National AOD Workforce Development Strategy

Submission By: Penington Institute

PENINGTON INSTITUTE

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Review and Revision of the National Alcohol and Other Drug (AOD) Workforce Development (WFD) Strategy

Submission

Penington Institute

March 2022

Introduction

Our mission

Penington Institute actively supports the adoption of approaches to drug use which promote safety and human dignity.

We address this complex issue with knowledge and compassion. Through our analysis, research, workforce education and public awareness activities, we help individuals and the wider community.

Our history

Launched in 2014, Penington Institute, a not-for-profit organisation, has grown out of the rich and vibrant work of one of its programs, Anex, and its 20 years' experience working with people and families directly affected by problematic drug use.

Penington Institute is inspired by and named in honour of Emeritus Professor David Penington AC, one of Australia's leading public intellectuals and health experts.

Our vision

Our vision is for communities that are safe, healthy and empowered to manage drug use.

Our understanding

Drug use trends, drug development and markets historically move faster than research and policy responses. With our outreach to the front-line we are well-placed to know and understand the realities of how drugs are impacting communities – well before the published literature surfaces significant issues.

We combine our front-line knowledge and experience with our analysis of the evidence to help develop more practical research and policy, support services and public health campaigns. Our strong, diverse networks provide an excellent platform for building widespread support for effective initiatives.

Our activities

We: -

- Enhance awareness of the health, social and economic drivers of drug-related harm
- Promote rational, integrated approaches to reduce the burden of death, disease and social problems related to problematic substance use
- Build and share knowledge to empower individuals, families and the community to take charge of substance use issues
- Better equip front-line workers to respond effectively to the needs of those with problematic drug use.

Our purpose is framed by our knowledge that we need to look at more effective, cost-efficient, and compassionate ways to prevent and respond to problematic drug use in our community.

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

An area of ongoing concern in the AOD workforce is the low priority given to harm reduction activities. The Draft WFD strategy refers to harm reduction only twice, and these mentions are only in regard to the Commonwealths National Drug Strategy where harm reduction is mentioned alongside demand and supply reduction. This oversight in some ways makes it challenging to comment on the draft strategy as the work that Penington Institute does is primarily focused on harm reduction, which is obvious only by its omission.

Harm reduction services, inclusive of needle and syringe programs (primary and secondary), like many sectors experienced significant service delivery impacts due to covid 19. The need for a strong harm reduction approach was immediately apparent when public health orders were in place, especially those that restricted movements, and reduced access to support. A rapid evidence review of harm reduction interventions and messaging for people who inject drugs during pandemic events (1) noted the need for harm reduction to be considered as essential during a pandemic. Key messages around infection control, uncertain drug supply and accessing services should be delivered via multiple channels. This is of significant consideration when considered regional and remote harm reduction services, when in many instances services such as needle and syringe programs (NSP) are staffed by generalist staff often with no or limited training specific to their role in reducing harm among people who use/inject drugs.

Further, with the challenges of working frontline services during covid taking its toll on the harm reduction workforce, including the changes in service delivery, lack of face-to-face work, and the increased strain on the mental health and wellbeing of staff, there needs to be a substantial investment in the retaining, supporting, and providing of opportunities to ensure a minimal loss of skill and experienced staff.

The proposed strategy, similarly to the preceding strategy, has a focus on the treatment sector, however with no acknowledgment of harm reduction, this leaves thousands of NSP workers who have direct, frontline interactions with people who use drugs, omitted from the AOD workforce. This leads to a lack of priority and, more importantly, significant missed opportunity to provide a health service to an often-marginalised population. NSPs have the most frequent interface with people who inject drugs (PWID), much greater than the treatment sector, and this interface happens in metro, regional and remote locations across the nation. These interactions are each an opportunity to provide a positive health interaction, to provide information about overdose risk, and to reduce disease and poorer health outcomes.

The Australian government has a goal to eliminate hepatitis C by 2030. In order to achieve this goal, it will be essential to engage the workforce who interact with PWID. The NSP program has a strong history of preventing and responding to disease and was instrumental in preventing HIV transmission among PWID, thus the workforce is well equipped to provide a similar impact to reduce HCV transmission, increase uptake of medication, and support the successful elimination goal.

A further priority issue that has not been addressed is that of overdose. Overdose prevention, education and more broadly, conversations. It is perhaps a given that the AOD specialist workforce engage in and understand overdose prevention, and have the skills and training in overdose response. However, as noted above, the NSP workforce have a far greater number of interactions with people who may be at risk, and therefore are well placed to deliver overdose prevention education, including around the use of naloxone. The recently published evaluation of the national naloxone trial demonstrated the success of such a program to save lives. In Victoria, new legislation due to come into effect in July 2022 will allow all NSP staff to provide naloxone to consumers who are collecting injecting equipment. This initiative demonstrates the role of the NSP in addressing and responding to a serious AOD risk, but also highlights that by omitting this harm reduction workforce the strategy excludes a mechanism to capture the strength and impact of this program.

Discussion question 2: What are the priority actions to improve WFD at the a) systems, b) organizational, and c) individual worker levels in the short-medium (3-5 years) and longer (6-10 years) terms?

Penington Institute suggests that this strategy could be improved through more substantial proposals for improving the harm reduction workforce.

Medium term, a priority action will be to distinguish between the different treatment and harm reduction workforce issues. To achieve this a separate Harm Reduction Workforce Development Strategy should be developed to properly address the unique challenges in this disparate workforce.

The aim of a harm reduction workforce development strategy should be to:

- Promote an evidence-based quality service that meets the health and social needs of the community
- Increase NSP access
- Increase the variety of equipment provided at NSPs to ensure consumer access to equipment required for sterile injecting to prevent injecting related injury and disease

- Improve understanding among NSP agency workers of the issues around injecting drug use, the need, and benefits of the service
- Promote a sense of pride among NSP workers for the role they play in improving the health of the community
- Create a welcoming and inclusive environment and encourage safe and positive interactions between clients and staff
- Encourage networking and referrals.

Discussion question 3: Thinking about specialist AOD workers:
(a) What are the priority WFD issues for AOD specialist workers?

There are ongoing issues involved with the provision of WFD to specialist AOD workers. There is great disparity in the professional status and training of specialist AOD workers. Whereas some areas of the AOD workforce are highly qualified and respected (for instance, addiction medicine specialists), others have little or no qualifications and are in less respected roles, such as primary NSP workers. If the national AOD WFD strategy is to accommodate the diversity of workers, it must be accessible and encouraging of less professionalised sectors of the workforce, such as NSP, while remaining relevant to more highly professionalised areas. Further, while it is important to match the skills of workers to the complexity of the tasks at hand, it is also important to support less qualified workers to undertake professional development. Of paramount importance is building upon the skills developed by NSP workers in their daily roles and providing them with relevant and accessible WFD that will assist them to provide responsive, consistent, and high-level support to people who use drugs.

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

The AOD sector needs to continue to recognise the link between inequity and health and ensure that accessible, high standard and respectful services are available to these vulnerable populations. The implications of this for the WFD strategy is to ensure the AOD workforce is knowledgable and responsive to the structural determinents of health inequalites without using these determinents as an excuse for poor client outcomes. Further, WFD strategy must ensure that the AOD workforce is able to provide professional and equitable service to all clients through regular training (including attitudinal training) in the area of health inequalitites.

The strategy for WFD needs to take into account that some of the most disadvantaged groups have the poorest access to services for instance those living in rural and remote areas. With this in mind it is important to target resources to isolated areas where access to evidence based practice may be limited. It should be noted that in addition to geographic isolation there are some communities impacted by cultural factors that may also restrict best practice. This requires improved training, education and support.

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

To attract and retain high quality staff the AOD sector requires improved wages and conditions, education and WFD opportunities and better potential for career pathways and flexibility regarding working hours.

Many people working in secondary NSPs won't necessarily have training in dealing with people who use drugs so focusing on mental health first aid and de-escalation is critical as is understanding brief interventions and referral pathways.

Discussion question 4: Thinking about generalist workers:

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

While NSP workers do work with people who use drugs they are for the most part not trained alcohol and other drug workers or counsellors. Although there are relevant elective subjects in the Certificate IV in Alcohol and Other Drugs qualification such as providing first aid or working with people with mental health issues, there isn't a separate, specialised NSP qualification. For the vast majority of secondary NSP workers it is an ancillary function to their primary responsibilities.

Australia's harm reduction workforce is essential in combating drug-related harm and helping people get treatment. Yet this strategy doesn't adequately take account of their particular circumstances and the challenges faced by workers such as those operating in secondary NSPs. If we are to encourage more people who inject drugs to obtain life-saving hepatitis C medications, to address risky injecting practices and seek treatment via referral from NSPs then we need to carefully consider the state of the harm reduction workforce.

Secondly, how effective an NSP is varies across regions due to factors such as whether the service receives funding to operate, staff attitude, experience working with people who use drugs, staff turnover, location, design, opening hours and the equipment provided. While the people working in NSP agencies are often supportive of the program, there are many who do not fully understand the benefits of NSP and a few that resent having to provide the service at all. Providing training, support and opportunities for PD in this area is paramount to reduce harm and to reduce stigma and discrimination. This is especially noted as a high need in regional and remote areas.

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

When examining the strategy, Penington Institute believes that the following points must be considered:

- The strategy must consider the particular challenges that the harm reduction workforce faces
- The harm reduction workforce plays a vital role reducing a range of harms associated with drug use and saving the lives of people who use drugs. With greater investment in education, training, and development these workers could achieve even greater outcomes
- Harm reduction workers, especially secondary NSP workers, would benefit from a comprehensive and standardised training and education system. It shouldn't matter where you work, every worker deserves to benefit from development opportunities.

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

The training received by workers in an NSP is dependent on the decisions made by each health centre. Each state and territory needs to invest in a comprehensive, standardised training system so that no one worker falls between the cracks. As things stand a worker may join an NSP and receive no training for six months. This lack of training and support could affect the ability of that worker to assist someone and importantly reduce a range of harms associated with injecting drugs. By professionalising NSPs and providing the workers with the acknowledgement they deserve we can increase their status and improve the services they provide. NSPs should not be considered an "add-on" to existing services but rather a core service that saves lives. In many ways, this requires a sustained and broad approach to create a cultural shift by front-line workers and their managers.

NSP workers are also on the frontline when it comes to assisting people with a range of other referral opportunities. Many of the people who inject drugs feel marginalised and have difficulties accessing the support they need to improve their physical and mental health and personal circumstances. NSP workers are ideally placed to provide advice on and refer people to emergency housing, healthcare options including dentists and counselling as well as social workers. Their role is far more consequential than simply handing out sterile injecting equipment, harm reduction workers need to be supported and trained to take full advantage of their unique role.

NSPs are not necessarily held back by a lack of will or application; rather it is simply the case that levels of training, education and development opportunities are inconsistent and most secondaries are not directly funded for staffing the service. Some workers receive the support they need to improve the service they provide while others are not provided with opportunities and support. This shortfall is having a particularly pronounced impact in rural, regional and metropolitan urban growth areas, where harm reduction services – particularly NSPs – are few and far between. If the NSP workforce in a hospital or community health centre is not adequately trained or prepared, then people who inject in these areas don't have other options to seek out assistance. We are effectively penalising them for not living in a metropolitan area where primary NSPs are more common.

PRIORITY GROUPS

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

No direct answer

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):

People who work in correctional facilities are uniquely placed to offer harm reduction services and advice/information and thus should be considered a priority area for WFD. People in prison who previously used drugs are vulnerable to a range of drug harms on release, including relapse and a heightened risk of overdose. In 2020 and 2021, Penington

Institute worked with Department of Justice and Community Safety to deliver online train-the-trainer workshops to staff at adult public prisons across Victoria. This training was designed to enable prison AOD staff to deliver overdose prevention education to prisoners including information about overdose risk, prevention and supports available, including supporting access to naloxone upon release. This training and subsequent intervention to increase access to naloxone for at risk people, is an example of effective WFD strategy that can be minimal cost, but maximum impact in that it can save a life.

Access and availability for emergency department staff to attend AOD training, in particular harm reduction training requires priority attention. ED staff are frontline workers who are likely to interact with PWUD, often in times of increased need. PD specific to working with PWUD and their families has potential to reduce stigma and discrimination, improve support and treatment pathways, and allow for increased harm reduction strategies to be actively promoted (such as providing naloxone to people who present with opioid overdose when leaving).

Private security companies would be an example of a workforce who would benefit from AOD harm reduction education and development opportunities. Security staff are often employed in areas of high-density housing and in places where active drug markets exist. Training security staff in harm reduction strategies, inclusive of naloxone and overdoes response, would undoubtable lead to better health outcomes for people.

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?

No answer

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?

People who inject drugs (PWID) and people who are or have been recently incarcerated are two populations that are not addressed as part of the WFD strategy yet, the data shows that risk of overdose and harms are disproportionate among these populations. The challenge

among PWID is the diversity of individuals that make up this group, all with differing needs and support. Women who inject drugs are more prone to disadvantage than their male counterparts, Aboriginal and Torres Strait Islander people who inject drugs face their own set of individualized challenges, an ageing injecting drug user cohort have often long-term complex health challenges.

A comprehensive WFD strategy should aim to acknowledge PWID, and their various sub-population specific needs, beyond simply providing clean injecting equipment. Providing AOD workers with the appropriate training and support to meet the individual needs of this group should be given immediate attention.

Secondly, priority to the NSP workforce and acknowledgement that this workforce is not only geographically disconnected (in particular in regional areas) from their direct peers, but also the diverse spread of people who provide injecting equipment to consumers means training that is specific to one set of NSP staff is not always relevant to another. While acknowledging that this makes professional development more challenging, ensuring that workplaces actively encourage and support their NSP staff to participate in currently available opportunities is imperative. Ensuring that all staff access and read the Bulletin magazine – the only publication that is specific to the NSP workforce, published online and accessible monthly; encouraging and allowing staff to attend networks such as Penington Institute's Harm Reduction Network - a fortnightly zoom meeting that brings together the harm reduction sector to hear from guest speakers, direct from the (Vic) department of health and police, and share trends, intel and opportunities.

INTEGRATED CARE

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?

An integrated care model represents a great opportunity for the sector. However, to achieve this we need a dual-skilled workforce and services that do not stigmatise clients seeking help. Specific WFD needs to be undertaken to provide workers from other sectors (for example MH) to understand the principles of harm reduction, the application of a harm reduction approach, and how to integrate harm reduction thinking into clinical care. The drug treatment sector

would also benefit from increased understanding and application of harm reduction principles and practice, including the importance of providing low threshold service access.

FUNDING MODELS RETENTION AND TRAINING

Discussion question 10: Considering funding models and arrangements in the AOD sector: (a) What are the priority WFD funding issues for the AOD sector? (b) What are the immediate priorities for attention and action in relation to WFD-related funding? (c) What types of funding models would best support the capacity and effectiveness of the AOD workforce?

Any government funding to boost the NSP workforce needs to be considered separately from funding for treatment workers. If funds were to be taken from the harm reduction workforce and given to drug treatment workforce the results will be dire. Yet this strategy doesn't adequately recognise the special needs of the harm reduction sector and the needs of its workers.

Discussion question 11: Considering recruitment and retention in the AOD sector: (a) What are the key issues and challenges? (b) What are the immediate priorities for attention and action? (c) What initiatives would best support effective recruitment and retention in the AOD sector?

No answer

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?

The AOD workforce needs quick access to credible information about new substances, including synthetics, to be able to respond to this type of drug-related harm. The sector needs to develop innovative and accessable ways to deliver this information to workers. Just creating a website will not be sufficient, there needs to be proactive communication strategies and consideration of regular refresher courses to ensure workers are up-to-date with the latest drug trends and associated risks.

Our training experience at Penington Institute suggests that workers feel intimidated by changes in drug trends. When they are not confident in their knowledge and understanding of a drug they are less likely to engage with service users and therefore less likely to provide education and support. For this reason, it is important to ensure that workers have access to credible information that is timely and relevant. Workers also need support to think outside a bricks and mortar paradigm of service delivery. For instance, if more drugs are bought online, and street markets are shrinking, this workforce needs to adapt its service strategy.

With Australia continuing to be one of the highest consumers per capita of stimulant drugs, there is a distinct and urgent need to provide WFD for both the specialist AOD and generalist workforces around amphetamine/methamphetamine overdose, risks and prevalence. Penington Institute draws attention to overdose and stigma each year on International Overdose Awareness Day (August 31st) for which we receive no government funding and this is an ideal opportunity to use this event to promote awareness, offering training and ensure all workforces are equip and have capacity to understand overdose signs and offer brief interventions.

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

Minimum education standards for specialist AOD workers should be consistent nationally, updated regularly and opportunity and support for continued PD to be available. As per the above, this must include harm reduction as a core unit, not captured within a treatment model approach.

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?

No asnwer

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 strategy does not provide any details about harm reduction initiatives, and this could prove troubling for the harm reduction workforce. Alcohol and other drug treatment services often have a relatively high profile and are in touch with the Department of Health program advisers. In contrast, many NSPs fall under the radar and people working in some secondary NSP locations such as hospitals may not even know they provide an NSP service. As secondaries are not funded, the often rely on a local champion worker as they are not considered a funded program and are therefore largely without key performance indicators and other management accountability.

Further, with the lack of minimum standards in the NSP workforce, there is no accountability requirements, no analysis, data collection (beyond ordering numbers), and no accountability to work under a harm reduction framework. The lack of priority that an NSP may be given leads to lack of engagement, knowledge, and understanding about the importance of the role of NSPs in communities over and beyond the simple provision of clean injecting equipment.

DIGITAL AND ONLINE PLATFORMS

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?

An ongoing challenge for regional and remote AOD services and NSPs is access to training opportunities and PD. Covid provided an opportunity for training providers, such as Penington Institute, to shift to a hybrid model of training to include online and in person options. This shift in available training options needs to be embraced and championed by leaders in the sector to ensure equity of PD. A hybrid model can help to ensure engagement with geographically isolated services with their peers and increase skills and experience knowledge sharing.

An immediate priority for action in this area is to ensure that service leaders and managers actively encourage and allow the PD time for staff to engage with the opportunity that online training can now provide.

DATA SYSTEMS, MONITORING AND EVALUATION

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?

Regular monitoring of AOD and NSP workforce activity is crucial in facilitating continuous improvement and monitoring the impact of changes to policy and practice. To date, the collection of data from NSP sites has been sporadic, simplistic, and inconsistent across jurisdictions and individual NSP sites.

The existing National Minimum Data Collection (NMDC) provides information on NSP service provision in relation to agency-level data, client-level data and needle and syringe distribution. But the collection of data in the context of an NSP is extremely challenging; while primary NSPs may have well-trained staff who are able to elicit required information from clients during their brief interactions, secondary NSPs – where data collection sometimes relies on clients themselves completing the form and where there may be little interaction with clients – are often unable to gather reliable client-level information. Further, not all jurisdictions are able to report against each of the NMDC areas, and some jurisdictions' data elements remain misaligned with the NMDC. Without reliable data being entered across the NSP network, the NMDC is limited in its ability to monitor progress and the impact of change.

There is little information collected on some aspects of AOD and NSP workforce activities. There is a need for nationally consistent, regularly collected data on opioid substitution therapy, for example, and more consistent data to be collected on treatment service provision. Little is known about secure dispensing machines and the impact of their availability. The development of consistent data collection standards and practices – whether via an NMDC or other mechanism – would allow better understanding of the different jurisdictional approaches to AOD issues.

Data collection on its own does little to inform evidence-based decisions; data need to be collected, reviewed, and monitored, and reported on to the public, so that the community can see how the AOD NSP sectors are working. Key performance indicators could include narrow measures such as the proportion of PWUD who share equipment or are engaged in opioid substitution therapy, population-wide measures such as hepatitis C and other blood-borne virus prevalence rates, and measures of perhaps the most extreme outcome of AOD system failure – overdose death. Penington Institute's *Annual Overdose Report*, for

example, could be used as a measure of the effectiveness of the system as a whole in its bid to reduce the impact of AOD-related harm.

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

To monitor the revised Strategy effectively, the following is needed:

- Clear and measurable key performance indicators which are monitored at least annually
- Consult with AOD/HR workforces, to identify key pieces of data that are directly
- relevant and meaningful for understanding progress.
- Consult with AOD/HR workforces to identify where data collection systems need to be upgraded to allow for the data to be collected.
- Create supporting documentation around data that are required, including data dictionaries and coding guides.
- Provide training to workforce staff to ensure that they are capable in data collection methods and technologies.
- Ensure that data that have been collected at the frontline can be submitted centrally via a simple and quick method.
- Once data have been analysed, provide information back to frontline staff and the community so they can see how the data are being used.

1. References

1. *Rapid evidence review of harm reduction interventions and messaging for people who inject drugs during pandemic events: implications for the ongoing COVID-19 response.* **Wilkinson R, Hines L, Holland A, Mandal S, Phipps E.** 2020, Harm Reduction Journal .