RACMA
ROYAL AUSTRALASIAN COLLEGE
of Medical Administrators

Submission to the Review and Revision of the National Alcohol and Other Drug (AOD) Workforce Development (WFD) Strategy: Discussion Paper

March 2022

About the Royal Australasian College of Medical Administrators

The Royal Australasian College of Medical Administrators (RACMA) is a specialist medical college that provides education, training, knowledge and advice in medical management. Recognised by the Australian and New Zealand Medical Councils, it delivers programs to medical managers and other medical practitioners who are training for or occupying Specialist Leadership or Administration positions.

RACMA is committed to achieving excellence in the Speciality of Medical Administration in Australia, New Zealand and the Asia Pacific Region, in order to enhance and maintain high standards of health care across the region.

RACMA Fellows occupy a wide range of senior positions including Chief Medical Officers/Director of Medical Services; chief executives of hospitals and universities; heads of divisions of medical services; heads of health authorities; chief health officers of government jurisdictions; Consultants to governments and private sector health services; and public policy and health program management in information technology and pharmaceuticals.

Consultation Introduction

The National Centre for Education and Training on Addiction (NCETA), Flinders University, has been commissioned by the Australian Government Department of Health to review and revise the National Alcohol and Other Drug (AOD) Workforce Development (WFD) Strategy 2015-2018 (the Strategy).

RACMA recognises the importance of well-trained and qualified alcohol and other drug workforce that can respond to the needs of people with AOD problems. An adequately staffed and sustainable AOD workforce is imperative to effectively prevent and respond to problematic use and related harms across Australia. The AOD sector needs to have capacity and resources to be able to respond to the needs of individuals, their families and the broader community with regard to the impact of problematic use.

RACMA is providing this written submission as part of the stakeholder consultation on the Discussion Paper. Overall RACMA is supportive of strategies to increase the AOD workforce as well as enhancing awareness, knowledge and skills for doctors in AOD assessment and treatment across Australia.

Discussion question 1: What are the priority WFD issues that have emerged since the first Strategy (2015-2018)?

The specialist AOD workforce is small in comparison to the societal impact that problematic AOD use has on the community. There is evidence that the AOD medical workforce is an aging population and that chronic and complex patient presentations are becoming the norm. This does support the need for expanded skill sets that can respond to the different needs of people presenting for help.

There is wide diversity in the AOD population and an ever-changing landscape of substance use patterns. Key minority and vulnerable groups would benefit from AOD workers who can provide a more tailored response, for instance rural and remote communities. The current specialist workforce aims to meet these needs but are often poorly resourced or based primarily in metropolitan areas.

Problems with limited training and career pathways and variable governance structures have led to service designs that vary and may not be evidence-based.

Discussion question 2: What are the priority actions to improve WFD at the:

a) Systems

RACMA supports review and development of clear frameworks for governance of service delivery by engaged competent AOD workers.

RACMA supports the need for long term system level funding initiatives that increase the AOD specialist workforce across the clinical disciplines in order to maintain a sustainable and responsive service delivery. Specific funding structures are needed to support consistent pathways for entering and retaining the workforce. As such, RACMA support the development of a transparent and readily available national AOD workforce census to guide planning.

Problematic AOD use is often associated with complex comorbidity and social problems. System level decisions need to facilitate a long-term focus on the interface between primary, secondary and tertiary services. Within the healthcare system, private practice can be used to ease the pressure on the public AOD system but requires a range of reimbursement options for specialist clinicians. There also needs to be consideration of the impact of social determinants of health within this sector and to bring greater cohesion to supports from the NGO sector through integrated care, collaborations and partnerships as well as with interagency stakeholders (e.g., police and criminal justice).

Long-term funding commitments should enable pre-vocational doctors to gain experience or follow a specialist training pathway through early exposure to the range of AOD settings. Alongside this, is the importance of providing placements for medical students that are likely to increase their understanding of problems people face with AOD use and to reduce negative perceptions and stigma against them.

b) Organisational

High quality supervision and support is critical for strengthening the quality of the AOD workforce. Subspeciality training remains a priority and organisationally there is a need to improve supports for trainee supervisors to strengthen and support delivery of robust supervision for trainees in rural and remote areas and for those in specific specialist areas like prisons.

Without support for skills development across the sector there will be a lack of capacity to set up new models of care. Partnerships between providers and consumers in service design can guide clarity in skill set development. Consumer representation in steering groups is also supported.

Support for collaboration between state and territory workforce planners, universities and increasing service funding for additional training posts or specialist teams in high-need locations.

(c) Individual worker

Increasing specialist allied health and nursing staff numbers is a short-term priority for AOD WFD. With increasing complexity of presentations, a multidisciplinary approach is the preferred model of service delivery. Inclusion of appropriately trained and supported peer workers within community based AOD services within multidisciplinary teams can provide lived experience support to people with AOD problems.

As with other areas of the health sector, improving remuneration and workplace safety is critical AOD workers.

Discussion question 3: Thinking about <u>specialist AOD workers</u>:

a) What are the priority WFD issues for AOD specialist workers?

The shortage of Addiction Medicine specialists is a major priority. A lack of medical specialists impacts on the provision of AOD services, particularly to those with complex needs or registered on opioid replacement programs.

(b) What WFD goals should be set for improving WFD outcomes for this group (i.e., what should be we aiming for?)

There are currently two major pathways for doctors to become specialists in AOD interventions: via an Advanced Training Certificate with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and Fellowship with the Chapter of Addiction Medicine (Royal Australian College of Physicians). RACMA supports reinforcing career pathways for doctors to become specialists including any opportunities for recognition of prior learning.

(c) What are the major steps in the short-medium and longer term to achieve these goals?

RACMA supports consideration of Commonwealth funded Specialist Training Positions (STP) that prioritise Addictions training positions within the public sector across metropolitan, regional and remote areas. Development of more integrated training options can enable opportunities for exposure to the AOD sector from within and across a range of Specialist Medical Colleges, e.g., Australian College of Emergency Medicine, Australian College of General Practitioners.

Discussion question 4: Thinking about generalist workers:

(a) What are the priority WFD issues for generalist workers?

Generalist workers as defined in the Discussion paper are an integral part of service delivery and community support as this workforce is made up of a range of clinicians and workers in the broader health, disability and support sectors.

b) What WFD goals should be set for improving WFD outcomes for this group (i.e., what should be we aiming for?)

While staff upskilling with integration of AOD content into training as well as increased accessibility to training, the practicalities of this are unclear. It could include clinical placements, access to / involvement in programs that offer AOD information and brief interventions and working alongside specialists delivering treatment and/or support.

(c) What are the major steps in the short-medium and longer term to achieve these goals?

This is outside the expertise of RACMA.

Discussion question 5: Thinking about the workforce groups who identify as Aboriginal or Torres Strait Islander:

(a) What are the priority WFD issues for these workers?

RACMA acknowledges the fundamental importance of the issues identified in the Discussion paper and recognise that recruitment and retention of Aboriginal and Torres Strait Islander AOD workers is a pivotal to addressing the challenges. RACMA recognises that appropriate strategies are required to change the underrepresentation of Aboriginal and Torres Strait Islander peoples working in the health sector in general and within medical workforce.

There is well established recognition of barriers facing Aboriginal and Torres Strait Islander peoples to progress in the health sector.

(b) What WFD goals should be set for improving WFD outcomes for this group (i.e., what should be we aiming for?)

Goals that aim to increase Aboriginal and Torres Strait Islander workers in the AOD workforce; promoting workplaces as culturally safe and improving the opportunities for of Aboriginal and Torres Strait Islander peoples to take up senior positions.

Partnerships with Aboriginal and Torres Strait Islander peoples in the design of services, decisions on recruitment methods and development of roles for Aboriginal and Torres Strait Islander mental health workers.

(c) What are the major steps in the short-medium and longer term to achieve these goals?

With specific regard to AOD, it is critically important to enable additional training and support for Aboriginal and Torres Strait Islander people interested in a career in the AOD sector to function within their communities. Access to culturally safe and relevant supervision, particularly in rural and remote areas.

Ongoing support for professional mentoring in specialist medical trainee years is required.

Discussion question 6: Thinking about other the workforce groups with unique needs (e.g. rural, regional and remote workers, peer workers, law enforcement and corrections workers):

(a) What are the priority WFD issues for these workers?

Workforce shortages will compound the already complex working conditions of regional, rural and remote areas.

The peer workforce has unique needs in that they are vulnerable to the conditions they are offering their vital lived experience to AOD treatment sector.

(b) What WFD goals should be set for improving WFD outcomes for this group (i.e., what should be we aiming for?)

Focused recruitment and retention strategies with a clarity on expectations for roles and orientation initiatives that recognise the unique risk factors that the AOD worker may face.

Flexibility and access to a range of specialists with unique knowledge of the area in which specific workforce groups function. Programs that enhance accessibility to professional development.

Opportunities for advanced training of rural generalists that specifically provides them with skills to manage their patient cohort.

Appropriate training for peer workers providing them with skills needed to succeed as part of the AOD workforce. Access to the same recruitment, retention and support strategies as other staff.

(c) What are the major steps in the short-medium and longer term to achieve these goals?

Funding supervision frameworks for groups with unique needs. From a medical perspective, support for supervisor positions to allow trainees to remain within their unique area (e.g., prisons, rural or remote).

Enabling training to be undertaken with greater flexibility on how to supervise, accredit and assess clinicians undertaking specific AOD training.

(d) Are there Australian or international examples of effective WFD for these groups that could be replicated/adapted?

This is outside the expertise of RACMA.

Discussion question 7: What WFD strategies for the AOD workforce will best support and ensure effective service delivery for client groups who identify as Aboriginal and Torres Strait Islander? What are the immediate priorities for attention and action in this area?

RACMA supports overarching recognition of the role of culture and community play in the healing process and having access to community-controlled organisations that can provide care and support embedded within communities.

A skilled and valuable Aboriginal and Torres Strait Islander AOD workforce needs funding structures that are sustainable that offer job security and various opportunities for training and support.

Placements and scholarships can encourage a committed workforce which is confident to deliver culturally relevant AOD services that utilise Aboriginal and Torres Strait Islander ways of working. Supervision structures need to be robust and culturally safe. Telehealth options require high grade technical quality.

Discussion question 8: What are the key WFD strategies for the AOD workforce will best support and ensure effective service delivery for client groups with specific and unique needs (e.g., younger or older people, people who identify as LGBTIQ+, clients with complex needs)? What are the immediate priorities for attention and action in this area?

AOD use varies across different populations and age groups. There is increasing clinical complexity with age and higher risk of violence and suicide in youth. The AOD worker is required to be able to adapt in an increasingly versatile manner and have competencies in AOD, mental health and physical health.

Clarity of role requirements when working in specific parts of the AOD sector with appropriate onboarding and packages will assist in recruiting workers with the right fit and identifying gaps in knowledge that need to be addressed in the workplace.

From a general health sector perspective, due to the ubiquitous nature of AOD problems, consideration should be made to opportunities for awareness building in orientation of new staff.

Discussion question 9: How can integrated care with other sectors (e.g., mental health) best be achieved in practice to support clients with multiple and complex needs? Are there Australian or international examples of best practice in this area that could be replicated?

Interventions should align with the National Standards focusing on chronic and complex care and so, from the health perspective, AOD needs to be better incorporated general service delivery.

Integration needs to consider not only AOD, mental health and physical health but also the social needs of people presenting with AOD problems. The impact is wider than health and needs to look for better understanding and recognition of broader community including education and law enforcement and provide pathways for pathways social interventions (e.g., Domestic &Family Violence).

Co-location of clinical care can enhance accessible clinical pathways and integration of care.

Discussion question 10: Considering funding models and arrangements in the AOD sector:

(a) What are the priority WFD funding issues for the AOD sector?

Vocational training opportunities including STP for Addictions training in both metropolitan areas and the public sector.

Activity Based Funding does not easily suit the AOD sector as most care in provided in the community and not as inpatients, and in hospital settings many consultations are of long duration. Grants or block funding may better suit this sector

A fee-for-service model of funding may not address the complexity and chronicity of care to be provided.

Robust telehealth services are not consistently available or able to be reliably monitored.

(b) What are the immediate priorities for attention and action in relation to WFD-related funding?

Medicare options for Addictions specialists.

(c) What types of funding models would best support the capacity and effectiveness of the AOD workforce?

Please see above.

Discussion question 11: Considering recruitment and retention in the AOD sector:

(a) What are the key issues and challenges?

Pay parity – in jurisdictions where private health and insurance reimbursements are based on an individual patient, people with AOD problems are unlikely to offer opportunities for Addictions specialists to conduct Right to Private Practice clinics in the public sector. In the private sector the limited options for Medicare reimbursement reduce attractiveness.

Clinical experiences of placements/working in AOD sector where the breadth of experience was too focused or limited.

Career pathways for other members of the multidisciplinary team (MDT).

(b) What are the immediate priorities for attention and action?

Alternative reimbursement strategies to support parity in public and private sector.

(c) What initiatives would best support effective recruitment and retention in the AOD sector?

Please see above.

Discussion question 12: What substances should be considered of particular concern for the AOD sector at the current time and into the future and what are the implications for AOD WFD to ensure effective responses?

This response depends on the viewpoint being taken. From a community perspective alcohol remains the biggest priority as it is widely used and problems with its use have significant impacts on the community.

Within an acute hospital setting methamphetamine is a high-risk drug, leading to damage to self and others, particularly staff in Emergency Departments and Mental Health Units.

Within the wider health sector, the prescribing of opioids is of concern and Opioid Stewardship programs need to be supported.

Discussion question 13: Should minimum educational qualification standards for specialist AOD workers be implemented in all jurisdictions?

RACMA acknowledges potential benefits of minimum qualification standards for specialist AOD workers across all jurisdictions in setting a baseline level for AOD skills and competencies. Minimal qualification standards can support the status of the clinical workforce with regard to its professional standing. However the inclusion of peer workers as part of the specialist workforce would not support a minimum qualification.

The implementation of a minimum qualification standard would need to be in keeping with the unique skills of each clinical craft group (e.g., from medical specialist to social worker).

There is also a risk that early implementation of minimum qualifications would be seen as a barrier to entering the workforce.

Discussion question 14: How well is the current vocational education system meeting the needs of the AOD workforce and sector? What are the immediate priorities for action in this area?

The current vocational education system does not appear to be adequately meeting the needs of the AOD workforce sector. There is support for opportunities to increase and improve the content of general training programs as well as for those entering specialist training.

Barriers to any specialist training include lack of training opportunities, the funding of positions, investment of time and support for workers within the workplace.

Access to on-the-job training, e-learning and short courses can assist with ongoing development of clinical knowledge and expertise.

Discussion question 15: What are the key issues and challenges for professional development (PD) in the AOD workforce? This may include issues related to accessibility, quality, modalities (e.g., supervision, training), content (e.g., priority KSAs) or other matters.

The key issues and challenges for PD are similar to those outlined above for training. Additionally employment award entitlements can impact on access to funds / time for PD.

A national perspective on scholarship and other educational funding options could be beneficial. The impact of the new continuing Ahpr professional development requirements for medical specialists may provide opportunities for furthering education and review.

Since COVID-19 there has been a significant increase in familiarity with technology and social media. While online learning, communities of practice and teaching / supervision options are supported, these can only be seen within the context of many options due to logistical or socio-economic disadvantage like lack/poor reliability in connectivity, individual capability and cost of access to the internet, and risks related to cyber-security.

Discussion question 16: What WFD strategies will best support AOD services, workers and clients to engage effectively with digital and online service provision? What are the immediate priorities for attention and action in this area?

Maximising current technology options and seeking to improve the quality of technology is critical. Alongside this, however, is the need to staff training in competence and recognition of safety concerns when delivering clinical care virtually.

Within the AOD sector there is also the significant issue of consumer affordability of access and their individual comfort in utilising online resources and virtual care.

Discussion question 17: To what extent is the development of a national AOD workforce data collection a priority (e.g., an AOD workforce census)? How could this data collection be integrated with, and leverage, existing jurisdictional AOD workforce data collections? What existing data collections could be used to monitor progress?

The development of a consistent and coordinated national AOD workforce data collection is a critical priority, particularly as this workforce is comparatively small in relation to the societal influence of alcohol and other drug use. While in principle, RACMA would support greater coordination across jurisdictional boundaries it is unclear as to how this would add value to decisions being made at a State and Territory level.

The breadth of the data collection may impact on the voracity of the data as the sector is made up of specialist and generalist expertise. A focus on the specialist AOD workforce in the first place will enable more considered funding and service delivery decision. Implementation would require joint governance and data sharing agreements across data custodians and the requirement to register a service/provider as a specialist service.

Discussion question 18: What are the priority actions for effective and timely monitoring and implementation of the revised Strategy?

Any reform should include an implementation and evaluation plan and the outcomes of this consultation process can form a basis for the plan. The development of an implementation plan with national oversight would require significant resources, even though this will support greater consistency and support for sharing across jurisdictions.

With an adequately resourced plan, the Commonwealth Government could set out key principles and overarching actions to hold States and Territories to account.