National AOD Workforce Development Strategy

Submission By:
The National Centre for Youth Substance Use Research

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

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Thank you for the opportunity to comment on the Review and Revision of the National Alcohol and Other Drug (AOD) Workforce Development (WFD) Strategy.

The National Centre for Youth Substance Use Research (NCYSUR) is one of the four Commonwealth-funded alcohol and other drug research centres in Australia, and the only centre dedicated to youth. We seek to reduce the prevalence and severity of problem alcohol and drug use in Australian communities; enhance research capacity informing national efforts to address substance misuse; and increase our knowledge on treatment approaches for emerging drugs of concern and innovative treatment models.

There are substantial benefits in investing workforce development resources to improve the health of young people by influencing life trajectories, creating opportunity, reducing vulnerability, addressing inequity and influencing the next generation. Young people often lack a clear voice, or perceived legitimacy in accessing addiction treatment services. Substance use typically commences in adolescence and early initiation is associated with a greater likelihood of later substance misuse and poor mental health. The World Health Organization (WHO; 2021) lists alcohol and other drug use as one of the 12 main health issues influencing global adolescent and young adult health. The Australian National Drug Strategy 2017-2026 also recognises young people as one of 7 priority populations.

This submission focuses on workforce issues that are most relevant to substance use in young people, as well as commenting more broadly on the Discussion Paper.

We fundamentally agree with the workforce issues identified by the NCETA Discussion Paper and the system, organisational and individual factors that need to be addressed. It is noteworthy that considerable attention has been given to negative impacts on wellbeing and career progression and pathways, including significant stress and burnout, low retention and high turnover, and stigma by association for AOD workers – which are well-recognised barriers to adequate workforce quality and sustainability.

The Discussion Paper addresses young consumers (p. 24, briefly) in statistical terms, demonstrating the disproportionate representation of this age group among those that have substance use problems. A broader discussion regarding the impact on workforce issues could contextualise these findings further (as flagged in Discussion Point 8), particularly given the inadequate number of AOD services targeted to young people, major gaps in service provision (particularly outside the capital cities) and the associated deficits in workforce training for this age group.

Young people affected by alcohol and other drug use typically do not seek help as many do not view their use as problematic. Some attend primary care services under parental/carer supervision, often without confidentiality provisions. Many more are identified though emergency, police, housing, domestic violence and forensic services, for example when they present to ED and other frontline services with AOD related injuries and acute intoxication. These patients typically do not go on to access treatment via available pathways. This is a missed opportunity, due in part to shortfalls in current workforce skill sets. We agree with the Discussion Paper that there needs to be minimum training and qualifications to work in the AOD sector, which is a major contributor to a sustainable and effective workforce. However, young people whose AOD use may put them at elevated risk often experience first and/or subsequent service contacts with practitioners who work across clinical and community-based contexts, outside the AOD sector.

For these reasons we believe further consideration could be given in the Discussion Paper to more effectively engaging with professional health bodies (e.g., the Australian Medical Association, Australian Psychological Society, Australian Health Practitioner Regulation Agency, Australian Nursing and Midwifery Accreditation Council) and police and legal/forensic providers to better upskill our next generation of professionals. These may not be AOD workers per se, but their duties will require them to assess, manage and often treat young people who have developed problems with alcohol and drugs, but encountered a gap between their needs and a youth substance use workforce.

The lack of AOD content in undergraduate university and vocational programs also needs to be addressed. The establishment of partnerships between AOD services and education/training institutions through the provision of guest lectures, and volunteer and student placements would not only enhance skill development, but also provide a pipeline for the recruitment of new workers into the sector. Micro-credentialling courses where AOD workers and other affiliated professions in contact with young people complete a series of short courses that can be articulated into a certificate or graduate diploma, could also be considered as a way of upskilling existing staff. This is critical for the future of AOD workforce development.

Young people that do seek AOD treatment typically reflect the more severe end of the AOD spectrum. It is well recognised there is a shortfall of clinical services available for young people experiencing problematic substance use, and this is reflected in the workforce that arguably has inadequate training in working with this age group. Publicly funded youth treatment services provide poor coverage, particularly in rural and remote areas, which discourages members of the AOD workforce from pursuing a career in these areas of critical need. The better resourced public hospital adult services (18+) do not admit youth. There are major service gaps in the precise age group where substance use is heaviest and most treatment gain can occur. There are several notable exceptions in each State of well-integrated youth AOD services, located in capital cities. For the remainder of Australia, parental/carer private health coverage for private AOD treatment remains one of the few viable options. With the lack of a public and non-government funded workforce in this space, there is a major risk of Australian AOD treatment services replicating the North American privatised model where treatment is largely inaccessible to the most vulnerable groups, including young people.

We agree that more stable and secure funding models, clearer career steps and pathways, access to clinical supervision and high-quality professional development and a level of renumeration that reflects the education, training, and experience of AOD workers will increase job security and retention. However, the increasing complexity of the clients presenting to AOD services is a major concern. Rather than expecting AOD workers to develop advanced and specialised skills in the treatment of multiple comorbidities, we wonder if a clearer focus on the role of AOD services in treating primary AOD use (including polysubstance use) problems with secondary comorbidities, may help to reduce the growing demands on AOD workers and services.

Regrettably, we know considerably less about what the most effective treatment approaches for youth with AOD problems are, including associated mental health comorbidities. There are major gaps in studies in this age group and high-quality research is central to determining what type of AOD professional can most effectively deliver which treatment, and when, to which age groups. Behavioural and pharmacological approaches have a more limited evidence base for youth populations, and most adjunctive AOD medications have not been approved for younger age groups. More research is needed to address these critical gaps in the evidence base for youth AOD treatment.

We need to know more about the treatment seeking characteristics of young people. The Alcohol and Other Drug Treatment Services National Minimum Data Set shows that AOD services predominately provide “Assessment Only” or “Information and Education”. Treatment, on average, involves contact with services on one or two instances – this is inconsistent with best practice evidence-based AOD treatment. For these reasons, which are particularly relevant for young people who can be more ambivalent about engaging in treatment, we require more effective strategies to engage youth in our workforce training. For example, brief interventions designed to support young peoples’ decision to enter AOD

treatment or other support services should be a future focus of broader workforce training and development roll out.

The Discussion Paper may also benefit from a framework for implementing draft recommendations with specific strategies that cut across state and federal workforce funding and AOD training models, and use existing advocacy and support mechanisms (e.g. The Australian Alcohol and Other Drugs Council [AADC], state peak AOD bodies) to facilitate and enact change. Working more effectively with health professional organisations (AMA, APS, AHPRA, ANMAC, etc) and other professional groups who provide service to our young AOD users is critical to the future of workforce development.

NB: *This document was prepared by Professor Jason Connor (Director), Professor Leanne Hides (Deputy Director) and Ms Sarah Yeates (Senior Research Assistant) from the National Centre for Youth Substance Use Research and may not represent the views of The University of Queensland or all staff and students affiliated with the Centre.*