National AOD Workforce Development Strategy

Submission By: The Queensland Network of Alcohol and other Drugs (QNADA)

Queensland Network of Alcohol and Other Drug Agencies Ltd

04 March 2022

National Centre for Education and Training on Addiction

Flinders Health and Medical and Research Institute

Flinders University

Adelaide SA 5001

Dear Professor Bowden

Thank you for the opportunity to provide a submission to the *Review and Revision of the National Alcohol and Other Drug (AOD) Workforce Development (WFD) Strategy*. The Queensland Network of Alcohol and other Drugs (QNADA) submission is attached.

QNADA represents a dynamic and broad-reaching specialist network within the non-government alcohol and other drug (NGO AOD) sector across Queensland. We have more than 50 member organisations, representing the majority of specialist NGO AOD providers. This submission is made following consultation with QNADA members.

QNADA is pleased to provide further information and would welcome the opportunity to discuss any aspect of this submission. Please don't hesitate to contact me

Yours sincerely

Rebecca Lang

CEO

Submission for the Review and Revision of the National Alcohol and Other Drug Workforce Development Strategy

February 2022

Contents

QNADA members delivered over 20,000 episodes of care to more than 14,000 Queenslanders in 2020-21, from over 100 service locations across Queensland.

About QNADA and its' members

QNADA is the peak organisation for the non-government (NGO) alcohol and other drug treatment and harm reduction sector in Queensland. We are committed to supporting our member organisations to deliver high quality, evidence informed alcohol and other drug treatment and harm reduction services to individuals, families, and communities in Queensland.

We have over 50 member organisations, representing the majority of specialist non-government alcohol and other drug services operating across the state. Our members provide a range of services including rehabilitation (residential and non-residential), withdrawal management (detox), psychosocial interventions, medication assisted treatment, and harm reduction services. QNADA actively engages and supports staff working at member organisations across all levels recognising that it is every part of an organisation that contributes to the quality of services provided.

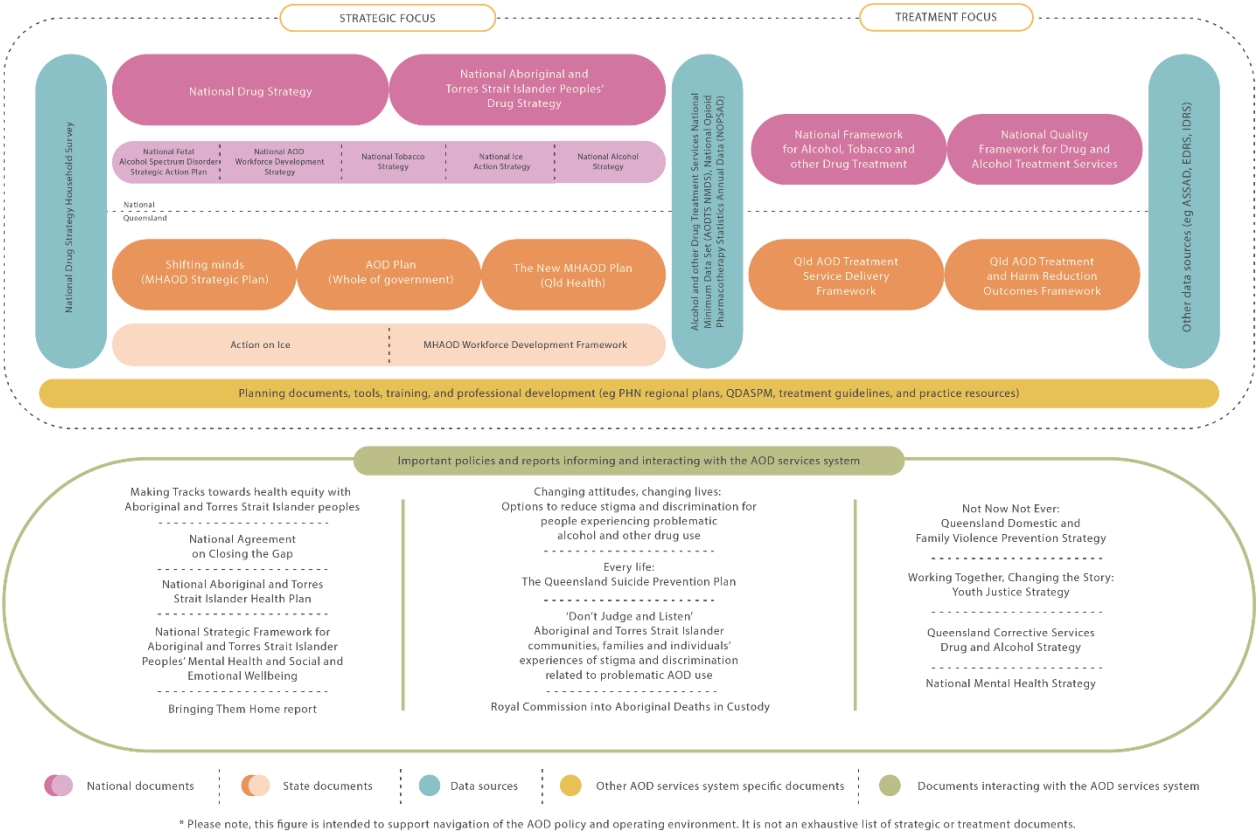
QNADA also engages our members, key stakeholders, the broader alcohol and other drug sector and other social and community sectors in activities designed to enhance workforce and sector capacity to respond to issues related to substance use.

Our strong connection to treatment providers, combined with our understanding of the Queensland context has meant we are well placed to identify the work that needs to be done; contribute to knowledge development and the translation of policy and research into practice; and to test the relevance, feasibility, and generalisability of our solutions to improve the health and wellbeing of Queenslanders.

PART ONE: The strategy

Strategy background and context

The National AOD Workforce Development Strategy needs to speak to a range of audiences to support effective AOD workforce development (eg treatment providers, policy-makers, researchers, commissioners of services, and the broader service system). Therefore, the strategy should appropriately locate AOD issues within the broader policy context to support implementation and application of the strategy across systems. There is an opportunity for the strategy to 'connect the dots' by using a figure similar to the one below,[1] which aims to highlight the range of national and jurisdictional AOD frameworks, strategies, and plans (eg PHN regional plans) that intersect with and inform each other. This would support alignment of jurisdictional activities with National AOD Workforce Development Strategy.



[1] Queensland Alcohol and Other Drugs Sector Network, "Queensland Alcohol and Other Drug Treatment Service Delivery Framework (Draft)," (Brisbane: Author, 2022).

To further enhance the strategy, background statistical information on rates of AOD use and problems in Australia should be included as follows:

- The range of patterns of AOD use, noting most people who use drugs do not experience problems or access treatment services
- Who is most likely to experience dependent or intensive use
- Workforces most likely to see people experiencing dependent or intensive use
- Locating use in the context of social, structural, historical, and cultural determinants of health.

This will help to inform people of what's relevant to them, as well as provide important context for the reasons AOD workforce development needs are varied and sit across many different but related areas. Likewise, it is important that actions arising from the strategy clearly articulate who is responsible, are process driven, and are measurable. This will facilitate effective evaluation of the strategy's implementation, and the results should be publically available.

Workforce focus and scope

Both the specialist AOD workforce, and generalist workforces that provide foundational responses to AOD issues, have an essential role in reducing AOD-related harm. While the majority of people who use alcohol and other drugs don't experience problems requiring treatment,[2] appropriate and non-stigmatising information, screening, assessment, and referral should be available at any point of contact with health and human services. This means all workforces should have some degree of specialist and generalist knowledge in order to facilitate an appropriate level of care that is within the scope of their role. However, the discussion paper and previous National AOD Workforce Development Strategy inaccurately frame the generalist workforce as part of the AOD workforce.

For example, the 2015-2018 strategy states:

> *'the AOD workforce includes workers whose primary role involves reducing AOD-related harm as well as those whose primary work focus is on other issues but, nevertheless, play an*

[2] United Nations Office on Drugs and Crime, "World Drug Report Booklet 2: Global Overview of Drug Demand and Supply: Latest Trends, Cross-Cutting Issues," World drug report 2018 (Vienna: United Nations, 2018).

important role in reducing AOD harm. Consequently, this document addresses the needs of workers from the health, welfare, criminal justice and education sectors. These could be workers acting in paid or unpaid capacities.' (p. iv).[3]

This is akin to describing the specialist AOD workforce as part of the education workforce because it can provide opportunities for people to engage/reengage with learning. Clearly this framing is redundant and unhelpful because AOD workers are not education professionals and vice versa, regardless of any responsibility to maintain basic cross sector knowledge.

While generalist workers may provide some response to AOD (eg screening, basic assessment, information, and referral), the workforce development needs of specialist and generalist workers vary significantly, as each has a different focus and scope of practice. We note Section 5.3 of the discussion paper (AOD workforce profile) appears to combine data for the specialist AOD workforce and generalist workforce together, reporting it as one homogenous group. The way this is reported will impact workforce planning and responses and which dilutes the needs of the specialist AOD workforce.

While the strategy should include identification of issues and recommendations for other systems and workforces to improve AOD responses, it should make clear that these systems need to contribute to solutions and upskilling in order to facilitate better cross sector responses. Similarly, we'd welcome a focus on the needs of specialist AOD workforce in enhancing its own responses in other areas in the context of AOD use (eg domestic and family violence). With this in mind, we strongly recommend that the revised strategy better articulates who the specialist AOD workforce includes and makes responses relevant to the specialist workforce the priority.

[3] Intergovernmental Committee on Drugs, "National Alcohol and Other Drug Workforce Development Strategy 2015-2018," (Canberra: Department of Health, 2014).

PART TWO: The specialist workforce and AOD treatment services

Recruitment and retention

Addressing worker shortages

Attracting and retaining a workforce with appropriate skills and experience is crucial to the delivery of quality specialist AOD treatment and harm reduction services. Workforce churn can undermine gains achieved through training efforts, hamper innovation, impose avoidable costs on services, affect the quality of care provided to clients, and place a burden on remaining staff.

For example, there is particular need for increased focus on development and maintenance of Aboriginal and Torres Strait Islander AOD health workers and practitioners, addiction medicine specialists, people with lived experience and peer workers, as well as AOD workers in regional, rural and remote parts of Australia. We note that these workforce groups often hold relatively lower status, lower paid positions.

Strategies to support recruitment and retention where there are workforce shortages may include:

- increased remuneration
- additional leave entitlements
- flexible working arrangements
- increased job security through longer term contracting arrangements.
- subsidised housing and utilities in regional, rural and remote communities.

Other strategies for developing and retaining specialist AOD workers include:

- Improving pathways to education
- Stable funding arrangements
- Leadership opportunities
- Developing clear career progression opportunities

There are also opportunities to support innovative models that support skilling of local community in delivering services, particularly in regional, rural and remote communities. We point to the excellent

work being done in Northern Queensland by Cape York Family Centre, who run a program supporting the community to become qualified to deliver substance use services and family therapy. Innovative programs such as these support people from regional, rural and remote parts of Australia to develop skills that stay in the community, meaning there is less pressure to bring in workers from other parts of the country who are often fly-in fly-out and short term.

Representation and participation

Investment in expansion of existing peer-led organisations to increase representation of people who use drugs and their influence in the development of AOD policies, systems, and services is essential. Important representation activities undertaken by peer-led organisations include:

- advocacy for drug law reform
- advice on service system reform
- work to reduce stigma, discrimination, and prejudice against people who use AOD across various systems of care and society at large.

QNADA recently partnered with the Qld Injectors Voice for Advocacy and Action (QuIVAA) and the Qld Aboriginal and Islander Health Council (QAIHC) to undertake consultation with people who use drugs in Queensland to understand their experiences, the issues that are important to them, and how their voices could be amplified to influence the policies, systems and services that are relevant to them. Key findings were:

- the population of people who use drugs is heterogeneous
- a range of peer-based organisations, including those who represent people who use drugs, already exist
- the representation required for AOD policy, system, and service improvement stretches beyond the health system to those such as the criminal justice and community sectors
- It is unlikely that a single peer-led organisation can represent the needs, perspectives, and experiences of all people who use drugs.

Considerations around representation and participation need to include people who currently use both illicit and licit drugs, people who have previously used drugs, and other significant people where appropriate to the representational need (eg family and friends).

Professional development

Clinical/Practice supervision and mentoring

Increasing access to individual external clinical/practice supervision for the specialist AOD workforce should be a key priority within the National AOD Workforce Development Strategy. Clinical/practice supervision has been identified as an essential AOD workforce development strategy, with evidence to suggest it has benefits for individual workers, their organisations and people who access treatment services.[4]

Access to individual external clinical supervision among AOD workers - which is considered best practice within the sector[5] [6] - remains limited, with only 24% of AOD workers reporting having access.[7] Instead, line managers often act as clinical/practice supervisors, which is problematic as it can result in role confusion, role ambiguity and could be perceived as a conflict of interest. This is consistent with findings that, when delivered by a workers' direct line manager, the effectiveness of clinical supervision in health care settings is diminished.[8]

Research suggests the primary barriers to AOD workers accessing effective clinical/practice supervision include limited resources such as cost, time and availability of skilled supervisors.[9]

---

[4] Courtney O'Donnell et al., "Barriers and Facilitators to Accessing Effective Clinical Supervision and the Implementation of a Clinical Supervision Exchange Model in the Australian Alcohol and Other Drugs Sector," *Drug and Alcohol Review* n/a, no. n/a (2022).

[5] Centre for Alcohol and Other Drugs Department of Health, "Drug and Alcohol Clinical Supervision Guidelines," (Gladesville, Australia: New South Wales Government, 2006).

[6] Queensland Alcohol and Other Drugs Sector Network, "Queensland Alcohol and Other Drug Treatment and Harm Reduction Outcomes Framework," (Brisbane: Queensland Alcohol and Other Drugs Sector Network, 2019).

[7] Natalie Skinner, Alice McEntee, and Ann Roche, "Australia's Alcohol and Other Drug Workforce: National Survey Results 2019-2020," (Adelaide, South Australia2020).

[8] Helen Kleiser and Diane L Cox, "The Integration of Clinical and Managerial Supervision: A Critical Literature Review," *British Journal of Occupational Therapy* 71, no. 1 (2008).

[9] O'Donnell et al., "Barriers and Facilitators to Accessing Effective Clinical Supervision and the Implementation of a Clinical Supervision Exchange Model in the Australian Alcohol and Other Drugs Sector."

QNADA is currently supporting a PhD project exploring how increased access to individual external clinical/practice supervision can be achieved in the Queensland context via a model of supervision exchange.

Education and training

The strategy should articulate how it will respond to the needs of:

- Workers not yet engaged with the AOD system (building workforce interest in tertiary settings)
- New specialist AOD workers (AOD universal and treatment specific, and cross sector knowledge and skill)
- Existing specialist AOD workers (AOD universal and treatment specific, and cross sector knowledge and skill)
- Generalist workers that may provide some response and referral in the context of AOD use (foundational skills to respond with a focus on stigma reduction strategies)

A useful mechanism for identifying existing workforce capacity to respond to the needs of people who access services is capability assessment tools. These can be used to monitor and evaluate workforce skill and knowledge and importantly, support continuous quality improvement. The Domestic and Family Violence Capability Assessment Tool for Alcohol and Other Drug Settings developed by the Alcohol Tobacco and Other Drug Association in the ACT is one such example.

However, there are a range of domains in which AOD workers require knowledge, confidence, and skill in order to respond appropriately, and refer as necessary (eg housing, parenting support and mental health), as well as various groups for which responses need to be culturally safe:

- Aboriginal and Torres Strait Islander peoples and communities
- People from culturally and linguistically diverse backgrounds
- Refugee and asylum seeker populations
- People with a disability
- LGBTIQ+ communities

Digital and online service provision

Queensland's specialist alcohol and other drugs services rapidly and successfully shifted to telehealth (e.g. online and telephone) responses as required throughout the course of the COVID-19 pandemic. The uptake of telehealth services during the pandemic demonstrated that these models are feasible and effective for client groups who might otherwise have limited access to services – such as those in regional, rural and remote areas. However, the full potential of telehealth is not yet realised. In our view, there are opportunities to use telehealth to improve cross-system coordination, collaboration, and connectedness, but this would require adequate planning, workforce development, and resourcing.

For example, telehealth models have been shown to be able to facilitate access to specialist treatment while people are in custody and ensure people continue to be supported when they re-enter the community. They can also facilitate access to opioid dependence treatment prescribers in regions where there are none and can enable specialist treatment access for people who would traditionally be unable to travel due to issues such as distance, cost, and time. While telehealth is not a substitute for face-to-face services, QNADA is supportive of continuing to grow the digital capability of the service system to support increased access to specialist alcohol and other drugs treatment.

Harm reduction

In response to 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' - Rather than focusing on specific 'substances of concern', the strategy should focus on actions that will build capacity and capability of the workforce to be forward-planning, and able to identify and effectively respond to problematic use of particular substances as required.

In particular, responses to emerging substances of concern should be harm reduction focussed. For example, wide implementation of early warning and monitoring systems that can help to identify patterns of use among particular populations, which in turn, can support harm reduction service providers to respond rapidly and effectively to the needs of those populations. The strategy should also consider the workforce development needs of drug checking services as they are likely to become more common in the Australian context during the life of the next strategy.

PART THREE: Policy

Qualifications and competencies

Minimum competencies

Inadequate pre-employment knowledge and skills can leave some new AOD specialist workers unprepared for their role and exposed to negative impacts on their wellbeing. It can also mean clients receive poorer quality care. There is variation across jurisdictions in relation to qualifications and competencies required to work in the specialist AOD field. However, it's important to note that most people working in AOD already hold bachelor and higher level degrees in a health related discipline.[10] Therefore, mandating AOD-specific minimum qualifications could act as a disincentive to experienced workers already in the field, and to existing or potential staff with other health-related qualifications (e.g. social work, nursing).

For example, requiring a qualified nurse to participate in further study for minimum AOD qualifications could see that person seek employment in other sectors where additional study is better rewarded or not required. Likewise, in the absence of salary award conditions commensurate with other health disciplines, experienced workers already in the field have little incentive to put time and money into obtaining an AOD qualification. Introducing mandatory minimum qualifications would also have cost implications, raising the question of who would be expected to meet these costs for the existing workforce.

[10] Skinner, McEntee, and Roche, "Australia's Alcohol and Other Drug Workforce: National Survey Results 2019-2020."

Introduction of minimum competencies is a better solution to support the service system to develop core capabilities, while also recognising experiential knowledge and skills among the workforce. However, the development of national or jurisdictional minimum competency frameworks would need to be closely consulted with and endorsed by the specialist AOD sector.

The Network of Alcohol and Other Drug Agencies (NADA) provide a useful example with their workforce capability framework. We also support on-the-job training and professional development as an effective pathway for many workers, which can lead to further study and professional development. This pathway is particularly important in regional, rural and remote communities with limited workforces, and in Aboriginal and Torres Strait Islander communities where experiential knowledge is essential to culturally safe care.

Higher education and training

Introduction of majors in AOD in undergraduate health and social services degrees has the potential to facilitate interest in the specialist AOD field and growth and sustainability of the specialist AOD workforce in the longer term. Nationally, dedicated AOD content in professional areas such as psychology, social work, medicine and nursing has been described as patchy. Interested students often need to actively seek out education in the field after obtaining their professional qualification by participating in postgraduate study. Where AOD content is offered within existing undergraduate degrees, it is likely to be brief and have a narrow focus. For example, a psychology student might learn about how substances interact with the brain over a lesson in neuropsychology but may not learn about AOD treatment issues and approaches.

PART FOUR: Systems

Integrated care

QNADA supports improving collaboration and coordination across systems of care and within the specialist AOD services system. However, the term integration is often poorly defined and understood differently depending on the focus, scope, and availability of the services in question. Actions in the strategy should clearly consider:

- The current level of AOD system coordination and planning with other systems (eg housing, corrections, mental health)

- The extent of AOD service collaboration, co-location, and coordination both within and outside the sector
- Issues around practice based coordination and treatment planning
- Tensions arising from differing treatment system philosophies and processes.

Without due consideration of the broader issues that impact 'integration', the limitations and constraints that exist in one system can lead to unintended consequences. For example, where there have been attempts to 'integrate' AOD and mental health systems in the past (by joining them up), it has resulted in a devaluing of specialist AOD treatment services and the incorrect assumption that AOD treatment could be provided in mental health settings.

Issues that impact good coordination and collaboration between systems of care include:

- a lack of understanding about what constitutes specialist AOD treatment from many planners, commissioners, other service systems, and the general community (sometimes related to stigma and discrimination)
- funding of the AOD system falls well short of treatment demand
- the size of the specialist AOD workforce (including planners and commissioners of AOD services) is comparatively smaller than other systems
- short-term or stop-start contracting arrangements, which stifle collaboration and coordination between systems of care and encourages a sense of competition for funding
- people who use drugs are heavily stigmatised and experience access issues in other systems of care.

We recommend being clear and specific when referring to integration (ie what systems, what processes of integration, and solutions to what issue). A focus should be on models of service that support and enable holistic and collaborative approaches to care, rather than those that collapse systems of care.

Service funding models

The specialist AOD workforce is stretched and under-resourced.[11] Increasing stability and predictability of funding is paramount to treatment access, recruitment and retention of a skilled workforce, and our ability to respond to treatment demand. This means prioritising funding models that stabilise rather than destabilise the workforce.

Funding mechanism	How it works	Our perspective
Block funding	Known level of payment for provider and purchaser, regular lump sum, routine reporting of activity and outcomes, performance managed via regular contracting and review	Predictable, stable, increases workforce sustainability
Activity-based funding	Payment based on level of activity or episodes of care, varying levels of payment, seeks to manage performance by incentivising efficiency	Difficult to determine appropriate units of activity due to complexity of alcohol and other drug system, open to 'cherry picking' less difficult clients in order to increase activity, less stable
Funding by outcomes	Payment based on performance (e.g. client health outcomes), seeks to manage performance by incentivising results	Potential outcomes vary based on individual and treatment approach, very difficult to determine given the complexity of people's lives, open to 'cherry picking' less difficult clients to show better results

[11] Alison Ritter et al., "New Horizons: The Review of Alcohol and Other Drug Treatment Services in Australia," (Sydney: University of New South Wales, 2014).

Cyclical short-term funding arrangements, particularly at the Commonwealth level, impact the capacity of services to effectively plan, develop and retain their workforce. Stop-start funding arrangements and last minute contract renewals creates a range of quality, safety, and treatment access issues for people seeking advice and assistance due to workforce churn. It also increases pressures in other parts of the system (e.g. mental health services, emergency departments) contributing to:

- coordination and collaboration issues, meaning people can fall through the gaps
- limitations in information and knowledge sharing which impacts the capacity of services to provide holistic and coordinated care
- a varying appetite for risk between systems which may result in punitive responses when people disclose their use
- unhelpful and outdated system responses and philosophies that can perpetuate stigma and discrimination.

Potential solutions to these issues include:

- The use of planning models to inform specialist AOD investment (eg QDASPM)
- Longer term contracting
- More lead time when contracts are due for renewal, particularly commonwealth level.