG) levels, the research questions underpinning the survey needed to reflect any potential differences between these routes. The key research questions were:

1) What proportion of UG and PG QSWPs include education on alcohol and other drugs?
2) To what extent do the two routes differ in a) the content/topics covered, b) the quantity of teaching and learning, or c) the delivery and leadership of teaching and learning on alcohol and other drugs?
3) What proportion of QSWPs offer:
    a. specialist AOD use session/s (for example, a half or one day workshop or lecture that sits outside a module or unit structure)
    b. specialist AOD use module/units (that is, one that focuses on AOD use specifically)
    c. an integrated model (where input on AOD use is embedded in other modules/units/sessions but not the main focus of the teaching and learning)
4) What differences exist in the delivery structure between programmes (i.e. sessions, modules or integrated approaches) and what might explain this (for example, type of faculty the QSWP is housed in or who facilitates/delivers the education)?
5) What are the differences in the content of alcohol and drug education between the different delivery structures (for example, is more time spent on teaching or are more topics covered in specialist modules than specialist sessions or integrated teaching)?
6) How do respondents feel about the priority of education on drugs and alcohol on the QSWPs?
7) To what extent do respondents anticipate any potential increases in teaching on AOD use?
8) What are the barriers and enablers to teaching on this topic?
9) What is the relationship between current input on alcohol and drugs and future plans, e.g. are those doing more currently more likely to increase or decrease their input in future?

2.3 Methodology

This section provides an overview of the methodology adopted for the survey of qualifying social work programmes.

2.3.1 Methods

The starting point for the development of the survey instrument was the previous survey tool used by Harrison in 1989 (Harrison 1992). The purpose of Harrison's research was to obtain basic information about training on AOD use provided by social work qualifying programmes across the British Isles. Its aim was to establish the amount of formal training that social work students received in working with people with alcohol and drug problems and to assess the priority social work educators accorded to alcohol and drugs education. In the survey, Harrison asked respondents to estimate time spent in lectures, seminars and other course input on alcohol and other drugs training during the years 1988 and 1989. Respondents were also asked to distinguish between compulsory and non-compulsory teaching in order to estimate how much formal teaching was available to most social work students.

The current study sought to explore changes in the amount and nature of formal teaching received by current social work students on QSWPs. Given the large number of courses in England running QSWPs, the use of a survey tool was decided to be the most appropriate. However, there are some key differences between Harrison's survey and the current survey:

1. The construction of questions had to be carefully considered in light of the restructuring that has occurred within QSWPs since Harrison's earlier survey. This led the researchers to include questions around the various structures for delivering formal teaching on alcohol and other drugs.
2. The mode of data collection is different from Harrison's postal survey due to advances in technology in the intervening years. Our online survey using specialist software Qualtrics, (https://www.qualtrics.com/) allowed for low cost survey design and data collection through web based tools.

The survey had four distinct sections (see appendix 1):

1. The first page of the survey contained the participant information sheet which included the purpose of the study, policies on data protection, confidentiality and the right to withdraw from the study. Finally, it contained contact details for the research team. This page was followed by questions requiring participants to provide their consent before they could proceed to the main body of the survey.
2. The second section of the survey asked respondents for information about their qualifying social work courses including: name of qualifying social work course; faculty/department within which the programme sits; part or full time status of programme; and number of students enrolled on the programme overall.
3. The third section of the survey navigated respondents through questions relating to the structure of their formal teaching (if applicable) on alcohol and other drugs. The section was split into three, with the same questions asked in relation to:
    i. specialist AOD use sessions,
    ii. specialist AOD use modules or units, and

iii. integrated teaching

Follow up questions included the length of time their teaching has been in place; who facilitates and delivers the teaching; the number of hours spent on teaching in lectures, seminars, skills workshops and other activities (as in Harrison's survey); which topics are covered in each structure from a provided list of nineteen topics on alcohol and other drugs; whether the teaching is compulsory or not; and the number of students receiving the teaching in the academic year 2011-2012.

4. The final section closed with more subjectively-oriented questions such as programme/ course leader's views on the priority given to formal teaching on alcohol and other drugs; their views on whether the levels of this teaching would be changing; and barriers and enablers to the provision of formal teaching on alcohol and other drugs.

2.3.2 Pilot Study

The survey tool was piloted among seven people experienced in the delivery of qualifying social work programmes. These comprised several members of the Project Advisory Group (PAG) and programme leaders/educators who would not be involved in filling out the official survey. Their constructive feedback was used to develop an amended final version of the survey.

On the basis of pilot feedback, two separate surveys were created to account for the fact that some programme leaders were responsible for two programmes (e.g. an undergraduate and a postgraduate programme) while the majority were responsible for just one. These were referred to as the 'dual survey' and 'single survey' respectively. The dual survey was subsequently piloted with three programme leaders and found to be effective at collecting the required data in a clear and streamlined manner.

2.3.3 Sampling Frame

The survey was intended to take a full census of social work qualifying programmes from all relevant institutions in England. The research team developed a full sampling frame derived in the first instance from an examination of the General Social Care Council (GSCC) list of accredited institutions offering qualifying social work programmes. The list was compiled in April and May of 2012 prior to the closure of the GSCC. To ensure accuracy and up-to-date information on active programmes, each institution's website was also visited to verify the programme was active and examined for programme information.

The research team targeted programme/course[1] leaders as research participants because it was felt they were most likely to have an overview of programme delivery. Programme leaders were identified from staff information on the University's relevant website. Where this information was not posted, the research team telephoned the social work programme administrator to find out. All institutions offering a QSWP in England were included in the final sampling frame and all programme leaders were accurately identified.

[1] A range of job titles is used for the programme lead role. For the sake of brevity we will refer hereafter to programme leaders.

2.3.4 Data Collection

The Qualtrics survey software contains a 'panel' feature that allows the uploading of participants' contact information into the software. Once uploaded it can be used to send out the survey and follow up reminder emails. The software also immediately logs survey completions including completed surveys, partially completed surveys, panel members who choose to opt out, and so on. This made it easy to monitor the pace of responses and report response rates.

Using the Qualtrics 'panel' function, contact was made with programme leaders during the week of 20 June 2012 to inform them of the forthcoming survey and to request their participation. A week later, a second email was sent containing a link to the survey on the Qualtrics secure site. This email contained a brief description of the aims of the survey and an appeal to programme leaders to take part. It also contained an 'opt out' link for those who did not wish to take part. Those who opted out would be logged by the software and would not receive on-going communication from the research team. Similarly those who completed the survey were logged by the system and did not receive reminders. Reminders were sent to programme leaders on a bi-weekly basis for two months, with a final closing date of 24 August 2012.

To boost responses an email was also sent to the Association of the Professors of Social Work asking them to encourage their programme leaders to take part and to members of the JUC social work education and research committees. It was also posted on the 'Curriculum and Delivery Group' of the Social Work Reform website, Ning.

2.3.5 Analysis

The data from Qualtrics was uploaded into SPSS to prepare for analysis. Data from the single and the dual surveys were merged to create a complete dataset and duplicate survey responses were deleted. Incomplete surveys were assessed for the degree of completeness, and where it was felt that these surveys lacked enough information for analysis, they were also excluded from the final dataset. The decision to include incomplete responses occurred where respondents completed *at least* sections one and two of the survey so that their teaching structures could be analysed. The data were 'cleaned' by running frequencies and descriptives on all variables and checking for errors and inaccurate responses. Statistical analysis involved primarily descriptive statistics on all variables and bi-variate and multi-variate analysis where possible. Responses to the open-ended questions were uploaded and managed in NVivo10, a software designed for managing qualitative data. Thematic analyses were then carried out on the open questions.

2.3.6 Ethics

Ethical approval for the research was gained through the two tier system at the University of Bedfordshire. First the Institute of Applied Social Research Ethics Committee approved the proposal, and subsequently University level approval was obtained. Each respondent gave their consent on the front page of the survey tool. Also the final page of the survey included an option to withdraw from the survey by ticking the relevant box.

2.3.7 Limitations

A key limitation of the methodology is its reliance on the programme leader having adequate knowledge about their qualifying social work programme to answer the questions fully and reliably. Social work programmes vary tremendously in terms of their size and structure, staffing and approach to programme delivery. Further, within qualifying social work programmes the level of communication between staff is variable. While some programme leads may have consulted with colleagues in order to respond to survey questions, it cannot be assumed that all did so, indeed some of the open survey questions suggest that some respondents did not. Thus the data presented do not claim to be a wholly reliable and accurate picture of AOD use education on qualifying social work programmes. To achieve this would require a survey design that has to be completed by all social work staff on all social work programmes. This is simply not possible to achieve within the existing resources for this research and, even with unlimited resources, may prove challenging to achieve. Future research needs to supplement the findings of this survey with qualitative research that seeks to demonstrate the nature and quality of the AOD use content, and its delivery, on qualifying social work programmes.

2.4 Findings: Response rate and sample profile

2.4.1 Response rate

The total sample consisted of 157 qualifying social work programmes including under graduate and post graduate, full and part time routes. These were delivered at 79 different Universities. The response rate is provided in table 2.1 below.

Table 2.1: Qualifying Social Work education providers responding to the survey, by university, programme

	Total no. of units	Total no. of responses	No. of incomplete surveys[2]	Non-responders	Overall response rate %
Universities	79	41	-	38	52
Programmes*	157	63	6	88	40

*This includes both part time and full time routes

2.4.2 Sample profile

Characteristics of the respondents' institutions are described below according to region, institution type, faculties in which the QSWPs are located, programme type and size of the programmes.

The representativeness of the sample has been included under each characteristic where the data allow a comparison between responders and non-responders to the survey. Both 'university' and 'programme' were used as units of analysis for the chi-square test used to explore associations between the variables and to highlight any significant differences (using $p<.05$ as the cut-off point for determining significance).

Where the analysis is presented using university as the unit of analysis, the data refer to 40 of the 41 universities because one respondent did not share relevant information about their institution.

a) Region

All geographical regions in England are represented by the sample, and there is good variation among regions. Five categories were derived from the nine categories officially recognised in England and used by, for example, the Census[3]. Of those universities from which at least one completed survey was received, the greatest number of responses came from Yorkshire & Humber and North East of England (n=11). Set against the total number of universities in each region, the highest response also came from Yorkshire and Humber (n=11/15, 73%), 10/21 (48%) came from the West Midlands and North West; 9/15 (60%)

[2] The number of incomplete surveys is included by programme only because programme was the target 'population' (not university). 'Incomplete' refers to those surveys that were opened but had very little data filled out; a further six surveys were partially completed but contained enough information to use for analysis, therefore these are included under 'total number of responses'.

[3] See, for example, ONS (2013). General Health in England and Wales, 2011 and Comparison with 2001. ONS, London.

were received from the East Midlands and East of England. The lowest responses came from universities in the London area, where we received 3/9 surveys (33%); and the South West and South East where completed surveys came from 7/19 institutions (37%). Figure 2.1 below shows the number of University respondents in each region set against the total number of institutions providing a QSWP in the region.

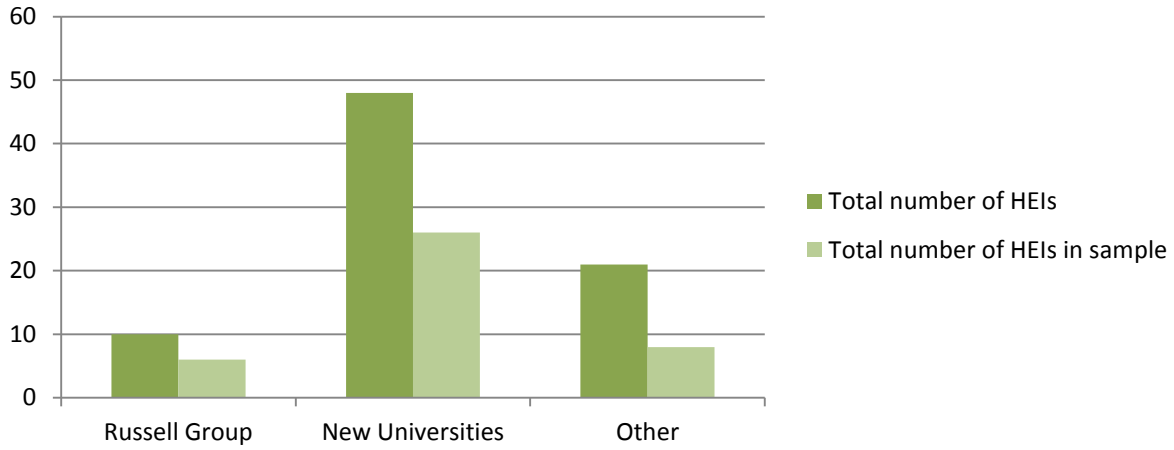
Figure 2.1: Region of institutions in the sample

In terms of representativeness, and using *university* as the unit of analysis, a comparison responders and non responders from the five regional categories and showed no significant differences by regional category ($\chi 2 = 6.22$, $df=4$, $p=.183$). However, significant differences were found by region (using the same five regional categories as above) ($\chi 2 = 10.44$, $df=4$, $p<.034$) when analysed using *programme* as the unit of analysis. This difference is likely to derive from the asymmetry among programmes; for example, some universities offer qualifying social work programmes through one route (i.e. a full time BA route) while others offer several different routes (i.e. a full time BA, a part time BA and a full time MA). Therefore some of the surveys returned provide duplicate information about some variables because they come from the same university. The implication is that some of the survey data from associated programmes is similar, inevitably introducing some bias into the sample and thus creating some observed differences. This bias is dealt with by using 'university' level data rather than 'programme' level data when considering some of the research questions.

b) Institution type

The universities were split into three groups – Russell Group universities (n=10), New universities (post 1992) (n=48) and Others (n=21) (see appendix 2 for details). The majority of institutions delivering qualifying social work courses are 'New' universities, while the fewest are Russell Group institutions; the remainder are 'Other' types of university. Just over half (n=26/48, 54%) of the new universities returned a survey and over half (n=6/10, 60%) of all Russell Group institutions and 8/21 'other' institutions (38%) completed and returned a survey.

Figure 2.2: Type of institutions in the sample



Using *university* as the unit of analysis found no significant differences between responders and non-responders according to university type ($\chi 2 = 1.91$, $df=2$, $p<.385$). Comparisons using *programme* as the unit of analysis also found no significant differences between responders and non-responders by university type ($\chi 2 = 1.19$, $df=2$, $p<.552$).

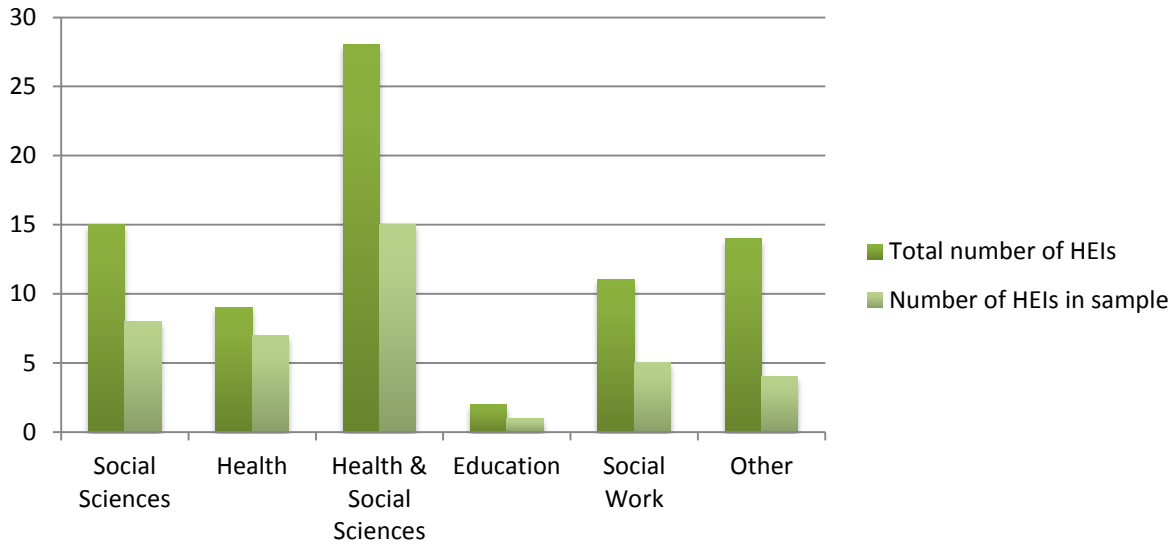
c) Faculty type

Respondents were asked to name the type of faculty in which their qualifying social work programme is housed. Some reported that they did not sit within a faculty but were housed in a department or were independent of a faculty. As a result the responses were categorised into the following groups:

- Social Sciences: included Arts & Social Sciences or Social Sciences only.
- Health: included only Faculty/Department of Health.
- Health and Social Sciences: this included, for example, Health and Social Care; Health and Community Studies; Health and Wellbeing.
- Education: included Faculty/Department of Education only.
- Social Work: some university/college departments do not sit within a 'faculty' and are just called Department of Social Work, or Department of Social Work and Social Policy.
- Other.

Figure 2.3 below shows that 38% of universities (n=15) locate their qualifying social work programmes within a health and social sciences faculty; 17% (n=7) within a health faculty; 20% (n=8) within social sciences; 2% (n=1) within education; and 3% (n=5) are social work 'schools' (i.e. independent of a faculty).

Figure 2.3: Institutions by Faculty Type

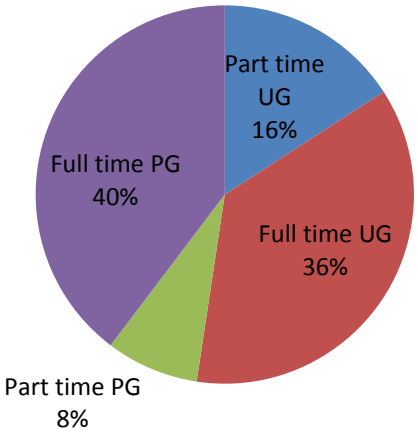


A comparison between the responders and non-responders using *university* as the unit of analysis found no significant differences between responders and non-responders in relation to faculty type ($\chi 2 = 5.64$, *df*=5, *p*<.343). Similarly, using programme as the unit of analysis also found no significant differences ($\chi 2 = 9.57$, *df*=5, *p*<.088).

d) Programme type (full or part time, undergraduate or postgraduate)

Thirty-three (52%) of the programmes which responded were undergraduate and 30 (48%) were postgraduate qualifying programmes (see figure 2.4 below).

Figure 2.4: Programme type



Again, responders and non responders were compared based on post graduate vs under graduate routes. There were no significant differences for the UG/PG distinction by programme at p<.05 ($\chi 2 = 2.773$, df=1, p=.096). Nor were there any significant differences found between PT and FT route by programme ($\chi 2 = 1.453$, df=1, p<.228).

e) Size of programmes

Respondents were asked to provide the numbers of students enrolled in the first, second and third years of their programmes for full time undergraduate routes, and first and second years for full time postgraduate routes. Respondents were also asked to provide the numbers of students enrolled in part time routes, allowing up to six years for part time programme completion.

Table 2.2 below sets out the average number of students enrolled on each qualifying route, as well as the minimum number of students and maximum number of students enrolled. Undergraduate programmes are represented in the table by 'UG' and postgraduate programmes represented by 'PG'.

Table 2.2: Number of students enrolled in QSWPs, reported by UG and PG status.

	Total Mean/Med (n of respondents)	Min/Max no. of students	UG Mean/Med	UG Min/Max values	PG Mean/Med	PG Min/Max values
First year, full time	48.03/46.50 (n=40)	15-120	53.28/50 (n=18)	20-86	43.73/40.50 (n=22)	15-120
Second year, full time	46.64/46,00 (n=39)	12-95	52.68/50 (n=19)	20-95	40.90/38.50 (n=20)	12-95
Third year, full time	50.05/48.00 (n=21)	18-86	51.21/48 (n=19)	28-86	-	-
First year, part time[4]	25.00/13.00 (n=11)	1-63	28.00/19.00 (n=8)	2-63	17.00/6 (n=3)	1-44
Second year, part time	27.90/18.50 (n=10)	3-77	28.38/18.50 (n=8)	3-77	26.00/26 (n=2)	7-45
Third year, part time	24.33/20.00 (n=9)	1-62	24.33/20.00 (n=9)	1-62	-	-
Fourth year, part time	17.00/15.00 (n=4)	10-28	17.00/15 (n=4)	10-28	-	-

On average (mean and median) UG full time programmes had a higher number of students than PG full time programmes. There is a similar pattern for part time programmes, however, the completion rate of the surveys for part time courses was low and the number is therefore too small to be reliable. The data that are available suggest there are fewer part time students than full time students at both UG and PG level.

[4] *Two programmes were removed from the analysis because they were outliers. One of these reported a total number of first year part time students of 500. Although there are no doubts about the accuracy of the reporting, its inclusion in the analysis skewed the figures for the remaining eleven programmes. Including this part time student figure increased the total mean and median to 25.00 to 64.58 and 13.00 to 19.00, respectively. Similarly one programme reported a total number of third year part time students of 350; including this programme increased the mean and median from 24.33 to 56.90 and from 20.00 to 23.50 respectively.

Summary of key findings: Response rate and sample profile

- 40% of qualifying social work programmes in England (n=63/157) responded to the survey.
- There was a good regional spread of universities with the lowest response rate from London and the South universities.
- Qualifying social work programmes were housed within a range of faculties, with the highest number in this sample housed in combined health and social science faculties.
- The number of UG and PG programmes responding to the survey was almost equal.
- Respondents reported more full time than part time QSWPs.
- In terms of representativeness, there are no significant differences between responders and non responders to the survey in terms of region, university type, faculty the programme was housed in, or whether the programmes were full or part time, under-graduate or post-graduate.

2.5 Findings (Part 1): Specialist sessions, specialist modules and integrated teaching

The following results describe the nature and extent of AOD teaching on QSWPs in our sample. Due to a large amount of missing data or partially completed surveys, some questions were not able to be analysed further and some of our original research questions have had to be excluded. These have been identified where appropriate and will be discussed further in section 2.9. Where further data analysis was possible, taking into account sample size and missing data, it is reported in the findings below.

2.5.1 Number of social work programmes providing teaching on AOD use

Of the 63 programmes for which data were provided, 59 (94%) reported some form of teaching provision on drugs and alcohol within their QSWPs. This is slightly higher than the 89% of programmes providing this teaching in Harrison's sample (1992). The remaining four programmes reported no formal teaching on this subject and were run by two universities. Therefore, using university as the unit of analysis, we can say that 95% of the universities within the sample reported some formal teaching on alcohol and other drugs. However, as Harrison found in his 1992 study, the amount of training delivered by the universities showed considerable variation and raises questions about the reliability of some of the data provided. This will be discussed further in section 2.9.

2.5.2 How alcohol and drug education is structured: specialist sessions, specialist modules and integrated teaching

Respondents were asked *how* they provided teaching on alcohol and other drugs in terms of delivery structure. They were offered three options:

i. *Stand-alone specialist sessions about AOD use*
   These sessions would sit outwith a specialist module or unit, for example, a day's workshop on drug awareness. They may or may not carry a small amount of academic credits.
ii. *Specialist modules or units on AOD use*
   These could be half or full modules but would cover the topic in greater depth and would usually carry academic credits.
iii. *AOD use teaching integrated into other elements of the course*
   This is where aspects of AOD use may be included in a range of teaching and learning opportunities, for example, in modules on child protection or skills-based learning, or teaching on poverty or the value base of social work.

Table 2.3 below shows the numbers of respondents delivering teaching on alcohol and other drugs by *delivery structure* as well as the total number of sessions or modules delivered by those programmes, and the *average number of sessions or modules per programme*. Full and part time courses are not considered separately because of the similarities evident in the data.

Table 2.3: Number of QSWPs delivering AOD teaching by delivery structure

	Sessions	Modules/units	Integrated
No. of QSWPs providing AOD input (total n= 63)	32 (51%) (15 – UG; 17 – PG)	12 (19%) (6 – UG; 7 – PG)	56 (88%) (29-UG; 27- PG)
Total no. of AOD sessions/modules reported by QSWPs	53 sessions	13 modules	111 modules
Average no. across sample	1 – 2 (Range 1-4)	1	2 (Range 1-3)

It was unusual for programmes to deliver teaching on alcohol and other drugs through one delivery structure alone. Of the 59 programmes which deliver some form of teaching on AOD, only 2 programmes delivered teaching through sessions only and no programmes delivered teaching through modules only. A higher number (n=21) delivered through integrated teaching only. The data show that more than half the programmes provide some form of teaching on alcohol and other drugs through a combination of stand-alone sessions, specialist modules and integrated teaching (n=36). Table 2.4 shows the combinations and number of programmes delivering those combinations. Teaching on AOD was integrated into a large range of modules, however the most common were those on the broad topics of children and families (n=16), mental health (n=13), practice focussed modules (n=12), and social work skills (n=9).

Table 2.4: Teaching delivery structure combinations by UG and PG programme (n=59)

	Undergraduate N (%)	Postgraduate N (%)	Total N (%)
Sessions only	2 (6 %)	0	2 (3%)
Integrated teaching only	12 (39%)	9 (32%)	21 (36%)
Modules only	0	0	0
Sessions and integrated teaching	11 (36%)	13 (46%)	24 (41%)
Modules and integrated teaching	4 (13%)	2 (7%)	6 (10%)
Sessions, modules and integrated	2 (6%)	3 (11%)	5 (8%)
Sessions and modules	0 (0%)	1 (4%)	1 (2%)
Totals	**31 (100)**	**28 (100)**	**59 (100)**

As the table shows, the most common combination of delivery of alcohol and drug teaching is through specialist sessions and integrated teaching. Only five programmes deliver teaching through a combination of all three delivery structures.

2.5.3 Nature and extent of teaching on alcohol and drugs

To explore the nature and extent of teaching on alcohol and drugs further each named specialist session (including those in which AOD education is integrated into) and specialist module was followed by a series of questions:

i. How long have programmes been delivering the specialist sessions/modules or integrating AOD into other teaching?
ii. Are specialist sessions/modules and integrated teaching on AODs compulsory?
iii. What content on AODs is typically covered within specialist sessions/modules or integrated teaching (from a provided list of 19 topics and an 'other' category)?
iv. Who a) facilitates and b) delivers specialist sessions/modules on drugs and alcohol and teaching on AODs integrated into other modules?

The following tables present a comparison of the responses to the above questions across the three delivery structures. The number of responses to different questions varied therefore the number of respondents has been clarified within the text or tables for each section.

a) Longevity of teaching and learning on topic

This question helps us to to establish whether teaching and learning on AOD had been recently introduced to QSWPs or whether they had been an established part of the curricula. Table 2.5 below shows that the majority of sessions (60%; n=32) had been running for less than five years. Just over half of specialist modules (58%, n=7) had been in place for five years or more with three of the remaining six modules described as 'new'. Finally, the majority (70%; n=64) of integrated teaching has been delivered in this way for more than 5 years.

Table 2.5: Length of time delivering teaching on AOD use

	Sessions (n=45/53)	**Modules/units (n=12/13)**	**Integrated (n=92/111)**
Length of time delivering AOD teaching	71% < 5 yrs (Mode – 3 years)	58% > 5 yrs 3 'new'	70% > 5 yrs (Mode- 5 years)

b) Compulsory or elective teaching

We also wanted to establish whether the teaching that was provided was compulsory or whether it was elective. Of those sessions, modules and integrated modules for which data was provided, the majority were compulsory and the remainder were elective, as presented in table 2.6 below.

Table 2.6: Whether or not teaching was compulsory

	Sessions (n= 47/53)	**Modules/units (n=12/13)**	**Integrated (n=92/111)**
Compulsory	40/47 (87%)	8/12 (67%)	100/111 (96%)

c) Teaching content

To determine the topics covered in the teaching on AODs, respondents were provided with a list of topics 18 topic areas, plus an 'other' category. They were asked to tick which topics were covered in their specialist AOD sessions, specialist AOD modules and integrated AOD teaching. Table 2.7 (below) shows the number and percentage of programmes for each delivery structure.

Table 2.7: Number and percentage of programmes covering AOD topics by delivery structure

Topic	Specialist Modules (n=13) (n=/%)	Topic	Specialist sessions* (n=43/53) (n=/%)	Topic	Integrated teaching** (n=84/111) (n=/%)
Attitudes and values	13 (100)	Government policy on AOD	29 (67)	Reasons people use and misuse	52 (62)
Impact on mental health	13 (100)	Attitudes and values	28 (65)	Impact on mental health	50 (60)
Impact on physical health	13 (100)	Reasons people use and misuse	28 (65)	Attitudes and values	49 (58)
How to assess risk relating to AOD use	12 (92)	How to assess risk relating to AOD use	27 (63)	Impact on children, families and parenting	45 (53)
How to talk about AOD issues	12 (92)	Impact on physical health	26 (60)	How to assess risk relating to AOD use	41 (49)
Identifying problematic alcohol use	12 (92)	Types of treatment available	26 (60)	Alcohol and its effects	39 (46)
Illegal drugs and their effects	12 (92)	Impact on mental health	25 (58)	Identifying problematic alcohol use	38 (45)
Impact on children, families and parenting	12 (92)	Impact on children, families and parenting	24 (56)	Government policy on AODs	35 (42)
Reasons people use and misuse	12 (92)	How to talk about AOD issues	22 (54)	Types of treatment available	35 (42)
Types of treatment available	12 (92)	Identifying problematic alcohol use	22 (51)	How to talk about AOD issues	33 (39)
Government policy on AODs	11 (85)	Working with or referring to specialist services	22 (51)	Illegal drugs and their effects	32 (38)
Identifying problematic drug use	11 (85)	Alcohol and its effects	21 (49)	Impact on physical health	32 (38)
Substance use theory	11 (85)	Illegal drugs and their effects	20 (46)	Working with/referring to specialist services	32 (38)
Alcohol and its effects	10 (77)	Ethnicity and cultural issues in sub. use	19 (44)	Identifying problematic drug use	30 (36)
Ethnicity and cultural issues in sub. use	10 (77)	Identifying problematic drug use	19 (44)	**Gender issues in substance use**	**27 (32)**
Prescribed drugs and their effects	10 (77)	Substance use theory	19 (44)	Ethnicity and cultural issues in sub. use	26 (31)
Working with or referring to specialist services	10 (77)	**Gender issues in substance use**	**16 (37)**	Substance use theory	25 (30)
Gender issues in substance use	**6 (43)**	Prescribed drugs and their effects	15 (35)	Prescribed drugs and their effects	22 (26)
Other	5 (36)	Other	2 (5)	Other	0 (0)

* Information on topics covered was completely missing for 10/53 (19%) specialist sessions

** Information on topics covered was completely missing for 27/111 (24%) integrated modules

i) Specialist modules
More than three quarters of programmes reported covering the majority of topics listed. The percentages are, overall, far higher than those reported for sessions, which makes sense given the greater length and depth of modules compared with sessions. 'Other' topics reported are homelessness and substance use, initiation of substance use, working with carers, harm reduction and relapse prevention.

ii) Specialist sessions
Overall the topic coverage was lower than with specialist modules, however there were far fewer specialist modules reported. More than half the topic areas were covered by more than half the sessions. Of those who reported that the session covers 'other' topics, only one specified what this was, saying that 'communication skills' are covered in the session.

iii) Integrated teaching
Only four topic areas were covered by more than 50% of the integrated modules. Overall, topics were covered to a far lesser extent in integrated teaching pathways than in specialist sessions and modules. However the reliability of data is questionable here as respondents may not know what is covered in modules taught by colleagues although it is possible that some may have checked before responding.

Further analysis of the names of the modules into which AOD use teaching was integrated found that modules clustered around similar themes. Those modules that integrated AOD use teaching most were:

* Children and families modules (n=16)
* Mental health modules (n=13)
* Working with people/service users (n=12)
* Social work skills (n=9)
* Assessment, risk assessment and protection (n=8)
* Working with adults (n=7)
* Critical social work practice (n=7)

Others included law and policy modules, human growth and development, research based teaching, methods and introduction to social work modules.

We explored the modules listed above to determine which topics they integrated into the teaching. Table 2.8 provides examples of the topics covered most by each module.

Table 2.8: Integrated modules and topic coverage

Name of integrated module (and number of modules in that themed group)	No. of respondents who provided detail of topic coverage	Topics covered most
Children and families modules (n=16)	12	• Impact on children and families and parenting (n=10) • Identifying problematic alcohol use (n=8) • How to assess risk relating to drug or alcohol issues (n=7) • Working with or referring to specialist alcohol and/or drug workers (n=5) • Reasons people use and misuse substances (n=5)
Mental health modules (n=13)	10	• Impact on mental health (n=10) • Types of intervention/treatment available (n=8) • Working with or referring to specialist alcohol and/or drug workers (n=7) • How to talk about AOD issues (n=6)
Working with people/ service users (n=12)	8	• Alcohol and its effects (n=8) • Reasons people use and misuse substances (n=7) • Illegal drugs and their effects (n=7) • Impact on physical health (n=6) • Impact on mental health (n=6) • Attitudes and values relating to substance use and problems (n=6) • Identifying problematic drug use (n=6)
Social work skills (n=9)	2	• Alcohol and its effects (n=2) • Attitudes and values relating to substance use and problems (n=2) • Reasons people use and misuse substances (n=2) • How to assess risk relating to drug or alcohol issues (n=2) • Impact on physical health (n=2) • Impacts on mental health (n=2) • Impact on children and families and parenting (n=2) • Types of intervention/treatment available (n=2) • Substance use and issues of ethnicity and culture (n=2) • Gender differences in alcohol and drug use (n=2) • Substance misuse theory (n=2)
Assessment, risk and protection (n=8)	8	• How to assess risk relating to AOD use (n=8) • Impact on children and families (n=5) • Government policy on AODs (n=5) • Alcohol and its effects (n=4) • Identifying problematic drug use (n=4) • Reasons people use and misuse (n=4) • How to talk about AOD issues (n=4)
Working with adults (n=7)	7	• Identifying problematic alcohol use (n=4) • How to assess risk relating to AOD use (n=4) • Types of intervention/ treatment available (n=4) • How to talk about AOD issues (n=4)
Critical social work practice (n=7)	5	• Attitudes and values (n=4) • Reasons people use and misuse (n=3) • Impact on mental health (n=3) • How to assess risk relating to AOD use (n=3)

As the table above shows there is usually one topic which each module covers most, usually the topic most allied to the focus of the module. For example, 8/8 modules in the area of assessment, risk assessment and protection covered 'how to assess risk relating to AOD use', similarly 10/10 modules on mental health covered the 'impact of substance on mental health'. Apart from that no clear pattern emerges. None of the modules cover both 'identifying problematic alcohol use' and 'identifying problematic drug use'; some cover one or the other and the skills modules cover neither. Only three of the module groups include 'how to talk about AOD use' excluding the skills module. Risk assessment relating to AOD use is included in a number of modules and perhaps reflects increasing awareness of risk relating to AOD use for adults and children. As table 2.8 highlights there is a huge range of topics covered through integrated teaching, from 1-18 topics.

iv) Topics least and most covered

It is notable that across all delivery structures, ethnicity and gender differences in relation to AOD use, and prescribed drug use are among the topics least covered on average, while attitudes and values, reasons people use, and the impact on mental and physical health are among the topics most covered (with the exception of integrated teaching that reported lower levels of coverage relating to impact on physical health).

d) Facilitation and delivery of teaching

Respondents were asked to tell us who a) facilitates and b) delivers specialist sessions on AODs. Delivery refers specifically to who teaches the students, while facilitation refers to the organisation of the teaching. Tables 2.9 and 2.10 below present the results across the different teaching structures.[5]

Table 2.9: Who facilitates AOD education on QSWPs

	Specialist sessions (n=49) **N (%)**	**Specialist modules/units (n=13)** **N (%)**	**Integrated (n=102)** **N (%)**
Members of sw teaching staff	41 (77%)	9 (64%)	102 (92%)
An external agency	11 (21%)	1 (7%)	11 (10%)
Member of staff from another department	2 (4%)	3 (21%)	2 (2%)
Service users and carers	5 (10%)	1 (7%)	0 (0)
Other	0 (0)	0 (0)	0 (0)
Joint facilitation	9 (18%)	1 (8%)	13 (13%)

[5] The percentages in the columns and rows do not add up to 100 because participants were able to tick any number of these combinations. What this indicates is that combinations of facilitation and delivery are variable from programme to programme and more than one source may be facilitating and/or delivering the sessions.

As can be seen, the majority of facilitation of AOD education involves members of social work teaching staff. Some differences are notable however. The facilitation of specialist sessions involved external agencies proportionally more than specialist modules or teaching within integrated modules. This may be a result of a number of specialist external drug and alcohol agencies, e.g. Drug and Alcohol Action Teams, offering free short training courses to health and social care professionals. Specialist sessions also involved more service users and carers than other delivery structures. The facilitation of specialist modules, on the other hand, involved colleagues from another department proportionally more than the other teaching structures. Given the more in depth nature of specialist modules, it is possible that greater expertise is sought from health colleagues, for example, in other departments within the university. However, numbers are low so caution is needed in interpreting these data. A large percentage of integrated teaching on alcohol and other drugs was facilitated by social work teaching staff as might be expected.

Joint facilitation of AOD education was evident in only a minority of cases across all three structures, with more specialist sessions proportionally (and marginally) facilitated jointly compared to the other two structures. Further exploration of the nature of the joint facilitation found that:

* Of the nine cases which jointly facilitate AOD learning in *specialist sessions*, four of these are jointly facilitated by social work staff and external agencies; four jointly facilitated by social work staff and services users; and one was jointly facilitated by social work staff, external agencies and service users;
* The single *specialist module* which is jointly facilitated is done so via social work teaching staff and service users;
* Of the 13 *integrated* modules which jointly facilitate AOD learning, a majority (n=11) jointly facilitate this via social work teaching staff and external agencies. Two said the modules were jointly facilitated by social work teaching staff and colleagues from another department; one specified this was a colleague from the BA Joint Honours programme who had a background in the area of AOD use.

Table 2.10 below presents the responses on who *delivers*, as opposed to facilitates, AOD education on QSWPs.

Table 2.10: Who delivers AOD education on QSWPs

	Sessions (n=43) N (%)	**Specialist modules (n=13) N (%)**	**Integrated (n=103) N (%)**
Members of SW teaching staff	29 (55%)	12 (86%)	89 (80%)
An external agency	24 (45%)	10 (71%)	34 (31%)
Member of staff from another department	0 (0)	1 (7%)	11 (10%)
Service users and carers	11 (21%)	3 (21%)	16 (14%)
Other	6 (2%)	2 (14%)	1 (1%)
Joint delivery	15 (35%)	11 (85%)	33 (32%)

Fewer social work teaching staff were involved in the *delivery* of the specialist sessions than in the delivery of specialist modules or integrated teaching. Far fewer social work staff were involved in delivering the specialist sessions than were involved in facilitating them suggesting they may be 'buying in' external teaching to fill their knowledge gaps.

More external agencies are involved proportionally in delivering specialist modules than either sessions or integrated modules. A higher proportion of integrated modules were delivered by members of staff from another department than were facilitated by them.

Across the board, service users and carers were more involved in the delivery of AOD learning across all three structures than they are in facilitating the learning. Some of the numbers within groups are quite small therefore we cannot say these are significant patterns.

Across all three structures, greater proportions jointly deliver AOD education than jointly facilitate it. Specialist modules jointly delivered proportionally more AOD education than specialist sessions or integrated modules (N.B. however, only 13 modules were described therefore this must be interpreted cautiously). Over a third of specialist sessions and integrated modules jointly deliver AOD learning.

Joint *delivery* of AOD education was described in the following ways:

* Of the 15 cases which jointly deliver AOD learning in specialist sessions, seven of these are jointly delivered by social work teaching staff, external agencies and service users; four were delivered by social work teaching staff and external agencies; three by social work teaching staff and service users; and one was delivered jointly by an external agency and service users;
* Of the 11 specialist modules which jointly deliver AOD learning, six are delivered by social work teaching staff and external agencies; three by social work teaching staff, external agencies and service users; two by external agencies and 'other', specified as a specialist non-social work staff member from the school; and one by social work teaching staff and service users;
* Of the 33 integrated modules which jointly deliver AOD learning, almost half (n=15) jointly deliver this via social work teaching staff and external agencies; 6 modules were delivered by social work teaching staff, external agencies, another department and service users; 5 by social work teaching staff and service users; 3 by social work teaching staff, another department and service users; two by social work teaching staff and 'other' (although this was not specified in the survey); 1 by external agency and service users; and 1 by 'other' and service users (but again, 'other' was not specified).

2.5.4 Number of topics covered in the teaching time allocated

Given that Harrison (1992) found a disparity between the number of hours taught and the reported content covered by respondents to his survey, this survey also sought to determine how many topics were covered in the teaching provided. The topic areas were summed and the averages and range of topics calculated. The table below shows the number of topics covered across the various delivery structures:

Table 2.11: The number of topics covered by delivery structure

	Specialist sessions	Specialist Modules/units	Integrated teaching
Avg. no. of topics covered	9.5 topics (median = 10) (mode = 8)	16 topics (median = 17) (mode = 18)	7.5 topics (median = 6) (mode = 6)
Range	1-18 topics	9-19 topics	1-18 topics

a) Specialist sessions

Considering the findings within the previous section which found that students receive an average (mean) of 4 hours of AOD teaching within specialist sessions, an average topic coverage of 9.5 topics is unlikely. If the figures are accurate, then it suggests that the topics are not being covered in any depth at all.

Further analysis of the sessions found that 25 of the 43 sessions that provided data on topic coverage appeared to be unrealistic about the number of topics they could cover in the time allocated to teaching. For example, a number of two hour sessions claimed to cover between 7-16 topics in that time. As noted in the methodological limitations, some survey respondents may not be directly involved in, or responsible for, the programme content and may therefore not be aware of topic coverage. An alternative view is that respondents were attempting to present a far better picture of their AOD teaching coverage than the reality depicts.

b) Specialist modules

These data were explored further to assess how much content was reported to be covered in the specialist modules (n=13), taking hours of teaching into account. Table 2.12 lists each individual module by number of hours of AOD across all activities, and presents the reported number of topics covered within the reported hours.

Modules reporting 20 hours of teaching and above include 16 or more topics. Five modules reporting six hours of teaching or less also report a high number of topics within far fewer hours. This suggests that the data quality for these five programmes is highly questionable and likely to be unreliable.

The specialist modules were subsequently placed into two groups to assess those with 'lower hours' of teaching compared with those reporting 'higher hours' of teaching. In this case, the cut-off point used to create the two comparison groups was 20 hours. This particular cut off point was used because more than half of the programmes offer 20 or more hours of teaching which seemed a reasonable number of hours delivered within specialist modules, while the remainder report 6 hours of teaching or less across all activities (see table 2.12 below for further explanation).

Table 2.12: Number of hours of teaching reported across all activities in specialist modules, by number of topics covered

Individual modules	No. of hours of teaching - all activities	No. of topics covered within module
Module 1	2 hours	17
Module 2	5 hours	9
Module 3	5 hours	10
Module 4	5 hours	14
Module 5	6 hours	16
Module 6	20 hours	16
Module 7	20 hours	18
Module 8	24 hours	19
Module 9	35 hours	18
Module 10	36 hours	17
Module 11	36 hours	17
Module 12	36 hours	18
Module 13	36 hours	18

The group reporting low hours of total teaching reported an average of 13 topics covered, whereas the group reporting high hours of total teaching reported an average of 17 topics covered. With an average of four hours of teaching among the lower hours group, the average of 13 topics is a great deal to cover in such a short period and raises questions about quality and depth of teaching or the reliability of the data.

c) Integrated teaching

Due to a technical error, those who integrated AOD teaching into other modules were not asked for the number of hours of teaching spent on AODs. However, table 2.7 (p.22) demonstrated that integrated teaching modules covered fewer topics in the list of 19 topics provided. Given that the nature of the integrated category is that AODs are only part of a wider teaching focus, this is not surprising. It is also more likely that topic coverage was in less depth.

Summary of key findings (Part 1): Specialist modules, specialist sessions and integrated teaching

- Of the 63 programmes for which data were provided, 59 (94%) reported some form of teaching provision on drugs and alcohol within their QSWPs.
- 32 programmes run specialist AOD sessions, 12 programmes run specialist AOD modules and 56 programmes integrate AOD education into other modules.
- Those modules that integrated AOD use teaching most were: Children and families modules (n=16), Mental health modules (n=13), Working with people/service users (n=12).
- The most common combination of delivery of AOD teaching is through specialist sessions and integrated teaching.
- Across all delivery structures, ethnicity and gender differences in relation to AOD use, and prescribed drug use are among the topics least covered on average, while attitudes

and values, reasons people use, and the impact on mental and physical health are among the topics most covered.

- The majority of sessions (60%; n=32) had been running for less than five years. Just over half of specialist modules (58%, n=7) had been in place for five years or more with three of the remaining six modules described as 'new'.
- The majority of AOD education was compulsory regardless of delivery structure.
- The mode of delivery affected who facilitated and delivered AOD education, for example integrated AOD teaching was far more likely to be delivered by social work staff than specialist AOD sessions that employed more external contributions.
- On average students taking specialist AOD 'modules' received 20 hours of AOD education; for those taking specialist AOD 'sessions' the average was four hours only.
- As with Harrison's (1992) research, there was a concerning degree of mismatch between the reported topic coverage and the hours in which it was taught. In a significant minority of specialist AOD modules and in half of all AOD specialist sessions far too many topics were reported as being covered in the time available. This suggests minimal coverage or inaccurate reporting

2.6 Findings (Part 2): Specialist sessions and modules - further analysis

Respondents who reported providing specialist sessions and specialist modules were asked an additional three questions:

i. Are academic credits assigned to the teaching?
ii. Is teaching on the topics of i) alcohol and ii) other drugs combined within sessions and modules, or are they treated separately?
iii. How many hours are spent on AOD within the following activities; i) lectures, ii) seminars, iii) skills workshops, vi) other activities?

We present the findings of each of these questions in turn.

2.6.1 Credits assigned

To determine the extent to which teaching and learning on AODs was considered part of the academic programme, we asked whether academic credits were assigned to the teaching provided. The following table shows that specialist modules were more likely to have credits assigned than specialist sessions with few of the latter carrying credits.

Table 2.13: Credits assigned to AOD specialist sessions and specialist modules

	Sessions	**Modules/units**
Credits assigned	2/53 sessions Both 15 credits	12/13 modules 4-20 credits (range) 15 credits (mode)

As the table shows only 2 of 53 sessions carried credits in contrast to 12 of 13 modules which carried a wide range of credits.

2.6.2 Combined or separate teaching on alcohol and other drugs

Historically, teaching on alcohol and other drugs has been delivered separately (Harrison 1992) and we wanted to determine how far this had changed since Harrison's study. Within both specialist sessions and modules, almost all the respondents reported that AOD sessions combined teaching on alcohol and other drugs. One specialist module delivered it separately as did two of the specialist sessions.

Table 2.14: Combined teaching on AODs on specialist sessions and specialist modules

	Sessions (n=32) N (%)	**Modules (n=12) N (%)**
AOD teaching combined	29 (91)	11 (92)

2.6.3 Hours spent on alcohol and other drugs in specialist sessions and modules[6]

In general, the quality of the data provided in response to this question was poor with a significant amount of missing data. It is therefore likely that these data are unreliable. With this in mind, the following tables present the hours spent in different types of teaching and learning methods first by specialist session (tables 2.15 and 2.16), then by specialist modules (table 2.17).

a) Specialist sessions

QSWPs can deliver more than one specialist session and this was accounted for in the survey design. Of the 32 programmes delivering specialist sessions, 28 provided data on the number of sessions provided:

- 12 provided one session
- 12 provided two sessions
- 3 provided three sessions
- 1 provided four sessions

A further four said that sessions were provided but did not provide the name of any sessions (although they answered other questions about the session). These were counted as having one session each. This totals 53 sessions from 32 programmes.

A total of 53 sessions were therefore available for analysis and the table below presents findings of all of these sessions combined. None of the respondents reported that teaching on AODs was delivered in 'other' activities within specialist sessions so this is not included in the table.

Table 2.15: Hours of AOD input by specialist session

	Lectures (n=36/47)	**Seminars (n=9/47)**	**Skills Workshops (n=22/47)**	**Total across activities (n=47/47)**
1-5 hours	35 sessions	9 sessions	17 sessions	39 sessions
6 to 10 hours	0	0	4 sessions	6 sessions
>10 hours	1 session	0	1 session	2 sessions
Min and max no. of hrs	1-18	1-4	1-20	1-24
Mean no. of hrs	**2.47**	**1.78**	**4.00**	**4.11**
Median no. of hrs/Mode	2.00/2.00	2.00/1.00*	2.00/2.00	3.00/2.00

**Two modes exist; this is the smallest of the two*

[6] The survey did not include a question about hours of teaching across integrated modules, only specialist sessions and modules. Follow up contact with respondents who provided integrated teaching attempted to rectify this. However, the small number of responses received demonstrated a lack of detailed knowledge of hours spent on AOD teaching in the various modules. As might be expected, it is unlikely that a programme leader will know the detailed content of all modules and the length of time spent on each one.

These data suggest that within specialist sessions, students receive *most* teaching within skills workshops, with an average of 4 hours and a median of 2 hours. They receive the *least* teaching via seminars.

We also analysed the hours spent on AOD teaching within programmes delivering one, two, three or four specialist sessions. Table 2.16 below shows the differences in the range and average amount of hours spent across the three teaching methods:

Table 2.16: Hours spent on AOD within different academic activities in specialist sessions

	Lectures	**Seminars**	**Skills Workshops**	**Total activities**
1 session (n=12)	(n=6) 1-5hrs (range) 2.33 (mean) 1.50 (median)	(n=2) 1 hr (range) 1.00 (mean) 1.00 (median)	(n=7) 1-20 hrs (range) 5 (mean) 2 (median)	(n=10) 1-20 hrs (range) 5.10 (mean) 3.50 (median)
2 sessions (n=11/12)	(n=8) 3-5hrs (range) 4.12 (mean) 4.00 (median)	(n=4) 2-4hrs (range) 2.75 (mean) 2.50 (median)	(n=5) 1-14 hrs (range) 7.80 (mean) 8.00 (median)	(n=11) 4-14 hrs (range) 7.54 (mean) 7.00 (median)
3 sessions (n=3)	(n=3) 3-6hrs (range) 5.00 (mean) 6.00 (median)	No data for this activity	(n=2) 6 hrs (range) 6.00 (mean) 6.00 (median)	(n=3) 3-12 hrs (range) 9.00 (mean) 12.00 (median)
4 sessions (n=1)	(n=1) 24hrs	(n=1) 4hrs	(n=1) 2 hrs	(n=1) 30 hrs

ii) Specialist modules

As with specialist sessions we analysed the number of hours of input on AOD teaching in a range of teaching activities. To recap, 12 programmes reported delivering specialist modules, with one of those programmes reporting that they deliver two specialist modules. Again data were missing within each activity, with the total number of valid responses reported across the top row of the table below. Because of the patchy data and very low numbers in some of the activities below, caution is needed in interpreting these results.

Total hours reported across all activities indicates an almost equivalent mean and median number of hours of teaching on AOD across specialist modules. Some of the low figures are highly questionable, given that modules tend to be a course of study where students learn about a topic area in some depth. Four respondents report low hours of teaching via lectures (<10 hours), with the remaining seven reporting more than 10 hours; in fact, these seven report 16 hours or higher. One interpretation could be that a majority of the teaching via modules takes place within 'other activities'. However, as table 2.17 illustrates, few respondents reported other activities.

Table 2.17: Hours of AOD input by specialist module

	Lectures (n=11)	Seminars (n=2)	Skills Workshop (n=6)	Other activities (n=3)	Total across activities (n=13)
1-5 hours	4 modules	2 modules	4 modules	1 module	4 modules
6 to 10 hours	0	0	0	0	1 module
>10 hours	7 modules	0	2 modules	2 modules	8 modules
Min. and max. no. of hrs reported	2-36	1-4	1-20	2-16	2-36
Mean no. of hrs	**16.73**	**2.50**	**7.17**	**11.33**	**20.46**
Median no. of hrs	18.00	2.50	4.00	16.00	20.00

A final analysis of lectures within modules was undertaken by removing those with the lowest hours (2-5 hrs) of teaching and looking at the remaining cases (n=7). Among this group, the minimum number of hours spent teaching within lectures is 16 and the maximum is 36 with an average of 24hrs and a median of 20hrs.

Summary of key findings (Part 2): Specialist sessions and modules – further analysis

- Only 2 of 53 sessions carried credits in contrast to 12 of 13 modules which carried a wide range of credits.
- Within both specialist sessions and modules, almost all the respondents reported that AOD sessions combined teaching on alcohol and other drugs. One specialist module delivered it separately as did two of the specialist sessions.
- Within specialist sessions, students receive *most* teaching within skills workshops, with an average of 4 hours and a median of 2 hours. They receive the *least* teaching via seminars.
- Within specialist modules, students receive most teaching within lectures and least via seminars. However missing data suggests these findings needed to be treated with caution.

2.7 Findings (Part 3): Practice learning, assessed work and teaching strategy

This final findings section reports on other opportunities for AOD education within QSWPs including Practice Learning Opportunities and assessed work. Further it summarises the qualitative data from respondents relating to the priority placed on AOD teaching within their programmes, the barriers and enablers to its inclusion and future teaching strategy on this topic.

2.7.1 Practice learning opportunities in AOD agencies

The survey also sought to determine the nature and extent of Practice Learning Opportunities (PLOs) (formerly known as 'placements') in alcohol or other drug agencies available to student social workers. These data were analysed by University as the unit of analysis (rather than programmes) as respondents gave one figure relating to PLOs regardless of how many programmes they offered.

While 34 of 41 *universities* provided data on PLOs, there were often missing data. Only 19 of the 34 were able to provide details on the number of PLOs available and in which type of agency the PLO opportunities were available (see table 2.18). Fifteen of the 34 who provided some response (44%) did not know how many students were placed in any PLOs (responding with 'DK' in the spaces provided). Further, for each agency type, there were some respondents who left the space blank which meant that interpretation was not possible (i.e. they did not indicate '0' or 'DK' so this data was treated as missing).

Table 2.18 presents the total number of PLOs available in the last academic year by type of agency, the mean, median and modal numbers of PLOs per university and the minimum and maximum number of PLOs per university.

Table 2.18: Number of PLOs in the last academic year by type of agency (n=19)

	Total no. of PLOs by agency type	Avg. no. of PLOs, per university (Mean/Median/Mode)	Min. and max. no. of PLOs per university
PLOs in specialist alcohol agencies	18	0/1.5/0	0-6
PLOs in specialist drug agencies	26	2/2/0	0-8
PLOs in specialist agencies working with both alcohol and other drugs	66	4.4/4/6	0-10
Total number of students in AOD agency PLOs in the last academic year	110		

Among the 19 universities that provided data, there were 110 PLOs in AOD agencies during the academic year 2011-2012. The trend within this small sample appears to be greater numbers of PLOs in specialist agencies that work with both alcohol and other drugs. This is likely to reflect the merging of alcohol and other drug services in recent years following changes in Government policy and funding and commissioning structures. However, clearly agencies that focus on either alcohol or drugs are still available to offer PLOs although this is unlikely to continue if the merging of services continues.

2.7.2 Assessed work on AOD topics

Additional learning on AODs can be gained through work that is formally assessed. Assessed work arguably reflects the importance a programme place on a topic area as well as serving to focus students' attention on it. Respondents were asked whether any assessed essay titles, exam questions or dissertations included AOD issues. Table 2.19 below indicates the average number, and the minimum and maximum number, of essay questions, exam questions or dissertations in the last academic year which addressed these AOD topics. Less than half of the programme respondents completed these questions, with the valid number responding to each indicated in the table below. Fifteen respondents out of 24 did not know how many assessed essay titles related to alcohol and other drugs; 16 out of 26 did not know how many questions in exam papers concerned alcohol and other drugs; and 12 out of 25 did not know how many dissertation topics addressed alcohol and other drugs. Thus, the resultant low number of responses need considering when interpreting the findings.

Table 2.19: Average number of assessment task incorporating AODs

Assessment tasks	No. of QSWPS that responded	Average no. of AOD related assessed tasks (Mean/Median/Mode)	Min. and max. no. of assessed tasks[7]
Assessed essay titles	22	1.5/0/0	0-10
Questions in exam papers	26	1/0/0	0-5
Dissertation topics	25	4/3/3	0-8

Among the three different academic tasks included in the survey question, there were more assessed essay titles, on average, which covered alcohol and other drugs than questions in exam papers or dissertation topics. There were few questions in exam papers reported. However, the unreliability of this data means that any interpretation must be done with caution.

2.7.3 Priority given to AOD teaching

Respondents were asked if the priority given to AOD teaching on their QSWP was 'too high', 'too low' or 'about right'. Fifty-seven of 63 respondents answered the question, none of which reported that the priority was 'too high'. Of these 57, 42 (74%) felt the priority was 'too low' and the remainder (n=15, 26%) felt that the priority is 'just right'.

Analysis of priority of teaching on AOD by faculty type provided some interesting trends, although a bi-variate analysis with Chi-square could not reliably be undertaken due to insufficient numbers within each grouping. A higher percentage of respondents from programmes located within a health (n=7, 27%) or health and social sciences (n=11, 42%) faculty/department reported that the priority given to teaching about AOD was too low, as compared with respondents from social sciences faculty (n=4, 15%); education (n=1, 4%); social work (n=1, 4%); or other (n=2, 8%). However, given the low numbers available for analysis, it is not possible to know whether this trend is real.

[7] One university reported that there were 100 assessed essay titles included AOD issues; it was thought that in light of other responses, this question may have been interpreted incorrectly. We therefore treated it as an outlier and excluded it from this analysis.

In the free text space which allowed additional comment, 19 individual respondents provided some further commentary about the priority accorded alcohol and other drugs in their programme. Over half of these (n=10, 52%) stated that the curriculum was currently under review and that they anticipated incorporating teaching on alcohol and other drugs in the future.

> *As we are developing a new programme for validation in 2013 we have prioritised this area for curriculum development.*

Six respondents (32%) mentioned that teaching on alcohol and other drugs competed against other areas for attention in the curriculum, for example:

> *Although I do think this is not an area which is given sufficient priority I think the same is true of a range of other issues. As the curriculum becomes increasingly prescribed and constrained it becomes increasingly difficult to focus on particular issues.*

Another participant shared this sentiment, identifying child protection as the primary driver of curriculum design:

> *The compulsory curriculum for social workers as currently shaped contains a lot of competing priorities, and public concerns about child protection often seem to drive the agenda of curriculum design.*

One participant drew attention to how embedded teaching on AODs was in their curriculum:

> *(University) has a long history of specialist modules on drug and alcohol use on both programmes.*

Another participant highlighted the importance of practice learning opportunities and illustrates how gaps in education may be filled through PLOs:

> *Whilst [AOD teaching] does not form a part of the academic curriculum (...other areas are left out also) many of our students are placed in such placement settings with some training provided.*

2.7.4 Future plans for AOD teaching – extent and delivery

Respondents were asked if they were planning to change the amount of teaching on AODs in the near future and, if so, to indicate whether they would be reducing the amount, 'maintaining the status quo', or increasing the amount of teaching. Fifty-three out of 63 programmes responded, and none said they would be reducing the amount of teaching. Thirty-four (64%) of these reported that they would be increasing the amount while the remainder stated they would maintain the current level (n=19, 36%).

A follow on question asked respondents whether or not they would make this training compulsory if they were to increase it in future years, and of the 51 who responded to this question, 32 (63%) said that they would make it compulsory, thus, there seems to be some support among the participants for this area of education.

Further, respondents were asked to name where in the curriculum the training would sit if it were to be increased. Twenty-nine respondents provided detail, and the table below illustrates the areas mentioned. Respondents were primarily unsure where it would sit, or felt that it would be integrated across a range of modules throughout the curriculum.

Table 2.20: Possible location of training on AOD within curriculum in future

	Number
Across modules/integrated throughout curriculum	8
Don't know/unsure	8
Within specific modules (e.g. Adults module, Mental Health Module, CYP and Families module, and a Working with People module)	4
Stand alone module	2
Extending current provision (but no clear detail)	2
Provided in year 2	2
Provided in year 1	1
Service User Groups	1
Practice skills training days	1

Finally, respondents were asked to name who would deliver this training if it were to be increased in the future. A majority said it would be delivered in partnership and by a mix of people including in-house social work academic staff, practitioners, specialist agencies, service users, and care workers. A further 10 said it would be delivered by academic staff, and noted that they would draw on colleagues with special interest and/or experience in the area. Nine said that it would be commissioned in by external agencies or specialists/ practitioners, with a few noting that the academic staff lacked the knowledge in this area to provide this teaching. Several were unsure who would deliver the teaching, and one noted that the QSWP was being discontinued so did not provide a further response.

Table 2.21: Who would deliver AOD training if it was increased

	Number
Mixture of stakeholders	12
In house social work academic staff	10
By external agencies or specialists/practitioners	9
Don't know/Unsure	2
Course is being discontinued	1

In the free text box which allowed respondents to add thoughts and comments on the topic of increasing the level of AOD teaching, 16 respondents provided some observation. Seven reported that they were currently undergoing review or restructuring and therefore definitive answers about the future of teaching on drugs and alcohol were difficult to

produce. A number stated that the inclusion of alcohol and drug education was being considered or increased in the new social work curriculum:

> *We are conscious that the current programme does not offer sufficient specific coverage of drug & alcohol issues, particularly regarding how these issues link into other relevant issues such as mental health, child protection, domestic violence and physical health. Our programme is currently undergoing a periodic course review and this area is one which we hope to address during this review.*
>
> *We are currently revising the curriculum of the social work degree in light of the reform board recommendations and we have identified problematic substance use as a priority area (along with mental health) for developing within the curriculum- so it will feature much more strongly in the new curriculum. We will ensure that all students get input in this area.*
>
> *We are currently revising our programmes. Alcohol and drug use is a valued and central element of the programme that will be retained and potentially expanded/be increasingly integrated*

Other respondents spoke of retaining an integrated approach to teaching AODs or moving towards integration.

> *We are engaged upon course re-approval in order to respond to the new requirements, and I envisage that we will retain the "embedded" approach (ie that the topic sits within other modules on each of the three years of the degree) but with greater prescription of what elements of the topic are delivered.*
>
> *The revalidated programme due to start in 2013 will take a more integrated approach to issues around substance use.*

2.7.5 Barriers and enablers

A free text box was included which asked respondents to provide detail of any barriers and enablers to the provision of teaching on alcohol and other drugs. Twenty-six respondents provided some information about this. Only two of these respondents mentioned enablers; the remainder mentioned only barriers. Four simply said there was no priority given to this area of teaching, without further elaboration.

One theme dominated the responses related to barriers, and was mentioned by 17 of the 26 respondents (65%). These respondents cited time and space pressures on the curriculum as reducing capacity to address alcohol and other drugs. The following quotes capture the overwhelming sentiment:

> *….there is a great deal of functional pressure on the curriculum with many competing priorities, and the challenge is to arrive at a course design that makes sense to the student experience whilst also meeting the many requirements.*

As with all areas of study it is a question of balancing competing priorities

Barriers of space in the curriculum to address a range of areas. Squeeze on curriculum time is always an issue (not just re drugs and alcohol).

One other respondent said that the barrier for their programme was the small core team delivering the curriculum, none of which specialise in this area. However, despite this challenge, the respondent described how his team overcomes the lack of in-house expertise by utilising the knowledge of other colleagues:

A small core team of permanent social work staff that has not included a [substance use] specialist for 3 years. However we are able to draw on a colleague with specialist knowledge who is well-placed to draw in specialist practitioners. The units are highly regarded by students.

Two further respondents noted that the challenge was the changing curriculum, with one of these also noting that it is their programmes' reliance on an external agency that determines their capacity to deliver training on AODs:

Along with the rest of the country we are having to revalidate our curriculum. We are clear that we need to at least maintain our current input on substance misuse. We are also reliant on our local DAAT to provide our two workshop days – if their funding is cut and they are no longer able to provide this for us, this would be a significant difficulty for us.

One final respondent mentioned problems in the payment system to service users, although they provided no further detail about what created problems for them. The implication is that such problems prohibit the involvement of service users in AOD use education.

Difficulties with payments for service users now preclude that addition to the discussion.

The final two respondents who provided some information in this section mentioned the things that enabled attention to alcohol and other drugs in the curriculum. One pointed out the advantage of having a research focus on alcohol and other drugs within the faculty/ department:

An enabler is the research activity conducted by members of the department.

The other respondent highlighted the growing focus on mental health issues more widely in social work, but also noted that interest and priority must be high within the team to ensure good provision of training on this subject:

Main enabler is the identification by [the] Reform Board that mental health issues in general need to be prioritised in social work education plus strong sentiment within team and stakeholders that it is a priority.

Summary of key findings (Part 3): Practice learning, assessed work and teaching strategy

- Among the 19 universities that provided data, there were 110 PLOs in AOD agencies during the academic year 2011-2012. The trend within this small sample appears to be greater numbers of PLOs in specialist agencies that work with both alcohol and other drugs, rather than alcohol only or other drugs only.
- Few respondents formally assessed student learning on AOD-related issues.
- Programme leads were often not aware of whether or not colleagues included AOD content in their teaching.
- The priority given to AOD teaching was considered to be too low by almost three quarters of the respondents. No respondents thought it was too high.
- Of those who responded (n=53), 34 programmes (64%) stated they would increase the amount of AOD teaching in the future, the remainder stated it would stay the same.
- Respondents cited time and space pressures on the curriculum as the main barrier for the inclusion of AOD education.

2.8 Feedback from the Knowledge Exchange Event

As mentioned on page 5, the Knowledge Exchange event was held towards the end of the project. Through the presentation of some preliminary findings to an invited group of social work professionals, the aim was to engage in a dialogue about the findings as well as their wider experience of AOD use education, training and practice. The dialogue would help to inform, and potentially refine, our analysis and planned outputs.

The first of the two group exercises that formed part of the event were tailored towards engaging the group with the findings for each strand. Questions for this strand asked people to discuss:

- estimates of the number of QSWPs providing input on AODs,
- what they anticipated would be the most common form of delivery, ie. sessions, modules or integrated,
- the average number of hours of teaching on AOD use,
- the AOD topics covered most and least (from a given list),
- who delivers most AOD teaching on QSWPs.

There was overall an expectation of very low numbers of QSWPs providing education relating to AOD use with '10% or lower' the figure cited. Some felt it would be higher as our respondents were likely to be those who were doing something already. However none anticipated the far higher levels of coverage claimed by the respondents to the survey (94%). There was agreement that it would not be a priority in social work education and that any coverage within the curriculum was more likely to be integrated and less likely to provide adequate quality and depth. This certainly seems to be borne out by the survey findings.

Specialist services were considered to be the main people delivering the training with only minimal amounts of service user or carer involvement. This reflected the findings although nobody considered social work programme staff as the main group delivering the teaching. One participant suggested that a current specialist practitioner should be employed to teach on AOD use in different areas of the qualifying social work programme. What and how many hours were delivered was felt to vary across the country with an overall sense that it was minimal ranging from two hours to half a day. Few full modules were anticipated. Again this was reasonably accurate although 12 programmes responding to our survey delivered full modules.

While participants pointed out that not all subjects could be covered in the preferred depth, they felt that illegal drugs, attitudes and values, the reasons people use and the impact of AODs on parenting would be among the most covered and that harm reduction and more practical skills, including talking to people about AOD use, would be among the lowest. Some people also discussed the need for more practical skills (generally but also specifically in relation to AOD use), including assessment questions, and issues around age and gender in preference to less theory-based education. It was felt by some people that the current context of limited resources and increased targets left people with little time to ask

questions about AOD use and joint training between children's and adults' services was identified as a further need.

The second of the two exercises followed the presentation of, and discussion about, the preliminary findings by the research team. It asked people to identify some solutions and good practice for addressing AOD use in social work education. General points were raised about helping those who are newly qualified to be critical learners as well as having clarity on what we expect them to know and relate to their practice. Despite guidance on not focussing on barriers, a further general point also echoed by the findings is the difficulty social work educators have in creating space on the social work programme to include the topic and the need, in its absence, to identify transferable skills.

Practice learning opportunities within AOD use agencies were seen as a valuable way of learning and reciprocal free training with the local Drug and Alcohol Action Team were seen as positive solutions. There was a note of caution about social workers adopting uncritical medical model approaches from some specialist agencies however. Some people felt there was duplication between local authority training departments and social work education in terms of delivering basic AOD use awareness, especially in the assessed year in employment post qualifying. People felt this duplication could be reduced and there was scope for greater working together. A service level agreement was suggested although potential difficulties around cost sharing were noted. Another suggestion was developing an 'App' (an piece of software or 'application' for use on mobile phones) relating to AODs for social workers.

A final common theme was the need for social workers to take more responsibility for their own learning on the subject supported by supervision. It was felt that social work education should not be expected to do it all.

2.9 Discussion

The survey data has four main limitations. First the data relate to only 40% of all QSWPs and non-response bias is likely to be present. However, 40% is a healthy rate of return for online surveys, particularly compared to paper based surveys (Nulty 2008, Sax *et al*. 2003). Further, as the comparison of responders and non-responders showed there were no significant differences between the groups on several key variables. Second, data analysis revealed significant amounts of missing data for some questions. The missing data primarily relates to questions that asked programme leaders for detail on student numbers or further detail of taught content and relevant assessments. It is clear from the responses that many programme leaders do not have detailed knowledge in terms of student numbers taking modules, hours of input or type of content covered on a particular topic as the following comments show:

> *Impossible to answer as I have not attended this teaching session for several years: I would expect most of the identified areas to be covered.*

> *As we do not have a specific unit on D & A it is up to individual lecturers to include the issues as relevant within their units and so it would be unit leads not course leads who could comment specifically.*

Respondents may have discussed their responses with other colleagues, others may have provided estimates or best guesses, some just did not know. As a result one particular question about the number of students who received AOD teaching across the year groups resulted in such limited and poor quality data that it could not be analysed further. To improve data reliability would require a survey of all social work academics and placement learning coordinators within every social work qualifying programme in England. This would require a very large and more resource intensive study.

Third, the data are self-reported data and are limited by a lack of triangulation in this particular study. However previous research by the authors with new (Galvani and Forrester 2011) and experienced social workers in practice (Galvani *et al*. 2011) provide additional resources from which to contextualise these data.

Fourth, the survey took place during a major period of reform in social work education and practice (TCSW 2012). QSWPs are restructuring and revalidating their social work programmes for the third time in 10 years. A considerable amount of time and effort is absorbed in the regulation processes for the new regulating body, Health and Care Professions Council, as well as ensuring programmes adhere to new Standards of Proficiency (HCPC 2012) and the new Professional Capabilities Framework (TCSW undated). This is likely to have created both time pressures and uncertainty about future programme content. While we focussed on the previous years' qualifying education, both factors could have had potentially negative effects on response rate and accuracy.

Nonetheless the findings of this study make a significant contribution to the evidence base. This survey is only the second of its kind in the UK and has been conducted 24 years after the original study in 1989 by Harrison (1992). The earlier study was UK wide and received a higher return rate, with 74% (n=59) of the 80 Higher Education Institutions (HEIs)

responding compared to 52% (n=41) of 79 universities in this survey. However, since Harrison's survey, the number of social work programmes has almost doubled even though the number of universities running social work programmes has not. This gives some indication of the increased demand for social workers and social work training in the intervening years and increasing pressures on programme delivery.

The majority of respondents to Harrison's study (89%) stated they were providing some formal training on alcohol and drugs with large variations in the amount of training provided. More than 20 years on, and in spite of AOD use being higher on national policy agendas, the current study found similar results. It is a positive finding that 94% of our respondents reported AOD use education of some kind. It appears that qualifying social work education is attempting to include AOD use as part of the curriculum. However, as Harrison found, there was a large range in both the hours spent on AOD use education and the topic content it included.

The variation in what is being offered suggests a lack of consistency across qualifying social work education in relation to AOD use education. It raises questions about whether or not the flexibility social work programmes have to choose course content always meets the needs of social workers and their service user groups. Social work education is guided by broad capability frameworks (TCSW undated) and some core subject benchmarks (QAA 2008) and requirements (DH 2002). However, there is no standardisation of subject content within social work programmes. Under the current revised frameworks for social work education this is unlikely to change. While we do not suggest that there is a 'one size fits all' approach to AOD education, there need to be minimum requirements for all social workers in terms of subject knowledge and skills. This learning needs to be developed with specialist pathway teaching and/or post qualifying education. TCSW guidance on reforming the social work curriculum includes "Substance misuse and addictions" in a list of topics which, it states, QSWPs "must" teach their students (TCSW 2012). It has also issued newly developed curriculum guidance documents, one of which focuses on AOD use (Galvani 2012). However, both are guidance documents only and do not make AOD education compulsory or any ways standardised. Similar guidance was provided to all QSWPs in 1992 by the Central Council for the Education and Training of Social Workers (CCETSW), the body governing social work programmes at that time (CCETSW 1992). That guidance failed to have any impact in increasing AOD education across qualifying social work education as these data show. At qualifying level, the aim must be to support social work practitioners to be comfortable and confident when talking to people about their AOD use. Asking about AOD use and handling responses in the right way are essential skills, regardless of the individual social worker's future specialist area of practice.

Arguments for the prescription of social work programme content to ensure consistency of training and a shared knowledge base have repeatedly been dismissed in successive Government reforms of social work education. They have been countered with arguments about responding to local need and allowing scope for specialist areas of practice. While this argument is powerful, it results in 'newer' subjects, such as AOD use, being overlooked as they are often less familiar to those delivering social work courses. This was evident in some of our findings about who facilitated and delivered AOD education on QSWPs. Further, social work curricula are often influenced by staff expertise and research interests and,

given the marginality of AOD use in the profession, there is rarely adequate expertise among social work staff. Previous research by the author and colleagues found that almost a third of social workers reported no training on AOD use during their qualifying training (Galvani *et al*. 2011). Those in wider social care roles fared even worse. Importantly the previous survey also found significant rates of AOD use on the caseloads of both adults' and children's social workers, and social workers who were attempting to address AOD use issues in practice without any formal guidance. Given that AOD use is an issue that cuts across all service user groups and is a key issue in relation to safeguarding concerns (Brandon *et al*. 2010), it seems untenable for it to remain an optional topic for inclusion within qualifying social work curricula. This is not an English problem alone. Studies from the USA have also found low rates of AOD use education on social work programmes (Decker *et al*. 2005, Quinn 2010, Smith *et al*. 2006) leading to accusations of "institutional denial or minimization" (Quinn 2010:8).

Harrison's survey also identified different delivery structures which he defined as "core teaching" (mandatory) or "electives" (optional). Within this study we differentiated between *specialist modules*, *specialist sessions,* and AOD use teaching that was *integrated* into other modules and asked whether they were compulsory or elective. The majority of our respondents (n=56) integrated AOD use education into other modules (n=111) and all but one was compulsory. This suggests that, when AOD use is taught, it is seen as an issue that is relevant to a range of practice areas as well as to skills-based learning and preparation for practice. This was reflected in the range of modules that teaching on AOD use was reported to be integrated into.

However, further analysis of topic coverage in the various delivery structures shows that modules that integrated teaching on AODs covered very few of the topics listed. It is possible that the programme leads responding to the survey simply did not know. But if it is an accurate reflection of topic coverage, it raises a fundamental question about whether the integrated AOD education reported is focussed on AOD use in a meaningful way or whether it is being referred to 'in passing', for example, as one of a number of risk factors in someone's deteriorating mental health or parenting capacity. In sum, integrated teaching was the most widespread delivery mechanism for the inclusion of AOD in the curriculum but it remains unclear what topics are being included and to what depth. It is possible that a little is being taught very well or a lot is being taught very poorly. Future research needs to move beyond the headlines identified in this study and explore the quality of the AOD education.

Perhaps unsurprisingly, the delivery structure had an impact on what was being delivered. Where QSWPs committed to specialist AOD use sessions or modules, there appeared to be more and greater depth of AOD use education throughout the programmes. Specialist modules and sessions were nearly always accompanied by integrated teaching. This suggests a greater awareness of, or commitment to, engaging with subject throughout the programme. However only 12 programmes had specialist modules and we know from the findings that the most common route for AOD education delivery was a combination of sessions and integrated teaching. The data on topic coverage and content for both of these routes raised questions about the quality and depth of the teaching.

Given the comments about the lack of space in the curriculum from academics at the knowledge exchange event and via the open questions in the survey, it is possible that, a number of modules are being run consecutively and students elect which to attend. Nonetheless, the majority of both specialist sessions and modules were compulsory although the majority of specialist sessions and almost half specialist modules have been more recently introduced to the social work qualifying programmes with three modules being described by respondents as "new". This suggests an improvement in some programmes in recent years and it will be interesting to note whether it signals a move more generally to include AOD education on social work programmes.

While Harrison (1992) asked about the objectives of AOD education, this study sought greater detail in terms of topic coverage across the three forms of teaching delivery. There were some similarities in that attitudes and values, reasons people use and misuse, impact on physical and mental health, impact on C&F and parenting, Government policy, and how to assess risk around AOD use, tended to be covered by approximately half or more of respondents regardless of mode of delivery. Given the centrality in social work training of ethics and values and managing risk - particularly to children - it is perhaps not surprising to see those subjects there. It suggests that attitudinal issues and reflections on people's lives and what leads to contact with services have been extended to include AOD use. Similarly there were common topic areas *least covered* by all modes of delivery including gender differences, ethnicity and culture in relation to AOD use, prescribed drug use, and identifying problematic drug use. Gender and ethnic differences relating to AOD use are clearly important as professionals must be sensitive to how such differences impact on assessment and intervention. Further there was a clear lack of input around prescribed drugs which is an important topic given the increasing numbers of older people with alcohol problems who may be on prescribed medication (Gossop 2008) as well as the already high numbers of people who live with mental distress and use substances (Needham 2007) and are likely to be prescribed medication.

Topic coverage was more extensive among the specialist modules/units followed by specialist sessions. However, this survey was not designed to collect information on the quality of AOD education delivered. While on the surface it appears that most specialist modules and sessions are covering the topic in more depth than others, it could be that the coverage is limited and that those covering fewer topics may be doing so in greater depth. Covering more is not automatically a better learning experience.

Specialist modules reported a mean of 20 hours of teaching input and an average of 16 topics were covered (range 9-19 topics) in that time. While this seems somewhat reasonable, this study largely found a disconnect between what was being taught and the amount of time it was being taught in for all forms of delivery. This was also a finding from Harrison's study in 1992. We assumed that covering two topics in one hour's input allowed for introductory topic coverage at least. The hours and topic coverage were reviewed on this basis. One module reported covering 17 topics in two hours; another reported covering 16 topics in six hours. Similarly, out of the 43 specialist sessions, 25 of them claimed to cover far too many topics for the time available, for example, several programmes reported one hour sessions covering 10-14 of the 19 topics on our list. A further five were also borderline for including too much in too little time, for example, seven hours of teaching covering 13

topics. This left 21 of the 43 sessions appearing to provide reasonable topic coverage. While firm conclusions cannot be drawn about the quality or depth of coverage of these topics the figures suggest that the information being supplied is not reliable, or the topics are not being covered in any depth. While the lower end of the range of topics is feasible within the average hours of teaching in each delivery structure, the higher end of the range, particularly for specialist sessions and integrated teachings seems rather a lot. In sum, the reliability of this data is questionable – it is difficult to know whether that is about respondents' ignorance of topic coverage being replaced with a 'best guess' or whether it is respondents wanting to appear to be covering the topic for the purpose of the survey.

It was positive that social work academics were involving external agencies to deliver – and to a lesser degree facilitate - AOD education where the expertise was not available within the team. AOD use services including local Drug and Alcohol Action Teams have increasingly been offering free training to social work practitioners and their local universities. In many ways this demonstrates good practice in working across disciplinary boundaries, seeking ways to fill the knowledge gaps of internal staff, and students often enjoy most the sessions delivered by people in practice and service users/carers. It also demonstrates that basic training does not need to drain departmental budgets and can be developed collaboratively between a partnership of academic colleagues (bringing the social work context), the practice expertise of specialists, and the first hand experience of service users and carers. Resources commissioned by the Higher Education Academy Subject Centre for Social Policy and Social Work (Galvani 2009a-e) are available to academics to support them in working alongside service users and practitioners in developing social work education on AOD use.

As with Harrison's study (1992) respondents were asked whether AOD topics were included in formal assessment activity including dissertations, essay titles or exam questions. Very few responses were received and many of them reported not knowing so the data must be treated cautiously. However indications are that the rates of assessed work were far lower than Harrison's 1989 study in which 50% of respondents stated they had some kind of formal assessment on the topic. While formal assessment is not the only measure of the importance placed on a particular area of study, it goes some way to demonstrating the commitment of the programme to a baseline of learning on, and application of, a topic.

Interestingly what was agreed among almost three quarters of respondents was that the priority given to AOD education was too low with the remainder feeling it was about right. This may suggest that this group of respondents is particularly invested in the topic with many commenting that current changes and reforms provide an opportunity to include teaching in this area. This more positive perspective was tempered with the usual concerns about finding time and space in the curriculum.

2.10 Implications and recommendations for social work education

1. AOD use needs to be a part of all social work qualifying curricula and given greater priority within it. While initial findings appeared positive in terms of AOD education, subsequent analysis showed huge variation in terms of what was being taught and how.
2. There are a range of delivery structures available for AOD use education – one size does not fit all. While space on the curriculum is a perceived barrier, many programmes appear to be managing to include AOD education.
3. Quality not quantity is important; breadth of topic coverage needs to be balanced with the depth and quality of learning experience.
4. Where specialist AOD modules or sessions were in place there appeared to be a greater degree of commitment throughout the programme.
5. Greater use of assessed work in relation to AOD education is needed to reinforce its importance within the curriculum and social work practice.
6. QSWPs need to establish basic AOD education that cuts across all service user groups and is a core part of qualifying education, with additional, more specialist, training in elective specialist pathways and at post qualifying levels.
7. As a basic requirement, social workers need to know the effects of AODs, how to talk about AOD use with a range of service users and how to work with, and refer on to, specialist services. These basic requirements need to take account of gender and ethnicity differences in the assessment and intervention process. Knowing the impact of AOD use is helpful but knowing what to do about it is more so – particularly for the service user. In particular understanding behaviour change has wider applications than AOD use.
8. There needs to be closer monitoring of qualifying course content at a local and national level in order for colleagues to fill gaps and avoid duplication. The current systems provide an unwieldy framework in which academics have very little idea about what is taught in each others' modules.
9. The quality of what is being delivered and how needs to be assessed both internally and through independent evaluation.
10. The current social work reforms offer the opportunity to change the curricula. Guidance is available and does not require funding or in-house expertise. They also offer the opportunity for joined up planning of AOD education with LA workforce development colleagues and specialist agencies.
11. QSWPs should give consideration to recruiting future social work academics with a background, expertise, or interest in AOD use.

2.11 Implications for research

1. Given that integrated teaching is the most common delivery structure for AOD education, research is needed that that unpicks what is being taught and how it is being integrated into the curricula. This would involve obtaining accurate data from those who deliver each module rather than programme leads.
2. Further research is needed that explores the quality of AOD education on QSWPs. This could include a small sample of QSWPs delivering AOD education using a range of delivery structures.

3. A clear research need is to explore the effectiveness of social work education on AOD use in relation to social workers practice and to determine whether different modes of delivery play a role in how effective it is.
4. A further gap in the research is determining what is currently being taught as part of post qualifying social work education. This needs careful planning given the large range of widely accessible training that qualifies as PQ education.
5. Given we are in a time of social work education and practice reform, a future survey of this kind will determine whether any changes have been made.

2.12 Conclusion

This research set out to determine the nature and extent of AOD use education within qualifying social work programmes in England. Of the 40% of social work programmes that responded, it is heartening that nearly all of them stated that AOD use education featured within their programmes. It is possible that the same applies for the 60% who did not respond but given previous evidence from social workers (Galvani *et al*. 2011), there may be a significant number of programmes that do not include AOD use education at all. However the initial euphoria was short lived. Of those who responded, few ran specialist modules or units in AOD use with the majority integrating AOD use education into other teaching modules or running a combination of specialist teaching sessions and integrated teaching. While it could be argued that something is better than nothing, further analysis showed that topic coverage is extremely limited on the integrated teaching route and the depth and quality of the AOD use content is called into question. There was very little formal assessment and the majority of respondents felt that AOD education was currently too limited. Importantly many respondents (programme leaders) had little knowledge of exactly what was being covered and by whom. On a wider level this raises concerns about an education system that is unable to monitor what is actually being taught within its programmes.

Current social work education and reform offers the opportunity for change although mandating course content has been ruled out by the College of Social Work (McNicholl 2013). As AOD use has been identified as an area of educational need for all social workers (TCSW 2012), it is hopeful that in future social work education may prepare its practitioners appropriately for working with the AOD use issues their service users present with. Further, as Health and Wellbeing Boards bring health and social care closer together structurally, there is an opportunity for in-house and post qualifying social work education to pick up where qualifying education leaves off and support its social workers to provide the informed service its service users deserve.

References

Brandon, M., Bailey, S. and Belderson, P. (2010) *Building on the learning from serious case reviews: A two-year analysis of child protection database notifications 2007-2009*. Available online at: https://www.education.gov.uk/publications/eOrderingDownload/DFE-RR040.pdf [accessed 18 August 2011]

Central Council for Education and Training in Social Work (1992) *Substance Misuse: Guidance Notes for the Diploma in Social Work*. London: CCETSW

Decker, J., Brenner, M. and Murtagh, M. (2005) 'Are Baccalaureate Level Social Workers Who Graduate from Accredited BSW Programs Prepared to Enter into Positions Working in Alcohol and Other Drug Treatment Programs?' *Journal of Social Work in Disability & Rehabilitation,* 4 (3), 25-38

Department of Health (2002) *Requirements for social work training.* Available online at: http://cdn.basw.co.uk/upload/basw_40833-3.pdf [accessed 26 February 2013]

Galvani, S. (2009a) *Learning and teaching digest: integrating substance use teaching into the social work curriculum*, London, SWAP.

Galvani, S. (2009b) *Helpsheet: involving alcohol and other drug specialists in social work education*, London, SWAP.

Galvani, S. (2009c) *Information sheet: domestic violence and substance use in the social work curriculum*, London, SWAP.

Galvani, S. (2009d) *Information sheet: Key resources for teaching substance use*, London, SWAP.

Galvani, S. (2009e) *Case studies: teaching substance use in social work education*, London, SWAP.

Galvani, S. (2012) Curriculum Guidance: Substance use. London: TCSW. Available online at: http://www.collegeofsocialwork.org/uploadedFiles/TheCollege/Media_centre/Curriculum%20Guide_Substance_17July2012_proofed.pdf

Galvani, S., Allnock, D., Dance, C. and Hutchinson, A. (2013) *Building Capacity, Bridging Gaps: Alcohol and other drugs in social care practice, education and employment-based training. Summary report: Strands 1-3*. Report to Funder. Luton: University of Bedfordshire

Galvani, S., Dance, C. and Hutchinson, A. (2011) *From the front line: alcohol, drugs and social care practice. A national study*. Luton: University of Bedfordshire.

Galvani, S. and Forrester, D. (2011) 'How well prepared are newly qualified social workers for working with substance use issues? Findings from a national survey.' Social Work Education, 30: 4, 422-439

Gossop, M. (2008) *Substance Use among Older Adults: A Neglected Problem*. Drugs in focus, no. 18. Briefing of the European Monitoring Centre for Drugs and Drug Addiction. Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

H.C.P.C. (Health and Care Professions Council) (2012) *Social Workers in England: Standards of Proficiency*. Available at: http://www.hpc-uk.org/assets/documents/10003B08Standardsofproficiency-SocialworkersinEngland.pdf [accessed 22 March 2013]

Harrison, L. (1992) 'Substance misuse and social work qualifying in the British Isles: A survey of CQSW courses', *British Journal of Addiction*, 87, pp. 635–42.

McNicholl, A. (2013) 'Social workers need compulsory substance use training, say experts.' *Community Care,* 26 February. Available online at:

http://www.communitycare.co.uk/articles/27/02/2013/118960/social-workers-need-compulsory-substance-misuse-training-say.htm?cmpid=NLC|SCSC|SCDDB-20130227-GLOB|news [accessed 26 February 2013]

Needham, M. (2007) *Changing Habits. North West Dual Diagnosis Intelligence Report. Informing the Commissioning, Management and Provision of Integrated Service Provision for Dual Diagnosis Treatment Populations. Emerging Findings — Access to Mental Health Treatment for Adults with Substance and/or Alcohol Misuse Problems Part of the CSIP National Dual Diagnosis Programme*. Hyde, Cheshire: North West CSIP

Nulty, D. (2008) 'The adequacy of response rates to online and paper surveys: what can be done?' *Assessment & Evaluation in Higher Education,* 33 (3), 301–314.

Quinn, G. (2010) 'Institutional denial or minimization: substance abuse training in social work education.' *Substance Abuse: Official Publication Of The Association For Medical Education And Research In Substance Abuse*. 31(1), 8-11

Sax, L.J., Gilmartin, S.K. and Bryant, A.N. (2003) 'Assessing Response Rates and Nonresponse Bias in Web and Paper Surveys.' *Research in Higher Education*, 44(4), 409-432

Smith, M.J.W., Whitaker, T. and Weismiller, T. (2006) 'Social Workers in the Substance Abuse Treatment Field: A Snapshot of Service Activities.' *Health & Social Work*, 31 (2): 109-115

The College of Social Work (2012) *Reforming social work qualifying education. The social work degree.* Available online at: http://www.collegeofsocialwork.org/uploadedFiles/TheCollege/_CollegeLibrary/Reform_resources/Refo rmingSWQualifyingEducation%28edref1%29%281%29.pdf [accessed 26 February 2013]

The College of Social Work (undated) *Guidance for the application of the generic Professional Capabilities Framework (PCF) to ensure learning covers all ages and service user groups*. Available online at: http://www.collegeofsocialwork.org/uploadedFiles/TheCollege/_CollegeLibrary/Reform_resources/GuidanceProfessionalCapabilitiesFramework%28edref3%29.pdf [accessed 26 February 2013]

Whitaker, S. (2004) 'Hidden learning disability.' *British Journal of Learning Disabilities,* 32(1), 39–43.

Appendix 1 – Qualifying Social Work Education Survey

1) What is the name of your institution?
2) What is your name?
3) What is your job title and area of responsibility? E.g. Senior Lecturer and Programme Leader for undergraduate and postgraduate courses.
4) What are the names of your qualifying social work courses? e.g. BA Social Work or MA Social Work and Nursing.
5) In what type of faculty/department do your qualifying social work courses sit?
    - Social sciences;
    - Health;
    - Health and Social Sciences;
    - Other (Please specify).
6) Do your courses run part- or full-time?
    - Full time
    - Part time
    - Both
7) If you are not responsible for all the above part- and full-time routes, please provide the relevant name(s) and email(s) of the appropriate staff and we will contact them separately.
8) During the academic year 2011-2012, how many students were enrolled on your qualifying social work courses?

We are now going to ask you about how you deliver any drug and alcohol education within your qualifying programme. We will ask you about three main delivery routes: 1. Through standalone sessions that sit outside of modules/units (e.g. this may take the form of one-off practice workshops). 2. Through a module or unit focused on alcohol or drug education. 3. Through the integration of teaching on alcohol and other drugs into other modules/units (e.g. teaching within a skills module or within a children and families pathway or unit). More than one of these options may be relevant to you; we will therefore ask you about each option in turn.

9) Do you provide a standalone specialist session(s) concerned solely with alcohol and/or drugs in your qualifying social work courses?
    - Yes
    - No.

This section asks a series of questions about your standalone specialist sessions on alcohol and other drugs. We realise that you may offer more than one session so we have provided space for you to tell us about all of them.

10) For historical reasons, education in alcohol and other drugs have developed in separate ways. Does your standalone specialist session(s) combine these issues or provide separate teaching on each?
    - Separate teaching
    - Teaching is combined
11) What is the name of the standalone specialist session(s) on alcohol and other drugs in your qualifying social work courses? We realise that you may offer more than one session so we have provided space for you to tell us about all of them. The names of your sessions will be carried through to the other questions in this section.
12) What is the credit value of the standalone specialist session(s) on alcohol and other drugs? If your session(s) is not assigned any credits but contributes to credits for other modules, please insert an X into the box.

13) Is the standalone specialist session(s) on alcohol and other drugs offered on either the UG or PG qualifying routes, or both? (Please tick all those that apply.)
    - UG route
    - PG route
    - Both
14) Who facilitates/coordinates the stand alone specialist session(s) on alcohol and other drugs? (Please tick all those that apply.)
    - Members of social work teaching staff;
    - External agency/consultants;
    - Member of staff from another department;
    - Service users and carers;
    - Other.
15) Who delivers the stand alone specialist session(s) on alcohol and other drugs? (Please tick all that apply)
    - Members of social work teaching staff;
    - External agency/consultants;
    - Member of staff from another department;
    - Service users and carers;
    - Other.
16) How long has your standalone specialist session(s) on alcohol and other drugs been running?
    - 1 year;
    - 2 years;
    - 3 years;
    - 4 years;
    - 5+ years;
    - Don't know.
17) In the stand alone specialist session(s), how many hours are spent on alcohol and/or other drug content within the following activities? If no hours are spent on alcohol and other drug content in any of the activities, please enter 0 into the box. Please indicate in the additional box if there are other activities you provide to students which include alcohol and other drug content and which we have not listed here. If you are unsure, please place 'DK' in the relevant boxes.
    - Lectures;
    - Seminars;
    - Skills workshops;
    - Other.

For each named session(s), please indicate if they cover any of the following topics (Please tick all that apply). If there are any topics not covered here, please tell us about them in the additional box provided.

- Alcohol and it's effects
- Identifying problematic alcohol use
- Illegal drugs and their effects
- Prescription drugs and their effects
- Identifying problematic drug use
- Reasons people use and misuse substances
- How to talk about alcohol and drug use
- How to assess risk relating to alcohol and drug use
- Impact on physical health
- Impact on mental health
- Impact to children and families and parenting

- Types of treatment/intervention available
- Substance use and issues of ethnicity and culture
- Gender differences in alcohol and drug use
- Working with or referring to specialist alcohol and/or drug workers
- Drug and alcohol government policy
- Substance misuse theory
- Other (Please specify)

18) Is the standalone specialist session(s) on alcohol and other drugs compulsory for students?
    - Yes
    - No
19) How many students in total received the stand alone specialist session(s) on alcohol and other drugs in the academic year 2011-2012?
20) If you offer a standalone specialist session(s) on alcohol and other drugs on both the UG and PG routes, are there any differences between the two routes? If so, could you briefly tell us about them here? For example, does course content differ; is there a difference in the amount of time spent on alcohol and other drugs; are students assessed in different ways?
21) Do you provide a specialist module/unit(s) on drugs and/or alcohol in your social work qualifying courses?
    - Yes
    - No
22) What is the name of the specialist module/unit(s) on alcohol and other drugs in your qualifying social work course?
23) What is the credit value for your specialist module/unit(s) on alcohol and other drugs?
24) Is the specialist module/unit(s) on alcohol and other drugs offered on UG or PG qualifying routes, or both?
    - UG route
    - PG route
    - Both
25) Who facilitates/coordinates the specialist module/unit(s) on alcohol and other drugs? (Tick all that apply)
    - Members of social work teaching staff;
    - External agency/consultants;
    - Member of staff from another department;
    - Service users and carers;
    - Other.
26) Who delivers the specialist module/unit(s) on alcohol and other drugs? (Tick all that apply)
    - Members of social work teaching staff;
    - External agency/consultants;
    - Member of staff from another department;
    - Service users and carers;
    - Other.
27) How long has your specialist module/unit(s) on alcohol and other drugs been running?
    - 1 year
    - 2 years
    - 3 years
    - 4 years
    - 5+ years
    - Don't know
28) How many hours are spent on alcohol and other drug content within the following module/unit(s) activities? If no hours are spent on drug and alcohol content in any of the

activities listed, please enter 0 into the box. Please indicate in the other box if there are other activities that you provide which include alcohol and other drug content. If you are unsure, place a 'DK' in the relevant boxes.

- Lectures
- Seminars;
- Skills workshops;
- Other.

29) Please indicate if your specialist module/unit(s) covers any of the following topics (Please tick all that apply). If there are other topics covered which are not listed here, please tell us about these in the 'other' box below.
    - Alcohol and it's effects
    - Identifying problematic alcohol use
    - Illegal drugs and their effects
    - Prescription drugs and their effects
    - Identifying problematic drug use
    - Reasons people use and misuse substances
    - How to talk about alcohol and drug use
    - How to assess risk relating to alcohol and drug use
    - Impact on physical health
    - Impact on mental health
    - Impact to children and families and parenting
    - Types of treatment/intervention available
    - Substance use and issues of ethnicity and culture
    - Gender differences in alcohol and drug use
    - Working with or referring to specialist alcohol and/or drug workers
    - Drug and alcohol government policy
    - Substance misuse theory
    - Other (Please specify)
30) Is the specialist module/unit(s) on alcohol and other drugs compulsory for students?
    - Yes
    - No
31) How many students in total received the specialist module/unit(s) on alcohol and other drugs in the academic year 2011-2012?
32) If you offer a specialist module/unit(s) on alcohol and other drugs on both the UG and PG routes, are there any differences between the two routes? If so, could you briefly tell us about them here? For example, does course content differ; is there a difference in the amount of time spent on alcohol and other drugs; are students assessed in different ways?
33) Are aspects of alcohol and drug education integrated into other teaching on your qualifying courses? For example, it may be integrated into other modules/units.
    - Yes
    - No
34) What is the name of the module/unit(s) that integrates teaching on alcohol and other drugs?
35) Is the module/unit(s) that integrates teaching on alcohol and other drugs offered on UG or PG qualifying routes, or both?
    - UG route
    - PG route
    - Both
36) What is the credit value of the module/unit(s) that integrates teaching on alcohol and other drugs?
37) Who facilitates/coordinates the integrated teaching on alcohol and other drugs? (Tick all that apply)

- Members of social work teaching staff;
- External agency/consultants;
- Member of staff from another department;
- Service users and carers;
- Other.

38) Who delivers the integrated teaching on alcohol and other drugs? (Tick all that apply)
    - Members of social work teaching staff;
    - External agency/consultants;
    - Member of staff from another department;
    - Service users and carers;
    - Other.
39) Is the module/unit(s) compulsory for students?
    - Yes
    - No
40) How many students receive this input?
41) Please indicate if your integrated alcohol and other drug teaching covers any of the following:
    - Alcohol and it's effects
    - Identifying problematic alcohol use
    - Illegal drugs and their effects
    - Prescription drugs and their effects
    - Identifying problematic drug use
    - Reasons people use and misuse substances
    - How to talk about alcohol and drug use
    - How to assess risk relating to alcohol and drug use
    - Impact on physical health
    - Impact on mental health
    - Impact to children and families and parenting
    - Types of treatment/intervention available
    - Substance use and issues of ethnicity and culture
    - Gender differences in alcohol and drug use
    - Working with or referring to specialist alcohol and/or drug workers
    - Drug and alcohol government policy
    - Substance misuse theory
    - Other (Please specify)

42) In the last academic year, how many students had practice learning opportunities in the specialist alcohol or drug teams or agencies: If none, please enter 0.
43) Please indicate how many dissertation topics, assessed essay titles, or questions in exam papers, included the topic of alcohol or other drugs in the last academic year. If none please enter 0 in the relevant boxes.
44) If there were exam or essay questions relating to alcohol and other drugs, were they compulsory?
    - Yes
    - No
45) If teaching on alcohol and other drugs is integrated into other modules on both your UG and PG routes, are there any differences between the two routes? If so, please briefly explain the differences here? For example, does course content differ; is there a difference in the amount of time spent on alcohol and other drugs; are students assessed in different ways?
46) Do you believe the priority attached to alcohol and other drug education in your courses is
    - About right

- Too high
- Too low

47) Are there any barriers or enablers within your qualifying course/programme(s) that impact on the delivery of substance use education?
48) In the near future, are you planning to:
    - Reduce the amount of substance use training;
    - Increase the amount of substance use training; or
    - Maintain the status quo
49) If you were to increase training on alcohol and other drugs, would it be compulsory? (as opposed to an elective/optional unit or module)
50) If you were to increase training on alcohol and other drugs, who would deliver it? Please specify, for example, social work faculty, another faculty such as psychiatry, outside partners
51) If you were to increase training on alcohol and other drugs, where in the curricula would it sit?
52) This survey has focused on qualifying social work programmes. We understand that there are many changes occurring to post-qualifying programmes at present: 1) Does your department/school offer a post-qualifying social work course and if so, what is it called? 2) To your knowledge does it include teaching on alcohol and other drugs? 3) Who is the course lead for the PQ programme (name and email please)?

Appendix 2 – Breakdown of Universities by type

Russell Group (n=15)

1 University of Birmingham (PG, FT)
2 University of Leeds (UG, FT)
3 University of Nottingham (PG, FT)
4 University of Sheffield (PG, FT)
5 University of York (PG, FT)
6 University of Birmingham (UG, FT)
7 University of Bristol
8 University of Durham
9 University of Leeds (PG, FT)
10 University of Sheffield (UG, FT)
11 University of York (UG, FT)
12 University of Manchester
13 University of Nottingham (UG, FT)
14 University of Southampton
15 University of Warwick

Other (n=38)

1 Brunel University (UG, PT)
2 Brunel University (PG, FT)
3 City Collge Norwich (UG, PT)
4 Goldsmith's College (PG, FT)
5 Havering College of H and FE (UG, PT)
6 Keele University (PG, FT)
7 Lancaster University (PG, FT)
8 New College Durham (PG, FT)
9 Stockport College (UG, PT)
10 University of Bradford (UG, PT)
11 University of Bradford (PG, FT)
12 University of East Anglia (PG, FT)
13 University of Hull (PG, FT)
14 University of Salford (PG, FT)
15 University of Salford (PG, PT)
16 University of Sussex (UG, PT)
17 University of Sussex (PG, FT)
18 City College Norwich (UG, FT)
19 Goldsmith's College (UG, FT)
20 Lancaster University (UG, FT)
21 Open University
22 Royal Holloway, University of London
23 University of East Anglia (UG, FT)
24 University of Hull (UG, FT)
25 University of Leicester
26 Bradford College (UG, FT)
27 Brunel University (UG, FT)
28 Havering College of H and FE (UG, FT)
29 Keele University (UG, FT)
30 Liverpool Community College
31 New College Durham (UG, FT)
32 Stockport College (UG, FT)
33 The University of Bath
34 University of Bradford (UG, FT)
35 University of Kent
36 The University of Salford (UG, FT)
37 University of Sussex
38 Wiltshire College

New universities (n=104)

1 Anglia Ruskin University (UG, FT)
2 Anglia Ruskin University (PG, PT)
3 Anglia Rusking University (PG, PT)
4 Bournemouth University (PG, FT)
5 Buckinghamshire New University (PG, FT)
6 Canterbury Christ Church University (PG, FT)
7 Canterbury Christ Church University (PG, PT)
8 Edge Hill (2nd)
9 Edge Hill (3rd)
10 Kingston University (UG, PT)
11 Kingston University (PG, FT)
12 Leeds Met (PG, FT)
13 Liverpool Hope University (PG, FT)
14 Liverpool John Moores University (PG, FT)
15 London Metropolitan University (UG, PT)
16 London Metropolitan University (PG, FT)
17 London South Bank University (UG, PT)
18 London South Bank University (PG, FT)
19 Manchester Metropolitan University (PG, FT)
20 Middlesex University (PG, FT)
21 Northumbria University (PG, FT)
22 Nottingham Trent University (UG, PT)
23 Oxford Brookes (UG, PT)
24 Oxford Brookes (PG, FT)
25 Oxford Brookes (PG, PT)
26 Sheffield Hallam (UG, PT)
27 Sheffield Hallam (PG, FT)
28 Staffordshire University (UG, PT)
29 The University Campus Suffolk (UG, PT)
30 University of Bedfordshire - Bedford
31 University of Bedfordshire - Beford (PG, FT)
32 University of Brighton (UG, PT)
33 University of Brighton (PG, FT)
34 UCLAN (UG, PT)
35 UCLAN (PG, FT)
36 UCLAN (PG, PT)
37 University of Chester (PG, FT)
38 University of Chichester (UG, PT)
39 University of Cumbria (PG, FT)
40 University of Derby (UG, PT)
41 University of East London (PG, FT)
42 University of Gloucestershire (PG, FT)
43 University of Greenwich (UG, PT)
44 University of Greenwich (PG, FT)
45 University of Greenwich (PG, PT)
46 University of Hertfordshire (UG, FT)
47 University of Huddersfield (PG, FT)
48 University of Lincoln (UG, FT)
49 University of Northampton (UG, PT)
50 University of Northampton (PG, FT)

51 University of Northampton (PG, PT)
52 University of Plymouth (PG, FT)
53 University of Portsmouth (PG, FT)
54 University of Sunderland (UG, PT)
55 University of West of England (UG, PT)
56 University of Wolverhampton (PG, FT)
57 Bournemouth University (UG, FT)
58 Buckinghamshire New University (UG, FT)
59 Coventry University
60 De Montfort University
61 Edge Hill University (1st)
62 Leeds Met (UG, FT)
63 Liverpool John Moores University (UG, FT)
64 Manchester Metropolitan University (UG, FT)
65 Northumbria University (UG, FT)
66 Nottingham Trent University (PG, FT)
67 Sheffield Hallam (UG, FT)
68 Staffordshire University (UG, FT)
69 Teeside University
70 University of Bedfordshire - Luton
71 UCLAN (UG, FT)
72 University of Chester (UG, FT)
73 University of Chichester (UG, FT)
74 University of Derby (UG, FT)
75 University of Gloucestershire (UG, FT)
76 University of Greenwich (UG, FT)
77 University of Hertfordshire (PG, FT)
78 University of Huddersfield (UG, FT)
79 University of Lincoln (PG, FT)
80 University of Northampton (UG, FT)
81 University of Portsmouth (UG, FT)
82 University of Wolverhampton (UG, FT)
83 Anglia Ruskin University (UG, PT)
84 Birmingham City University
85 Canterbury Christ Church University (UG, FT)
86 Kingston University (UG, FT)
87 Liverpool Hope University (UG, FT)
88 London Metropolitan University (UG, FT)
89 London South Bank University (UG, FT)
90 Middlesex University (UG, FT)
91 Oxford Brookes (UG, FT)
92 Ruskin Collge
93 Southampton Solent University
94 The University Campus Suffolk (UG, FT)
95 University of Brighton (UG, FT)
96 University of Cumbria (UG, FT)
97 University of East London (UG, FT)
98 University of Plymouth (UG, FT)
99 University of Salford, Manchester
100 University of Sunderland
101 University of the West of England, Bristol (UG, FT)
102 University of West London (Thames Valley)
103 University of Winchester
104 University of Worcester