The role of VET in alcohol and other drugs workforce development

NATIONAL CENTRE FOR EDUCATION AND TRAINING ON ADDICTION

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Additional information relating to this research is available in *The role of VET in alcohol and other drugs workforce development: support document* and *The role of VET in alcohol and other drugs workforce development: survey technical report*. They can be accessed from NCVER's website <http://www.ncver.edu.au/publications/2319.html>.

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Australian Government

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The NVETRE program is based upon priorities approved by ministers with responsibility for vocational education and training (VET). This research aims to improve policy and practice in the VET sector. For further information about the program go to the NCVER website <http://www.ncver.edu.au>. The author/project team was funded to undertake this research via a grant under the NVETRE program. These grants are awarded to organisations through a competitive process, in which NCVER does not participate.

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About the research

The role of VET in alcohol and other drugs workforce development

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The Alcohol and Other Drugs Council of Australia has identified attracting and recruiting staff as a problem area for the sector. An obvious strategy is to recruit people from a broad range of backgrounds, and then provide specific industry training. The vocational education and training (VET) sector is well placed to provide this training. The potential of VET to play this role was tested through surveys of managers of alcohol and other drugs service agencies and analysis of student enrolment data.

Key messages

- The majority of managers preferred to employ workers with higher education qualifications because university graduates are seen to have higher levels of professionalism and better interpersonal skills.
- Nearly one in four managers was dissatisfied with vocational education and training. They suggested that training could be improved by placing greater emphasis on counselling and intervention, co-morbidity issues and clinical work placements.
- The new CHC08 Community Services Training Package, which has replaced the CHC02 Community Services Training Package, may address some of the concerns relating to training content but it may not resolve the managers' concerns about delivery and assessment.
- Most managers supported the notion of a minimum qualification for the alcohol and other drugs sector. They indicated that it should be higher than a certificate IV level.

Tom Karmel
Managing Director, NCVER

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Executive summary

This report examines the role of vocational education and training (VET) in addressing the workforce development needs of the alcohol and other drugs sector of the health and community services industries. With a workforce comprised of diverse occupations and undertaking a wide range of activities in different organisational settings, the alcohol and other drugs sector represents an example of the wider health and community services industries.

The study involved two components and had four main goals. First, a survey of alcohol and other drugs treatment agency managers was conducted to examine:

- employers' attitudes towards and levels of satisfaction with vocational education and training qualifications in alcohol and other drugs work
- employers' opinions of vocational education and training qualifications in alcohol and other drugs work as a minimum qualification for working in the alcohol and other drugs sector.

Second, analyses were undertaken of 2008 data for VET students enrolled in the Certificate IV and the Diploma in Alcohol and Other Drugs Work and higher education undergraduate students enrolled in courses relevant to alcohol and other drugs to:

- identify the demographic profile of these students
- examine pathways between the vocational education and training and higher education sectors.

Key findings

A total of 186 alcohol and other drugs treatment service managers responded to the survey (58% response rate). Of these, 59% were managers of non-government services. The size of services ranged from 1 to 700 staff (median 15 staff), with the largest number of clinical staff employed by any single service being 210. Treatment agencies offered a variety of services that required workers to have a diverse range of skills.

Most specialist workers (64%) held formal qualifications in alcohol and other drugs work. A larger proportion of workers employed in government treatment agencies (65%) held graduate or postgraduate qualifications compared with workers employed in non-government agencies (40%).

Preferred worker qualifications

In terms of preferred qualifications of staff, the majority of managers (86%) preferred specialist workers to have either higher education qualifications with explicit alcohol and other drugs content, or relevant higher education qualifications with additional accredited or non-accredited alcohol and other drugs training. When seeking to employ workers, the least preferred option of managers was for applicants possessing only VET qualifications in alcohol and other drugs work.

Nearly half of the managers (44%) believed that the alcohol and other drugs skills and competencies held by their current specialist workers were the minimum they expected, while 9.7% believed they were less than expected. The majority of managers (60.4%) believed that most specialist workers they employed required more alcohol and other drugs training.

Minimum alcohol and other drugs qualifications

Most managers (82%) supported a compulsory minimum alcohol and other drugs qualification for specialist workers in the alcohol and other drugs field. While VET qualifications were seen as 'sufficient' for a minimum qualification, just over half of all managers indicated that the qualification level should be higher than certificate IV, with more than one in three supporting a minimum qualification at the undergraduate or postgraduate level.

Managers' views of vocational education and training

A substantial proportion of managers (nearly one in five) were dissatisfied with the VET sector's provision of courses in the area of alcohol and other drugs. Reasons for this dissatisfaction included:

- poor-quality training and assessment
- lack of correspondence between what was learned through training and skills required on the job
- training content being out of date or out of touch with industry developments
- lack of practical experience/work placements.

Managers' dissatisfaction also stemmed from a perceived variability in the quality of VET and limitations in its ability to adequately equip workers with the necessary skills and knowledge to meet the increasingly complex needs of alcohol and other drugs clients.

Managers' dissatisfaction may be due to real or perceived deficiencies in VET provision. Relatively high levels of dissatisfaction may also stem from an unrealistic expectation or misperception of what VET can deliver at the certificate level. Similar areas of dissatisfaction were identified in a recent review of the CHC02 Community Services Training Package, which led to the implementation of the new CHC08 Community Services Training Package. While this new training package may address some of the concerns about training content, issues related to the quality of training delivery and assessment and lack of practical experience/work placements are unlikely to be resolved. However, whether the new training package will deal with all the identified problem areas will not become apparent for some time.

Suggestions to improve vocational education and training

Suggestions for improving vocational education and training in alcohol and other drugs work included placing greater emphasis on:

- counselling
- intervention
- mental health/alcohol and other drugs comorbidity issues (the presence of two or more disorders)
- provision of clinical work placements.

Managers also noted that, in the employee-selection process, good interpersonal, social and communication skills were considered as important as a potential employee's qualifications. While the new CHC08 Community Services Training Package addresses some of these issues, concern was expressed that the introduction of generic topics into the new package has been at the expense of alcohol and drug-specific topics and content.

2008 enrolment data

Secondary analysis of 2008 data identified 1825 VET students enrolled in the Certificate IV and Diploma in Alcohol and Other Drugs Work and 42 032 higher education undergraduate students enrolled in topics relevant to generic alcohol and other drugs work (for example, counselling and client support). Compared with higher education students, VET students were older.

Vocational education and training–higher education pathways

An important aspect of this project was an examination of two-way flows and relationships between the VET and higher education sectors. Available data indicate that 10% and 20% of VET students who were enrolled respectively in certificate IV and diploma courses held a pre-existing higher education qualification. Students holding only a secondary school level education (high school Year 12 or less) were more likely to enrol in certificate-level courses than diploma courses. The larger proportion of students (1 in 5) enrolled in VET diploma courses with an existing higher education qualification suggests that an increasingly high standard of course content and delivery may be expected by students and required by employers in the future. This indicates that the VET sector could offer more advanced qualifications that are comparable with higher education qualifications and which address the complex issues and diverse skills needed by the sector.

Importantly, 11% of higher education students also had commenced or completed prior VET qualifications, indicating that the VET sector may provide a pathway into the higher education sector for a significant proportion of students.

Recommendations and implications

The imperative of the sector to move towards a universal adoption of a minimum qualification provides an opportunity for the VET sector to contribute to the workforce development needs of the alcohol and other drugs sector. While VET currently plays an important role in the provision of entry-level qualifications, it also has potential to meet the increasingly complex needs of alcohol and other drugs work by providing ongoing training and higher-level qualifications at the vocational graduate level. However, for this potential to be realised, the relatively high levels of dissatisfaction with the VET sector and concern over the ability of certificate IV level training to meet the needs of the alcohol and other drugs workforce warrant attention.

Development of more effective linkages and relationships between the VET sector and the alcohol and other drugs sector may go some way towards achieving this. The linkages that currently exist are largely informal, and considerable scope exists to strengthen and formalise these relationships. Improved linkages and relationships could increase the quality of training being provided by the VET sector and may assist in addressing the workforce development needs of the alcohol and other drugs sector.

Introduction

Background

Community services and health are growth industries. In 2007, these industries displaced manufacturing as Australia's third largest employer (with more than one million workers) and are expected to account for 24% of all new workforce growth to 2012 (Community Services & Health Industry Skills Council 2008a). There is a range of reasons for this growth, including an ageing Australian population, changes in welfare and health service technologies and increasing consumer expectations. Such growth in demand for community and health services creates an imperative for the provision of a skilled workforce.

Skills development in the community services and health industries has been identified as a priority workforce development issue (Community Services & Health Industry Skills Council 2008a). Roche defines workforce development as:

> a multi-faceted approach which addresses the range of factors impacting on the ability of the workforce to function with maximum effectiveness … Workforce development should have a systems focus. Unlike traditional approaches, this is broad and comprehensive, targeting individual, organisational and structural factors, rather than just addressing education and training of individual mainstream workers. (Roche 2002, cited in Roche & Pidd 2010, p.2)

Such an approach to workforce development includes issues like recruitment and retention, workforce planning, professional and career development, and worker wellbeing. A broader role for education and training was also recognised in the most recent environmental scan of the services and health industries (Community Services & Health Industry Skills Council 2009). From this perspective, vocational education and training can play an important workforce development role by providing both entry-level qualifications and building skill levels, and by contributing to career development through the provision of pathways to higher-level qualifications in the higher education sector.

However, the extent to which VET fulfils the workforce development needs of the community services and health industries is relatively unknown. Lack of information may be due to the size, complexity, and range of workforce development issues in these industries which provide a large and diverse range of services, including clinical health services, child care, aged care, community welfare, disability support, and community services. Moreover, occupations within these industries range from those that are highly skilled, requiring postgraduate qualifications, to those that are less skilled and requiring only basic qualifications at workforce entry level.

A case illustration from the alcohol and other drugs field

The alcohol and other drugs sector itself illustrates the complexity surrounding the skills development and wider workforce development issues in the community services and health industries. The Australian alcohol and other drugs specialist workforce includes occupations such as nurses, generic alcohol and other drugs workers, psychologists, counsellors and social workers (Wolinski et al. 2003; Roche, O'Neill & Wolinski 2004). The workers in these occupations

undertake a range of activities (for example, counselling, treatment, prevention, education) in a variety of organisations (government, non-government, and private).

As with most health and community services workforces, the alcohol and other drugs sector is experiencing a strong growth in demand for services. The sector has also experienced unprecedented changes over the last 20 years that have major implications for the development of a responsive and sustainable workforce. These changes include the increased complexity of alcohol and other drugs issues, an expanding knowledge base and an emphasis on evidence-based practice, and a growth in demand for services. These changes have occurred in parallel to issues facing the wider workforce such as advances in technology, an ageing workforce, and a tight labour market (Roche & Pidd 2010).

As recently as 2006, approximately a third of the alcohol and other drugs workforce held no formal alcohol and other drug-specific qualifications at the certificate, undergraduate, or postgraduate levels (Duraisingam et al. 2006). The need to improve the quality of alcohol and other drugs services by raising the skills and qualification levels of workers is a particularly important workforce development issue. It remains unclear at this point in time what the appropriate direction for change might be.

Minimum qualifications

One approach often posited as an appropriate strategy for upskilling a workforce is the introduction of a minimum qualification, and indeed this strategy has been employed as a means by which to upskill the existing alcohol and other drugs workforce and to ensure a qualified workforce into the future. While previous surveys have found that the majority of agency managers and workers support the adoption of a minimum qualification (Deakin & Gethin 2007; McDonald 2006), to date, only two jurisdictions (Victoria and the Australian Capital Territory) have introduced a minimum qualification strategy. Both jurisdictions require alcohol and other drugs specialist workers without tertiary qualifications to be accredited to at least the level of certificate IV, while workers with relevant undergraduate/postgraduate qualifications need to obtain four core units of competency at certificate IV level.

A minimum qualification strategy that utilises nationally recognised Australian Qualifications Framework (AQF) accredited training has the capacity to address a range of workforce development issues and also has the potential to:

- ✧ provide workers with relevant knowledge and skills
- ✧ raise the professional profile of the workforce
- ✧ provide consistency in the assessment of standards of practice
- ✧ be used as practice benchmarks in quality improvement processes
- ✧ contribute to the development of formal career paths
- ✧ allow for transportability of skills between jurisdictions and organisations.

Although the Certificate IV in Alcohol and Other Drugs Work has been nominated as a minimum qualification in Victoria and the Australian Capital Territory, potential barriers remain to its adoption nationally as a minimum qualification. First, while the majority of workers support it as a minimum qualification level (McDonald 2006; Connolly 2008), there is less support among alcohol and other drugs agency managers (Petroulias 2009).

In a review of Victoria's minimum qualification strategy, which was introduced in 2006, Petroulias (2009) found that half of the managers surveyed (51%) believed the minimum qualification level should be raised to the diploma level or above. Second, a minimum qualification based on certificate-level qualifications may be an appropriate strategy for workers with few or no relevant

skills, but it may *not* be appropriate for the substantial and growing proportion of alcohol and other drugs workers who have relevant (but not alcohol and other drug-specific) graduate or postgraduate qualifications. Finally, some agency managers have expressed dissatisfaction with certificate IV level training (Deakin & Gethin 2007; Gethin, 2008; Wolinski et al. 2003). This dissatisfaction relates to alcohol and other drugs knowledge, procedural deficits and variation in the quality of VET (Deakin & Gethin 2007; Gethin 2008).

Within the alcohol and other drugs sector, the types of training most frequently undertaken are accredited and non-accredited short courses (Duraisingam et al. 2006; Wolinski et al. 2003). Over the past decade, there has been a substantial increase in both the availability and utilisation of long-term accredited courses in the VET and higher education sectors (Roche et al. 2008). However, little is known about the degree to which VET at the certificate and diploma levels meets workforce development needs. Even less is known about the extent to which VET qualifications lead to workers seeking more advanced qualifications in the higher education sector.

Aims and method

The overall aim of this project was to examine the extent to which the VET sector addressed current alcohol and other drugs workforce development needs. The specific research questions were addressed in two components of the study. First, a survey of treatment agency managers was conducted to examine:

- employers' attitudes toward and levels of satisfaction with VET in alcohol and other drugs work
- employers' opinions of VET qualifications in alcohol and other drugs work as a minimum qualification for working in the alcohol and other drugs sector.

This national survey was administered online and it obtained data on manager and agency demographics, managers' attitudes toward and levels of satisfaction with VET, and managers' opinions about minimum qualifications.

Second, analyses were undertaken of 2008 data for students enrolled in the Certificate IV and Diploma in Alcohol and Other Drugs Work and higher education undergraduate students enrolled in courses related to alcohol and other drugs to:

- identify the demographic profile of these students
- examine pathways between the VET and higher education sectors.

This involved secondary analyses of National VET Provider Collection data and Higher Education Student Statistics Collection data. The former, managed by the National Centre for Vocational Education Research (NCVER), involves an annual collection of information on VET students and the courses they undertake.

Data collected from student enrolments in alcohol and other drugs courses at the certificate IV and diploma levels as part of the 2008[1] National VET Provider Collection were subjected to secondary analysis to identify the demographic profile of VET students. The specific VET alcohol and other drugs courses were:

- CHC41702 – Certificate IV in Alcohol and Other Drugs Work
- CHC51102 – Diploma of Alcohol and Other Drugs Work.

The Higher Education Student Statistics Collection, managed by the Department of Education, Employment and Workplace Relations, involves the annual collection of information on higher education students and the courses they undertake.

[1] 2009 National VET Provider Collection data were not available at the time of analysis.

Data collected from student enrolments in 2008 at the undergraduate level were subjected to secondary analysis to identify the demographic profile of higher education students. The analysis was restricted to specific alcohol and other drug/addiction undergraduate courses and undergraduate courses with explicit alcohol and other drugs content.

Specific demographic variables included in the analyses of both VET data and higher education data were:

- ✧ age
- ✧ gender
- ✧ location of residence
- ✧ previous highest education level.

Online survey details

An online survey comprising 34 questions was developed and administered between mid-January and the end of March 2010. Included in the sample frame were alcohol and other drugs specialist treatment agencies listed in the 2006 Clients of Treatment Service Agencies database and the current National Centre for Education and Training on Addiction database. Contact was also made with government health departments and alcohol and other drugs peak non-government bodies in each jurisdiction to inform them of the survey and invite their member agencies to participate in the survey. In addition, the survey was advertised on the Alcohol and Drug Council of Australia's Update email distribution list. For further information on the survey see the supporting *Survey technical report* available at <http://www.ncver.edu.au/publications/2319.html>.

Alcohol and other drugs treatment agency managers' survey findings

A total of 186 alcohol and other drugs treatment agency managers responded to the survey (response rate = 58%).

Agency demographics

More than half (59.6%) of the respondents managed non-government agencies (not-for-profit). The largest proportion of respondents managed agencies located in city/metropolitan areas only (36.1%), followed by regional only (8.3%), rural only (7.2%), and remote only (1.1%) areas. Nearly one in five respondents (23.4%) managed agencies located in more than one geographical location, and 23.9% managed agencies that operated in all locations.

The largest number of agencies was located in New South Wales and the number of government, non-government and private agencies varied between jurisdictions (table 1).

Table 1 Alcohol and other drugs agency type and state/territory location

Agency location & type	n (%)				
	Government	Non-government (NFP)	Private	Other[1]	Total
Australian Capital Territory	2 (22.2)	7 (77.8)	-	-	9 (4.8)
New South Wales	31 (60.8)	19 (37.3)	1 (2.0)	-	51 (27.0)
Northern Territory	6 (85.7)	1 (14.3)	-	-	7 (3.7)
Victoria	2 (6.3)	27 (84.4)	3 (9.4)	-	32 (17.0)
Queensland	12 (48.0)	13 (52.0)	-	-	25 (13.3)
South Australia	9 (23.7)	25 (65.8)	2 (5.3)	2 (5.3)	38 (20.2)
Tasmania	1 (11.2)	8 (88.9)	-	-	9 (4.8)
Western Australia	5 (29.4)	12 (70.6)	-	-	17 (9.0)
Total	**68 (36.2)**	**112 (59.6)**	**6 (3.2)**	**2 (1.1)**	**188 [2] (100)**

Notes: 1 Other = peak bodies.
2 Some managers were responsible for agencies in more than one state.

Services most commonly offered by agencies were outpatient counselling and case management, followed by health promotion and/or community development, and services to diversion clients (table 2).

Table 2 Main services offered by alcohol and other drugs agencies[1]

Main alcohol and other drugs agency service	n (%)
Withdrawal management – Outpatient	58 (7.8)
Withdrawal management – Inpatient/residential	46 (6.2)
Outpatient counselling and case management	113 (15.2)
Pharmacotherapy	53 (7.1)
Residential rehabilitation	48 (6.4)
Services to diversion clients	91 (12.2)
Day programs	41 (5.5)
After care programs	53 (7.1)
Health promotion and/or community development	98 (13.2)
Policy and/or advocacy	65 (8.7)
Research and evaluation	52 (7.0)
Specific project(s)	24 (3.2)
Total	**745[1] (100)**

Notes: Not answered n = 3.
1 Most agencies offered more than one service.

Alcohol and other drugs agency staff

The number of staff (full-time, part-time, and casual) employed at agencies managed by respondents ranged from 1 to 700, with wide variability between agencies (M = 43.8, SD = 92.4). The median number of staff was 15.

Alcohol and other drugs specialist treatment staff

An alcohol and other drugs specialist worker was defined as a frontline staff member who provided alcohol and other drugs counselling, treatment and/or rehabilitation services. This included counsellors, case workers, rehabilitation workers, therapists, psychologists, psychiatrists, medical practitioners, pharmacists, and nurses. It excluded administration staff, generalist support workers (for example, gardeners, residential support workers, housing and welfare officers), or non-alcohol and other drugs specific clinicians (for example, mental health workers, generalist medical practitioners, occupational therapists).

The number of specialist staff employed at agencies ranged from none to 210, with wide variability between agencies (M = 20.4, SD = 32.0). The median number of specialist staff was nine.

Recruitment and retention issues

One hundred-and-fifty-two managers responded to a question on recruitment difficulty. Of these, 25% (n = 38) had experienced 'a lot of difficulty' recruiting specialist workers in the previous 12 months, while 43.4% (n = 66) had experienced 'some difficulty'.

One-hundred-and-twenty managers responded to a question concerning the length of time it took to fill vacancies. Of these, 80% (n = 96) had advertised for at least two specialist positions in the last 12 months. More than half (54.2%; n = 65) reported that vacancies took two to three months to fill, 16.7% (n = 20) reported that vacancies took four to six months to fill, and 9.2% (n = 11) reported that it took more than six months to fill vacancies. In addition, two-thirds (67.4%; n = 89) reported that less than adequate numbers of applicants applied for each vacancy.

Thematic analyses were undertaken of qualitative data to determine managers' perceptions of factors contributing to the length of time it took to fill vacancies. The most frequently reported

factor was a lack of potential applicants with the required experience or qualifications (n = 23). For example:

> Lack of skilled and appropriately qualified staff.
>
> No suitably qualified or experienced applicants …

Other factors included difficulty in recruiting in remote/regional areas (n = 9), a complex and difficult recruitment process (n = 9), and inadequate salary offered (n = 5).

Managers were asked to comment on what they believed might contribute to insufficient numbers of applicants applying for advertised vacancies. The most common reason provided was a lack of potential applicants with the required experience or qualifications (n = 35), followed by the low rates of pay being offered (n = 17), and lack of potential applicants for rural/regional/remote vacancies (n = 17). This was highlighted by one respondent who stated that insufficient applicants resulted from:

> Difficulty in attracting qualified, competent and experienced people. Regional location, more money elsewhere in other positions.

The lack of appeal of drug and alcohol work (n = 14) and poor work conditions (n = 8) were also identified as factors contributing to a lack of applications for positions.

Managers reported that, on average, specialist workers were employed at their agency for approximately four years (*M* = 4.78, *SD* = 3.31, median = 4). Annual turnover rates for agencies averaged around 10% (*M* = 12.96, *SD* = 13.76, median = 10).

Alcohol and other drugs specialist workforce qualifications

Managers were asked to indicate the number of specialist workers at their agency who held relevant alcohol and other drugs qualifications. The majority held some form of formal qualification; however, 11.3% (n = 290) held no formal alcohol and other drugs qualifications (table 3). Government agencies employed the largest number of specialist workers with undergraduate degree qualifications, while non-government agencies employed the largest number of workers with VET qualifications (table 3).

Table 3 Alcohol and other drugs specialist workers qualifications

Alcohol and other drugs specialist workers qualifications	Agency type			
	Government n (%)	NGO[1] n (%)	Private n (%)	Total n (%)
No formal qualifications	162 (15.8)	127 (8.9)	1 (0.9)	290 (11.3)
VET alcohol and other drugs qualifications	182 (17.7)	675 (47.2)	10 (9.4)	867 (33.8)
Relevant university undergraduate degree PLUS non-accredited alcohol and other drugs training	326 (31.8)	189 (13.2)	43 (40.6)	558 (21.8)
Relevant university undergraduate degree PLUS accredited alcohol and other drugs training (statement of attainment)	85 (8.3)	174 (12.2)	25 (23.6)	284 (11.1)
Relevant university undergraduate degree PLUS accredited alcohol and other drugs qualifications	39 (3.8)	82 (5.7)	11 (10.4)	132 (5.2)
Undergraduate degrees with explicit alcohol and other drugs content	125 (12.2)	51 (3.6)	5 (4.7)	181 (7.1)
Postgraduate alcohol and other drugs qualifications	89 (8.7)	78 (5.5)	5 (4.7)	172 (6.7)
Other	18 (1.8)	54 (3.8)	6 (5.7)	78 (3.0)
Total	**1026 (100)**	**1430 (100)**	**106 (100)**	**2562 (100)**

Notes: Not answered n = 61.
1 NGO = non-government (not for profit).

Managers' views of alcohol and other drugs specialist worker qualifications and skills

One-hundred-and-fifty-five managers responded to a question requesting their view of their workers' qualifications. Of these, 68.4% (n = 106) agreed that most specialist workers in their employment held appropriate alcohol and other drugs qualifications, while 15.5% (n = 24) believed they did not.

Nearly two-thirds (60.4%, n = 93) of managers also believed that most specialist workers they employed required more alcohol and other drugs training. Nearly half (43.5%, n = 67) believed that the alcohol and other drugs skills and competencies of specialist workers they employed were the minimum they expected and 9.7% (n = 15) believed they were less than expected.

Managers were asked to identify the type of training their specialist workers required. The types of training most frequently reported (n = 35) concerned core alcohol and other drugs skills, such as counselling, motivational interviewing and assessment, as illustrated by the following statements:

> More training on counselling skills …
>
> Motivational interviewing, pharmacology … case management.
>
> Assessment skills, pharmacology, clinical assessment of patients in withdrawal/intoxication.

Other common areas included ongoing training to accommodate the changing nature of alcohol and other drugs issues and treatments (n = 29), and comorbidity training (n = 20). For example:

> I believe that the alcohol and other drugs sector is a continually changing area and continuing training is beneficial for all.
>
> Comorbidity is easily identified as requiring attention in training and development of staff.

Preferred alcohol and other drugs specialist workforce qualifications

The majority of managers preferred specialist workers to have either higher education qualifications with explicit alcohol and other drugs content, or relevant higher education qualifications with additional accredited alcohol and other drugs training (table 4). Alcohol and other drugs qualifications obtained from the VET sector were the least preferred option of the majority of managers.

Table 4 Preferred alcohol and other drugs specialist worker qualifications

Alcohol and other drugs qualifications	Most preferred n (%)	Least preferred n (%)
VET alcohol and other drugs qualifications	17 (13.8)	56 (66.7)
Relevant university undergraduate degree PLUS non-accredited alcohol and other drugs training	9 (7.3)	13 (15.5)
Relevant university undergraduate degree PLUS accredited alcohol and other drugs training (statement of attainment)	27 (22.0)	1 (1.2)
Relevant university undergraduate degree PLUS accredited alcohol and other drugs qualifications	29 (23.6)	-
Undergraduate degrees with explicit alcohol and other drugs content	14 (11.4)	3 (3.6)
Postgraduate alcohol and other drugs qualifications	27 (22.0)	11 (13.1)
Total	**123 (100)**	**84 (100)**

Note: Not answered n = 59.

Managers were asked to provide reasons for their preferences. The most frequently cited reasons (n = 26) for preferring undergraduate or postgraduate training focused on the ability of these qualifications to provide higher levels of professionalism and better overall skills. They also considered that these qualifications would ensure an evidence-based approach and an ability to

work with all types of clients and reduce the need for on-the-job training. This is illustrated in the following statements by respondents:

> Prefer those with relevant postgraduate alcohol and other drugs qualifications as this generally minimises amount of 'on-the-job' training that needs to be provided.

> I would prefer my employees to concentrate on general undergraduate and postgraduate qualifications with essential clinical training. It is essential my staff have the knowledge and counselling experience to work with all types of clients with all sorts of issues and not just an alcohol and other drugs symptom.

> Postgraduate alcohol and other drugs qualifications would ensure evidence-based assessment and intervention, professionalism and free my senior staff from the incessant need to provide basic training to underqualified team members.

Reasons for not preferring VET qualifications centred on their inability to provide workers with the skills required to address the complex needs of alcohol and other drugs clients. For example:

> Vocational education and training alcohol and other drugs qualifications don't provide a good theoretical framework for managing clients with complex needs.

> I think that the technical and further education alcohol and other drugs course is not particularly focused on harm reduction. Often it is easier to work with someone who has a basic degree in social science or nursing and for us to do the harm reduction training ourselves.

> Some vocational education and training sector qualified staff cannot demonstrate skills or competencies that should have been attained at the appropriate level.

In addition, variability in the quality of VET was also noted as a concern:

> I think there is much inconsistency out in regional and remote registered training organisations, and a lack of scrutiny of the work of some of these registered training organisations.

By contrast, those managers who did prefer VET qualifications liked their practical orientation and lower costs. For example:

> Cert IV qualifications are quite good and with a bit of coal face experience, provide a good mix. They also fit within funding budgets.

> In my experience I have found that the technical and further education training is very suitable for our service.

For some managers, accredited VET was preferred over non-accredited training, as it was more consistent and ensured attainment of competencies.

> Non-accredited alcohol and other drugs training can be inconsistent and levels of participation difficult to ascertain. Attainment of vocational education and training qualifications at least offers hope that there is some attainment of competencies.

For other managers, workers' qualifications were not the most important issue. In some cases, emphasis was placed on the worker's analytical and interpersonal skills and these skills were seen as a determining factor in deciding which staff to hire. For example:

> To be honest it depends on the nature of the work they are doing. In our case, it is more important that they have good research and analytical skills and interpersonal skills.

> Qualifications alone are not the decider for effective recruitment. Relevant demonstrable skill sets which generally are found in qualified persons make part of someone's employability. Attitude, adaptability, learning ability and team fit are also important.

Barriers to employing workers with preferred qualifications

The most common barrier to employing workers with preferred qualifications, identified by 32% of 129 respondents, was insufficient numbers of suitably qualified workers. A further 24% of respondents identified salary/award restrictions, 22.2% reported insufficient funding to pay appropriate salaries, and 10% reported short-term contracts as a barrier. Only a small minority of managers (6.6%) reported no barriers. Other respondents (n = 8) expressed concern about a mismatch between applicant attributes and specific job conditions. For example:

> Abstinence is a condition of employment.
>
> Shift work only attracts a small percentage of workers.
>
> Insufficient personal skills.

Attitudes toward minimum qualifications

One-hundred-and-seventy managers responded to a question on minimum qualifications. The majority (81.8%, n = 139) agreed that there should be a compulsory minimum alcohol and other drugs qualification level for specialist workers.

The most frequently cited reason (n = 50) for supporting a minimum qualification was that it provided baseline knowledge and ensured consistency in workers' competencies and quality of service. The following responses typified this view:

> Essential for quality services and the appropriate intervention by multi-disciplinary teams.
>
> Important to have a benchmark for service and staff competence.
>
> People have the right to be offered the same standard of care, evidenced-based, from any service that they may wish to attend. A minimum alcohol and other drugs qualification level would help ensure this happens.

Other responses indicated that, while a compulsory minimum qualification level was desired, practical issues such as increased difficulties in recruiting and paying staff for their qualifications also needed to be considered. For example:

> I agree with having a compulsory qualification for specialist workers. The drawback is the fact that there is a lack of qualified personnel to fill the positions. Qualified and unqualified workers receive the same remuneration rate. Until such times as qualified personnel are recognised for their qualification with a premium on their pay rate it is pointless completing studies for a qualification.

Other practical considerations raised included the need to acknowledge prior learning and experience:

> Many alcohol and other drugs workers have been in the field for many years and have had consistent training over those years. To bring in a minimum qualification for alcohol and other drugs specialist workers you would need to take that into consideration. [My experience has been that] having to complete these [vocational education and training] qualifications by very experienced university trained staff created some dissension.

Managers were asked what alcohol and other drugs qualifications should be the minimum level for specialist workers. Of the 127 managers who responded to this question, 61.4% (n = 78) supported VET qualifications, 37.8% (n = 48) supported the certificate IV level and 15.7% (n = 20) the diploma level. Nearly a third (29.1%, n = 37) indicated that a minimum qualification should be at the undergraduate level and 9.5% (n = 12) indicated it should be at the postgraduate level.

The proportion of managers who preferred certificate-level qualifications as a minimum varied across jurisdictions. The smallest proportions of managers preferring certificate-level qualifications were located in Tasmania (11.1%), Victoria (18.8%), New South Wales (18.8%), South Australia (34.2%) and Western Australia (35.3%). Larger proportions of managers who preferred certificate-

level qualifications as a minimum were located in the Northern Territory (71.4%), Queensland (41.7%), and the Australian Capital Territory (57.1%).

Satisfaction with VET alcohol and other drugs qualifications

The majority of managers were satisfied with the quality of vocational education relating to alcohol and other drugs provided by TAFE (technical and further education) colleges, universities, and private training providers. However, more than one in four were dissatisfied with the training provided by TAFE colleges (table 5). A smaller proportion of managers were dissatisfied with training provided by private training providers and very few managers were dissatisfied with training provided by universities.

Table 5 Managers' levels of satisfaction with VET provided by TAFE colleges, universities and private training providers

	Overall vocational education and training qualification satisfaction, n (%)					
	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied	Total
TAFE colleges	14 (14.0)	38 (38.0)	22 (22.0)	21 (21.0)	5 (5.0)	**100 (100)**
Universities that provide VET qualifications	8 (9.8)	42 (51.2)	25 (30.5)	6 (7.3)	1 (1.2)	**82 (100)**
Private training providers	8 (10.0)	22 (27.5)	36 (45.0)	8 (10.0)	6 (7.5)	**80 (100)**

Note: Not answered n = 78.

Managers' reasons for dissatisfaction with vocational education and training in TAFE colleges included concerns over the assessment process. In particular managers were concerned that some students were guided through the assessment process and were passed too easily. For example:

> Having taught alcohol and other drugs at the local TAFE, I was surprised at the number of students who were 'assisted' through by TAFE coordinators and passed without sufficient merit.
>
> TAFE students are often 'guided' through their courses/tasks to the extent where they do not always show self-initiative. In comparison, university education places responsibility on the individual to ensure the completion of educational requirements.

Dissatisfaction was also related to variability in training content and quality. For example:

> Private providers and TAFE are inconsistent and the quality of education depends on the actual institution that provides it.
>
> Private providers can be very inconsistent. Some of the TAFEs have also been inconsistent.

In addition, some managers believed that the content of the vocational courses did not match the on-the-job skills required and that the content was out of date or out of touch with industry developments. For example:

> Lack of correspondence between what is learned through training and the actual skills required for the job.
>
> Lack of real counselling skills … not much reference to best practice and research interventions.
>
> Material was out of date, teachers were not in touch with current developments in the field.
>
> Some of the content is old and from presenters who have not worked in the field for years.

Other managers believed that VET courses did not provide trainees with enough practical experience or specific skills development. For example:

> There is not enough practical clinical content, and too many generic units.
>
> Lack of exposure to anything but common counselling settings is evident.

However, some managers had higher levels of satisfaction with vocational education and training after dealing with training organisations that provided trainees with work experience. For example:

> We are in a position where we have quite a few TAFE placements so we often use this as a way of looking at a prospective employee. Because of these practical placements in services these students have a better understanding of what the job entails.

There was also a belief among some managers that higher education training was superior, as the longer and more detailed training produced a better-rounded and more professional worker. For example:

> It seems that the longer engagement at undergraduate level (e.g. Addiction Studies) produces better understandings and more potential for building on skill sets.

> I believe it is difficult to cover aspects of professionalism, such as maintaining empathy, engagement, boundaries and ethics that are covered in a degree program over a course such as cert, dip or advanced dip.

There was a view among some managers that VET had become 'commercialised' and that the focus was on producing 'certified' workers, rather than skilled and competent workers. This was based on a belief that some trainers were qualified to deliver training, but not qualified in the content of the training they delivered. For example:

> Overall I have found the vocational education and training program to have become a commercial operation with poorly skilled and experienced people providing training in fields they know little about.

To overcome this, it was suggested that a more stringent quality-control process needed to be established:

> Unless some serious quality controls are put in to the vocational education and training system I feel the whole value of a minimum qualification set becomes a nonsense.

Suggestions to improve training

Other managers' responses provided insight into how satisfaction levels could be improved. In general, managers indicated that training providers who worked closely with industry produced better workers, which resulted in higher levels of employer satisfaction. For example:

> Private providers do on-the-job, hands-on training relevant to the work required, whilst also having access to best services to get student placements, they consult individual managers/services to work out needs of the staff, the trainer becomes an important member of the team where staff can reflect and gain on-the-job support.

> Private/specialised RTOs deliver and assess on-the-job and have the benefit of best practice placements in the alcohol and other drugs sector.

> Alcohol and other drugs agencies that deliver accredited training tend to have graduates that are more familiar with issues pertaining to the AOD sector and familiarity with clients.

Managers could also select from a number of strategies for improving VET courses in alcohol and other drugs work. The most frequently selected option concerned the provision of more content relevant to alcohol and other drugs work, including comorbidity, addiction, case management, drug knowledge, harm reduction, referral pathways and complex needs. The emphasis on content was also evident in comments provided by managers. For example:

> More emphasis on counselling skills … brief interventions, motivational interviewing.

> [Lack of emphasis on] counselling skills to me is one of the biggest limitation of the current courses available.

While some responses indicated a need to focus content on specific populations such as families, young people and the aged, others suggested improvements should focus on the quality of VET delivery and assessment rather than course content. For example:

> More professional delivery. Greater focus on skills assessment.
>
> I am not sure the content of the training is what is lacking, it is the assessment tasks and follow-up of trainees.

Some managers also highlighted the need for more clinical work placements and on-site competency assessment. For example:

> More placements.
>
> Maybe more in situ observation of how people work would be beneficial prior to getting an endorsement.

Views on necessary skills

Managers were asked to indicate the importance of a range of different alcohol and other drugs skills listed. While the majority believed that knowledge relevant to drugs and having the ability to deal with clients with substance abuse issues were important or very important skills, they believed that empathy and interpersonal/social skills were equally important.

Managers' final comments

Survey respondents were given the opportunity at the end of the survey to add any further comments about VET qualifications in alcohol and other drugs work or minimum qualification levels for alcohol and other drugs specialist workers. Three main themes emerged:

1 The need for vocational education and training to include placements and practical training.

> It would be great if vocational education and training can have a placement program to provide practical training for students who are new in the field.
>
> Field experience will always be the most appropriate part of the learning, so a vocational education and training course should include placements both in an alcohol and other drugs and mental health setting.

2 The need for consistency in vocational training content, quality and delivery.

> There is a huge inconsistency in vocational education and training qualified workers.
>
> Build in better consistency of the vocational education and training programs across the nation. If we are having a nationally recognised qualification we need to be absolutely sure that what training occurs in one region or state replicates that of another.

3 The need for additional funding and support for non-government workers to access vocational training and to provide salaries commensurate with qualifications obtained.

> For the non-government sector—the ability to have backfill funded was of great assistance in the ACT to get us the employers on board with enrolling our staff—great initiative, it removed many barriers.
>
> Government subsidies should be provided for all certificate IV alcohol and other drugs training.
>
> Qualified workers need to be recognised for their qualification in the remuneration package within all agencies. Until such times as the qualified workers are recognised, unqualified workers are at a greater advantage financially.

2008 vocational education and training and higher education enrolment data findings

This section is presented in two parts. The first presents an examination of vocational education and training enrolment data and the second provides an examination of higher education enrolment data.

National VET Provider Collection data

Demographic profile of vocational education and training students

A total of 1825 students were enrolled in alcohol and other drugs specific VET courses in 2008 (table 6). The majority (75.4%, n = 1376) were enrolled in CHC41702 – Certificate IV in Alcohol and Other Drugs Work.

Gender and age

Females comprised more than two-thirds (67.7%, n = 1236) of the total number of students enrolled in alcohol and other drugs courses. Gender ratios for certificate (males = 32.1%) and diploma (males = 32.7%) courses were similar. The median age for all students was 36.5 years (certificate IV = 36 years, diploma = 40 years). Only seven students were aged less than 18 years (0.4%).

Geographical location

The proportions of students residing in major cities and inner or outer regional areas were similar for those enrolled in certificate IV or diploma courses. A larger proportion of students residing in remote or very remote areas were enrolled in certificate IV courses compared with those enrolled in diploma courses (table 6). Overall, nearly two-thirds of enrolled certificate IV and diploma students resided in major cities.

Table 6 VET alcohol and other drugs course: students' location of residence, 2008

Geographical location[1]	Certificate IV		Diploma		Total	
	n	%	n	%	n	%
Major city	891	64.8	244	54.3	1135	62.2
Inner regional	370	26.9	169	37.6	539	29.5
Outer regional	84	6.1	34	7.6	118	6.5
Remote/very remote	28	2.0	2	0.4	30	1.6
Overseas postcode	3	0.2	0	0.0	3	0.2
Total	**1376**	**100.0**	**449**	**100.0**	**1825**	**100.0**

Note: 1 Geographical location was derived from postcode details and classified using the ABS *Standard Geographical Classification Remoteness Area* classification.

Nearly half the students resided in Victoria (table 7).[2] The proportions of students in each state or territory generally reflected the population and the relative size of the alcohol and other drugs sector in each jurisdiction. However, there were state and territory differences in the proportions of students enrolled in certificate IV and diploma courses. In the Australian Capital Territory, Queensland, Tasmania and Victoria, a larger proportion of all students were enrolled in diploma courses than in certificate IV courses. This contrasts with New South Wales, the Northern Territory, Western Australia and South Australia, where larger proportions of students were enrolled in certificate IV than in diploma courses.

Table 7 VET alcohol and other drugs course: students' state/territory of residence, 2008

State/territory	Certificate IV		Diploma		Total	
	n	%	n	%	n	%
Australian Capital Territory	41	3.0	33	7.3	74	4.1
New South Wales	444	32.3	59	13.1	503	27.6
Northern Territory	10	0.7	2	0.4	12	0.7
Victoria	635	46.1	269	59.9	904	49.5
Queensland	122	8.9	53	11.8	175	9.6
South Australia	50	3.6	8	1.8	58	3.2
Tasmania	14	1.0	22	4.9	36	2.0
Western Australia	57	4.1	3	0.7	60	3.3
Overseas	3	0.2	0	0.0	3	0.2
Total	**1376**	**100.0**	**449**	**100.0**	**1825**	**100.0**

Highest prior education level

The most commonly held prior qualification among both certificate IV and diploma students was a certificate/diploma/associate degree, followed by a Year 12 or less qualification (table 8).

Table 8 VET alcohol and other drugs course: students' highest prior educational level, 2008

Highest education level[1]	Certificate IV		Diploma		Total	
	n	%	n	%	n	%
Year 12 or less	487	35.4	108	24.1	595	32.6
Cert./dip./assoc. degree	578	42.0	201	44.8	779	42.7
Bachelor degree	140	10.2	92	20.5	232	12.7
Miscellaneous	88	6.4	16	3.6	104	5.7
Not answered	83	6.0	32	7.1	115	6.3
Total*	**1376**	**100.0 (75.4)***	**449**	**100.0 (24.6)***	**1825**	**100.0**

Notes: * % in brackets = % of total enrolments

1 Highest education level was identified by AVETMISS highest education level measures and collapsed into these categories.

Examination of age and gender differences by highest education levels indicated that students with a Year 12 or less education were slightly younger than those who held prior qualifications at the certificate/diploma/associate degree or bachelor degree levels (table 9).

[2] This may largely be due to the introduction of the Minimum Qualification Strategy into Victoria in 2006. This strategy required workers employed in alcohol and other drugs agencies funded by the Victorian Government to hold certificate IV-level qualifications in alcohol and other drugs work as a minimum qualification (Roche & Pidd 2010). A review of this strategy in 2009 indicated that a substantial number of workers had obtained certificate IV and diploma-level qualifications in alcohol and other drugs work since the strategy's introduction (Petroulias 2009).

Table 9 VET alcohol and other drugs course: students' highest prior educational level by median age and gender, 2008

Highest education level[1]	Certificate IV			Diploma			Total		
	Age	Gender %		Age	Gender %		Age	Gender %	
		M	*F*		*M*	*F*		*M*	*F*
Year 12 or less	33	31.2	68.8	33	33.3	66.7	33	31.6	68.4
Cert./dip./ assoc. degree	37	33.7	66.3	42	35.3	64.7	39	34.1	65.9
Bachelor degree	42	31.4	68.6	40	31.5	68.5	41	31.5	68.5

Note: 1 Highest education level was identified by AVETMISS highest education level measures and collapsed into these categories.

Higher education data

Higher education data collected from student enrolments in 2008 were examined to identify students who had enrolled in specific alcohol and other drugs/addiction undergraduate courses and undergraduate courses with explicit alcohol and other drugs content.

Specific alcohol and other drugs courses identified in higher education data

Relatively few higher education students enrolled in specific alcohol and other drugs work courses could be identified. In a large number of cases, higher education providers did not provide sufficient coding detail in their datasets to distinguish alcohol and other drugs-specific courses from the broader higher education field of study area. The types of alcohol and other drug-specific courses that could be identified from the data included:

- ✧ Graduate Certificate in Addiction Studies (Edith Cowan University)
- ✧ Graduate Certificate in Drug and Alcohol Harm Minimisation (Edith Cowan University)
- ✧ Bachelor of Arts (Psychology and Addiction Studies) (Edith Cowan University)
- ✧ Master of Social Science (Addiction Studies) (Charles Sturt University)
- ✧ Master Health Studies (Addiction Studies) (University of Queensland)
- ✧ Graduate Diploma in Substance Abuse Studies (Victoria University)
- ✧ Graduate Certificate in Mental Health Nursing (Dual Diagnosis) (University of Western Sydney).

Only 112[3] students who were enrolled in these courses in 2008 could be identified. Of these, only 34 students were enrolled in undergraduate courses. Due to the low numbers of students detected, no further analyses of this data were undertaken.

Undergraduate enrolment data: 2008 'health' or 'society and culture' topics

The managers' survey indicated that, for positions that did not specifically require a degree, a substantial proportion of managers preferred to employ workers with relevant undergraduate qualifications over workers with VET qualifications. Thus, an analysis of higher education students enrolled in selected undergraduate 'health' or 'society and culture' topics was undertaken. Course topic codes were selected for analysis on the basis that the topic would be relevant to generic alcohol and other drugs work such as counselling or client support. Such generic work roles do not

[3] A much larger number of students are known to be enrolled in higher education alcohol and other drugs specific courses. However, due to limitations in the data provided, these students could not be identified. In many cases course coding did not provide enough information to distinguish alcohol and other drugs-specific courses from other courses in the same field of study area. For example, the Master of Social Health (Alcohol and Other Drugs) course could not be distinguished from other Master of Social Health courses using the course code contained in the dataset provided. This is highlighted as a data deficit that warrants attention and remediation.

require an undergraduate degree and are also open to workers with certificate or diploma-level VET qualifications. The selected topic codes are outlined in table 10.

Table 10 Selected field of education codes (relevant to alcohol and drug work) under 'health' and 'society and culture' topics for 2008 higher education enrolment data

Health		**Society and culture**	
Field of education (FOE) codes		Field of education (FOE) codes	
Code	**Field of study**	**Code**	**Field of study**
61305	Indigenous health	90301	Sociology
61309	Community health	90311	Indigenous studies
61399	Public health not elsewhere classified	90313	Gender specific studies
69999	Health not elsewhere classified	90399	Studies in human society not elsewhere classified
		90501	Social work
		90505	Youth work
		90513	Counselling
		90515	Welfare studies
		90599	Human welfare studies and services not elsewhere classified
		90701	Psychology
		90799	Behavioural sciences not elsewhere classified

Demographic profile of undergraduate higher education students

There were a total of 42 032 students enrolled in the selected health or society and culture topics in 2008. Most of these students (94.6%, n = 39 743) were enrolled in society and culture topics. The majority of health or society and culture students (91.0%, n = 38 242) were enrolled in an undergraduate bachelor degree.

The age of students ranged from 16 to 85 years (median = 23). Only a small minority of students (4.4%) were under the age of 18 years. The age of males (median = 22) and females (median = 23) was similar.

Most resided in New South Wales (27.2%) and Victoria (27.1%), with 72.2% residing in a major city (table 11). The most commonly held prior qualification (34.6%) was completion of the final year of secondary education at school or a TAFE college.

Just over one in ten (11%) had commenced or completed a prior VET qualification. The median age of higher education students with prior VET qualifications was 23 years and the majority (79.4%, n = 9097) were female.

No further relevant information could be ascertained from the higher education datasets.

Table 11 Demographic profile of undergraduate students enrolled in alcohol and other drug-relevant higher education topics, 2008

Higher education undergraduate students		n (%)
Gender	Male	9 723 (23.1)
	Female	32 039 (76.9)
State	Australian Capital Territory	992 (2.4)
	New South Wales	11 428 (27.2)
	Northern Territory	260 (0.6)
	Victoria	11 380 (27.1)
	Queensland	7 463 (17.8)
	South Australia	3 729 (8.9)
	Tasmania	771 (1.8)
	Western Australia	3 880 (9.2)
	Other/overseas	1 986 (4.7)
	Not known	143 (0.3)
Geographical classification remoteness area[1]	Major cities	30 366 (72.2)
	Inner regional	6 858 (16.3)
	Outer regional	2 348 (5.6)
	Remote	220 (0.5)
	Very remote	114 (0.3)
	Overseas	1 983 (4.7)
	Not known	143 (0.3)
Previous higher educational level	A complete postgraduate level course	567 (1.3)
	A complete bachelor level course	1 921 (4.6)
	A complete sub-degree level course	1 307 (3.1)
	An incomplete higher education course	5 811 (13.8)
	A complete final year secondary education course at school or TAFE college	14 562 (34.6)
	A complete TAFE or VET award course	4 297 (10.2)
	An incomplete VET award course	307 (0.7)
	Other qualification, complete or incomplete	1 680 (4.0)
	Not a commencing student	7 504 (17.9)
	Not known/No prior educational attainment	4 076 (9.7)

Note: 1 Geographical location was derived from postcode details and classified using the ABS *Standard Geographical Classification Remoteness Area* classification.

Discussion

The managers' survey

The demographic profile described in the results is consistent with previous national surveys of treatment agency managers (Duraisingam et al. 2007; Roche & Pidd 2010; Roche, O'Neill & Wolinski 2004; Wolinski et al. 2003) and a similar profile to other community services and health industry sectors (Community Services & Health Industry Skills Council 2008a), thus confirming that the findings are representative of these areas.

Satisfaction with vocational education and training

An important finding of this study was that nearly one in four managers was dissatisfied with the training provided by the VET sector, in particular training provided by TAFE colleges. A smaller, but still substantial, proportion of managers were dissatisfied with VET courses provided by private training providers, while relatively few managers were dissatisfied with university training. This finding conflicts with recent NCVER data relating to employer satisfaction levels, which indicated that fewer than one in ten employers were dissatisfied with VET (NCVER 2009). However, the NCVER data are based on a sample of all organisations with at least one employee within Australia and are not restricted to one particular sector. Nevertheless, the level of dissatisfaction remains a difference between the two surveys.

While the extent of managers' dissatisfaction differed from NCVER data on employer satisfaction levels, reasons for dissatisfaction were similar. Managers cited poor-quality training and assessment, lack of correspondence between what is learned through training and skills required on the job, training content being out of date or out of touch with industry developments, and inadequate levels of practical experience/work placements. Overall, the survey indicated concern among some managers that VET qualifications did not adequately equip workers with the necessary skills and knowledge to meet the increasingly complex needs of alcohol and other drugs clients.

The alcohol and other drugs sector is complex, and treatment agencies offer a varied range of services that require a diverse range of skills. This complexity and diversity are reflected in the wide range of skills that managers considered important and the number of topics managers suggested to improve the VET courses. Managers preferred workers to hold higher education qualifications, with additional accredited or non-accredited alcohol and other drugs training, rather than only VET qualifications. This view may be based on a belief that these qualifications result in more professionally trained workers with skills specifically relevant to their particular needs. As Cully identified:

> Employers choose the form of skill development that best suits their needs. The relevance of training and flexibility is more important to them than who provides it and whether it is accredited. (Cully 2005, p.1)

From this perspective, some dissatisfaction with VET among managers may be due to an (unrealised) expectation that training at the certificate IV level can provide all the skills and knowledge necessary to support the diverse range of services offered by alcohol and other drugs treatment agencies. One solution may be for the VET sector to offer more advanced qualifications comparable with higher education qualifications and which address the complex issues and diverse

skills needed by the sector. In support of this view, Priest (2009) argues that the VET sector can incorporate broader dimensions of learning and knowledge transfer by providing higher-level qualifications (for example, vocational graduate certificates). Such an approach may not only change beliefs about the superiority of higher education over vocational education and training but may also provide:

> a strong alternative to university graduate qualifications, focusing on the high level of applied and complex knowledge for the new workplace. (Priest 2009, p.17)

Thus, the relatively high levels of dissatisfaction with VET among agency managers may be due to real or perceived deficiencies. There may be inconsistencies in the quality of training provided by different organisations in the sector that need to be addressed. Alternatively, dissatisfaction with VET may be due to a lack of understanding about how the sector works and what it can deliver, rather than any actual deficiency (Smith et al. 2005).

Regardless of whether managers' dissatisfaction with VET is based on real deficits or perceived concerns with the quality, content, or relevance of qualifications and training provided, this dissatisfaction is likely to be a barrier to employers' support for VET. Stanwick (2009) has identified a number of methods for overcoming this type of barrier, including facilitating links and networks between employers and the VET sector and the development of more flexible and responsive training. One strategy that encompasses these methods is Buchanan's (2006) 'skills ecosystem' approach. A skills ecosystem involves:

> clusters of high, intermediate and low level competencies in a particular region or industry, which are shaped by interlocking networks of firms, markets, and institutions…
>
> (Buchanan 2006, p.14)

The facilitation of networks and links between training providers was identified by managers as a strategy for improving training outcomes. Some managers indicated that they were more satisfied with training providers who worked closely with them as this resulted in more competent workers with skills relevant to workplace needs. Such trainer–industry relationships allowed for on-the-job training and assessment and consultation with individual managers to identify worker and service needs.

However, all these methods for enhancing employers' engagement with the VET sector face the challenges of securing cooperation and coordination between all relevant stakeholders and the provision of adequate funding to ensure success. Meeting these challenges is vital if the sector is to play a major role in the development of the alcohol and other drugs workforce. The sector's potential role is an important consideration as the alcohol and other drugs sector examines the feasibility of introducing minimum qualification strategies.

Minimum qualifications

The majority of alcohol and other drugs agency managers believed that there should be a compulsory minimum qualification for specialist workers in their industry. Managers maintained that minimum qualifications provide a baseline of knowledge and ensure consistency in workers' competencies and in the quality of service provided. However, while the majority of managers indicated that VET qualifications were sufficient for a minimum-level qualification, one in three indicated it should be at the undergraduate or postgraduate level. Moreover, for specialist positions that required workers to have either vocational or higher education qualifications, most managers (64%) preferred workers to hold higher education qualifications with specific alcohol or drug content or additional accredited or non-accredited alcohol and other drugs training. The least preferred option of the majority (67%) of managers was to hire workers who only held VET qualifications.

Managers were of the view that appropriate training and qualifications were important not only for new workers but also for their existing workforce. While the majority of managers agreed that existing specialist workers held appropriate qualifications, more than half also thought that the alcohol and other drugs skills and competencies of these workers were the minimum or less than

they expected and believed that existing workers required more training. The most frequently cited areas in which managers considered workers needed more training were the core skills of counselling, motivational interviewing and assessment. In addition, managers supported ongoing training to accommodate the changing nature and increasing complexity of alcohol and other drugs issues and treatments.

Managers preferred higher education qualifications over VET qualifications, as the latter did not deliver appropriate levels of theoretical knowledge and professionalism. This belief may be based on the traditional view that the higher education sector provides largely theory-based education for professionals, while the VET sector provides skill-based (competency) practical training for tradespersons (for example, James 2000). In contrast to the simple assessment of achieved/not achieved for competency-based training, broad subject-based learning in the higher education sector assesses achievement differentially (for example, fail, pass, credit, distinction, high distinction). Some managers who were particularly critical of a competency-based assessment approach suggested that this more complex process of assessment was needed in the VET sector. Several managers saw VET qualifications as a 'commercial product', where students were 'guided' or 'assisted' through the training and were passed, regardless of merit.

The preference for higher education qualifications may also explain the large number of managers who reported a lack of skilled and qualified workers. More than two-thirds of managers reported difficulty in recruiting staff and one in four reported that it took four months or more to fill advertised vacancies. The most frequently cited reason for recruitment problems was a lack of potential applicants with the required experience or qualifications. Other reasons included salary/award restrictions on what workers could be paid, insufficient funding to pay the appropriate salaries, and being able to only offer short-term contracts. However, recruitment problems may be partly due to managers' preference for workers to hold higher education qualifications. There may be fewer applicants with these qualifications as they may expect higher remuneration than can be offered and/or may be less attracted to positions that offer only short-term contracts or limited options for career advancement.

Some managers pointed out that the introduction of a minimum alcohol and other drugs qualification also needs to consider practical implications, such as funding and resource allocations. In particular, provision of adequate funding for training—and backfill for staff to attend training—and to meet salary provisions associated with increases in newly acquired skills and qualification levels needs to be addressed.

Implications of the CHC02 review

Many of the issues raised by managers concerning satisfaction with VET were also identified in a recent review of the CHC02 training package (Community Services & Health Industry Skills Council 2007). This review resulted in the development of the CHC08 training package introduced in 2009. However, training providers were not required to implement this new training package until 2010, and NCVER enrolment data indicated that in 2009 very few students were enrolled in the CHC08 version of the Certificate IV or Diploma in Alcohol and Other Drugs Work. Thus, the views of managers reported here are based on training undertaken as part of the earlier (CHC02) training package; it is therefore unknown to what extent the new training package will address managers' concerns.

The review of CHC02 recommended improvements to career pathways across the community services sector and better articulation between higher education and VET (Community Services & Health Industry Skills Council 2008b). To achieve this, the review recommended the establishment of four major sector worker classifications to increase transferability across community service areas: individual client services; community services and development; children's and youth services; and client services. As a result, through the new CHC08 training package, the Certificate

IV and Diploma in Alcohol and Other Drugs Work will offer more diversity and flexibility in topics and curricula content and a much larger number of unit topics.[4]

However, many of these unit topics are generic community service topics, and there is some concern in the sector that the inclusion of these generic topics and the greater flexibility in choice of electives have come at the expense of alcohol and other drugs specific topics (personal communication with Victorian Alcohol and Drug Association and the New South Wales Network of Alcohol and Other Drug Agencies, June 2010). An example of this is demonstrated by the replacement of CHCAOD10A (work with clients who have alcohol and other drugs issues) as a core competency of the CHC02 training package with CHCMH401A (work effectively in mental health settings) as a core competency in the new CHC08 training package. While managers report that they regard mental health and drug comorbidity as an important alcohol and other drugs issue, there is also a view that CHCMH401A does not address this issue and is somewhat irrelevant to alcohol and other drugs work. In addition, the new CHC08 training package largely addresses training content and career pathways and appears to do little to address other issues raised here by managers, such as the need for practical experience via clinical placements, dissatisfaction with the quality of VET assessment, variations in the quality of training across training providers, and lack of industry experience among trainers.

Suggestions for improvement

Managers specifically identified that more emphasis on alcohol and other drugs content, clinical skills development (for example, counselling skills) and provision of clinical work placements would improve the usefulness of VET for alcohol and other drugs workforce development. Themes identified in managers' qualitative responses included the need for a more rigorous method of assessment and more stringent quality controls relating to training content and delivery. Some managers indicated that better training outcomes would occur if there was improved correspondence between what is learned through training and skills required on the job; if training content was kept up to date with industry developments; and if the content knowledge of trainers was improved. Managers also indicated that the facilitation of networks and links between training providers and industry could help to achieve these aims. Some managers expressed the view that having training providers working closely with them resulted in more competent workers who acquired skills relevant to workplace needs. Development of trainer–industry relationships allowed for on-the-job training and assessment, consultation with individual managers to identify worker and service needs, and the opportunity to oversee training content, delivery and assessment.

VET and higher education enrolment data

The second part of this project included an examination of VET and higher education enrolment data. Limitations in both of these datasets restricted our ability to adequately examine the workforce development implications of training delivered through these two sectors. VET data may not have included all private training provider and government-funded program enrolments. In addition, VET enrolment data did not allow for a distinction to be made between students enrolled to complete the full certificate IV and those enrolled to complete only the four core competencies. This latter limitation is particularly relevant to an examination of the implications of training in an industry sector that is supportive of a minimum qualification strategy, one that requires substantial proportions of workers to only obtain four core competencies.

[4] For example, new topics in the Certificate IV, such as CCOM403A (use targeted communication skills to build relationships) are consistent with the importance managers place on communication skills and topics such as HLTHIR404B (work effectively with Aboriginal and/or Torres Strait Islander people), which focus on specific client populations. In doing so, the new training package provides the flexibility to match workers' skills with specific workplace needs.

It was also intended that this project would undertake an analysis of higher education enrolment data for alcohol and other drugs specific courses. However, these data also proved to be very limited. Enrolments in alcohol and other drugs specific courses could not be readily identified as this level of specificity was often missing. As an alternative, an analysis of higher education enrolment data in alcohol and other drugs 'relevant' courses was undertaken.

The analyses of enrolment data that could be undertaken revealed key differences in the demographic profile of VET and higher education students, which have implications for workforce development strategies. Approximately half the number of students enrolled in VET at the certificate IV and diploma level resided in Victoria. This may largely be due to the introduction of the Minimum Qualification Strategy in Victoria in 2006. This strategy required workers employed in alcohol and other drugs agencies funded by the Victorian Government to hold certificate IV-level qualifications in alcohol and other drugs work as a minimum qualification (Roche & Pidd 2010).

VET students were generally older than higher education students. This suggests that the VET sector could have an important role to play in retraining older workers (for example, those who have been retrenched through the downsizing of industries such as manufacturing) to meet the recruitment needs of growing service industry sectors.

By contrast, enrolment data indicated that higher education students were much younger. Given that contemporary data indicate that more than half (59%) the alcohol and other drugs workforce are older than 40 years (Roche & Pidd 2010), this finding indicates that recruitment campaigns targeting higher education students may go some way towards addressing this ageing workforce.

Higher education and VET pathways

Around one in ten higher education students (11%) had commenced or completed prior VET qualifications. The proportion of students identified who utilise VET qualifications as a pathway to higher education is similar to previous estimates (Young 2007). However, around 10% of VET students enrolled in the certificate IV and 20% of VET students enrolled in the Diploma in Alcohol and Other Drugs Work held a prior higher education undergraduate qualification. This may indicate that a proportion of higher education graduates who hold qualifications in health or society and culture topics utilise the VET system as a pathway to employment and/or skill development.

In addition, the larger proportion of students with higher education qualifications enrolled in diploma courses may provide some insight into the course content and delivery standards increasingly expected by students and required by employers. The higher proportion of graduate-qualified students enrolled in diploma courses in some states and territories may also be explained by the availability of financial assistance to undertake a diploma (FEE-HELP); however, this is unlikely to explain the higher proportions of graduate-qualified students enrolled in diploma courses in Victoria and the Australian Capital Territory, where certificate IV training was provided free of charge as part of minimum qualification strategies. Closer examination of the relationships between VET and higher education is required to inform future course development and career pathway advice to students and to identify ways to best serve the industries involved.

Conclusion

The most recent environmental scan of the health and community services industries (Community Services & Health Industry Skills Council 2009) identified that training packages delivered in the VET sector were fundamental to future workforce development and reform in the health and community services industries. The current study indicates that the VET sector has the potential to play a similar role in the alcohol and other drugs sector—not only in providing entry-level qualifications and ongoing training, but also in providing higher-level qualifications at the diploma level. Moreover, VET has untapped potential to provide qualifications at the vocational graduate

certificate level, which would meet the need for more complex in-depth training and alternative articulation pathways.

However, the current study identified relatively high levels of dissatisfaction with VET that may negatively influence its potential to meet the workforce development needs of this important health-related sector. Overcoming this barrier and enhancing the potential of VET may require more effective linkages between the alcohol and other drugs and VET sectors in conjunction with a range of other strategies to improve the quality of training provided. Appropriate resourcing and sufficient support from key players would make this a feasible endeavour.

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Support document details

Additional information relating to this research is available in *The role of VET in alcohol and other drugs workforce development: support document* and *The role of VET in alcohol and other drugs workforce development: survey technical report*, which can be accessed from NCVER's website: <http://www.ncver.edu.au/publications/2319.html>.

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