National AOD Workforce Development Strategy

Submission By: Royal Australian and New Zealand College of Psychiatrists

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

The National Centre for Education and Training on Addiction

National Alcohol and Other Drug Workforce Development Strategy (2015-2018)

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Improve the mental health of communities

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP has more than 7400 members including more than 5400 qualified psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

Consultation Introduction

The Australian Department of Health has commissioned the National Centre for Education and Training on Addiction (NCETA), Flinders University, to review the National Alcohol and Other Drug (AOD) Workforce Development (WFD) Strategy (2015-2018). The first part of the review is for feedback to a Discussion Paper.

The RANZCP recognises the importance of well-trained, sufficiently staffed, AOD workforce which is able to provide evidence-based, person-centred support for those with mental health conditions. A highly skilled, qualified and sustainable alcohol and other drug (AOD) workforce is imperative to effectively prevent and respond to problematic AOD use and related harms within Australia. The AOD sector has experienced substantial change over recent decades, and it is vital that the workforce has the capacity and support to be dynamic and responsive to meet these changing needs.

The RANZCP is contributing a written submission in relation to the Discussion Paper. Members from a range of RANZCP Committees including the Faculty of Addiction Psychiatry have provided feedback to the consultation and their responses inform this submission.

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

WFD issues are pertinent to psychiatrists - increased clinical expertise from psychiatrists and addiction sub-specialists is required to sufficiently manage comorbid mental health conditions. The Productivity Commission Report recommends a national plan be developed to increase the number of practising psychiatrists, and the RANZCP supports those calls, particularly for addiction psychiatry specialists. There remains a lack of publicly funded psychiatry therapy within the AOD sector. This leads to a lack of psychiatry input within the AOD workforce, regarding the management of people presenting to both residential and non-residential settings with AOD problems.

An increased understanding on mental health comorbidities amongst general AOD workforce is also required. Led by addiction psychiatrists, it is a priority to address the significant lack of understanding and in some cases, systemic discrimination, of people with mental illness who access the AOD treatment system. The New South Wales Special Commission of Inquiry identified cases where people accessing residential rehabilitation treatment are frequently asked to cease their mental health medications prior to admission, due to misunderstandings regarding the medication and the role it plays in the person's recovery.

The RANZCP is also aware of increasing disparities between rural and metropolitan AOD workforces. The AIHW highlights that in 2018, there were 16.0 FTE psychiatrists per 100,000 population in major cities, 6.9 in inner regional areas, 5.7 in outer regional areas, 6.7 in remote areas and 3.1 in very remote areas. Under-investment in rural mental health and psychiatry services results in fewer work and training

opportunities for psychiatrists and trainees. This is exacerbated by a medical education system that is predominantly designed and delivered in metropolitan areas to meet the needs of metropolitan communities.

Investment in training pathways for comorbidity and addiction specialist management is another priority issue. Trainees' limited exposure to managing substance use disorders during their training limits the number of trainees who chose to subspecialise in this area and limits the generalist expertise and familiarity with managing mental health comorbidities.

There are issues with trainees being overworked in under-resourced environments, increasing the likelihood of burnout. Many inpatient units are operating with a minimal level of staff, meaning if one staff member takes leave, remaining staff have a higher clinical load. Overworking and overreliance on trainees also impacts the quality of training.

The AOD WFD strategy must also specifically address stigma. Systemic stigma (relating to people with substance use disorders) within the healthcare workforce (within and external to psychiatry) is a major barrier to care. Addressing and combating stigma through training initiatives, exposure/training rotations, and through a coordinated anti-stigma strategy at a national level, would go a significant way towards improving equitable access to care for people with substance use disorders.

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

a) Systems Level

The RANZCP advocates for a range of system level funding initiatives to increase the AOD specialist workforce with addiction psychiatrists. Long term funding is required for a WFD system to be sustainable and meet the growing demands on AOD services. Targeted funding structures should aim to establish a sustainable pipeline of staff through creating consistent employment entry points, improving remuneration and security for AOD workers. Long term funding also supports the capacity of leaders and managers of the AOD workforce to be responsible for the recruitment, engagement, and development of AOD workers.

The RANZCP's pre-budget submission 2022-23 advocates for long term investment in the Psychiatry Interest Forum (PIF), to attract medical students and pre-vocational doctors to become psychiatrists (with pathways to specialising) through high-quality early exposure.

Long-term funding commitments should include a greater investment in training placements for generalist trainees within psychiatry settings to gain exposure and familiarity with common presentations. They should also include training and training supervisor posts under the Psychiatry Workforce Program, which aims to reduce the workforce specialisation gaps. The RANZCP's submission to the Care Workforce Labour Market Study also recommended investment in a care workforce that has the capacity to treat vulnerable groups with specific needs.

Whilst funding models emphasise greater cost effectiveness, efficiency, and investment, it is also imperative that adherence to these principles does not take precedence over patient care. In regional areas for instance, AOD services need to be effective before they can be cost effective.

System level changes are also required to facilitate long-term co-production between AOD and other mental health services. This includes not only secondary and tertiary mental health services but primary care systems, to ensure the AOD workforce receive assistance from these various organisations. Private practice is a key part of the Australian healthcare system and can be used to ease the pressure on the public AOD system. Similarly, the NGO sector can support the AOD workforce through integrated care, collaborations and partnerships.

The RANZCP highlights the priority to improve the AOD's expertise and capacity in treating mental health comorbidities for high-prevalence low-severity problems, with a strong subspecialist addiction psychiatry workforce. Growth in the core number of psychiatrists subspecialising in this area enables both service provision (to AOD services and mental health services), as well as succession planning and supervision for a pipeline of trainees.

The RANZCP also highlights a need for funding commitments to support psychiatrists who wish to upskill and/or subspecialise in addiction psychiatry, where psychiatrists can have secondments or placements working within tertiary addiction services to gain experience in subspecialist addiction skills.

b) Organisational

It is a priority action to change the programming of internships to support AOD WFD. The RANZCP recommends that the National Framework for Medical Internship ensures that psychiatry training is made an explicit requirement for all prevocational doctors, which could include experience within AOD settings in the first two postgraduate years. This would ensure that all medical doctors, regardless of specialty, are better equipped with skills and experience in substance use disorders and their relevant mental health comorbidities.

Another organisational priority is to increase training in the early years of university and medical training, to support an individual's journey towards specialisation in addiction psychiatry. Programs such as the RANZCP's Psychiatry Interest Forum, have had a marked effect on the transition of interested graduates into specialty training, and would stand to benefit AOD services.

Training should also be available to workforce, regardless of their choice of specialisation. Primary care and emergency medicine are frontline services which are often first ports of call for people with AOD problems. It is pertinent to ensure that this workforce has a basic level of understanding of substance use disorder.

To facilitate relevant training, there is a need to improve supports for trainee supervisors to strengthen and support their resilience as they manage the challenges of supervising trainees, especially in rural and remote areas. Adequate supervision and support are vital for strengthening the quality of AOD workforce. Providing appropriate and adequate supervision to meet accreditation standards should be a central part of AOD WFD strategy.

c) Individual worker levels in the short-medium (3-5 years) and longer (6-10 years) terms?

Increasing specialist mental health nurses is a short-term priority for AOD WFD. The projected shortfall of mental health nurses is between 11,500 and 18,500 by 2030. Investment would bridge critical gaps in mental health and AOD care, particularly in community settings. Mental health nurses have clinical skills that are complementary to psychiatric care and AOD treatment.

Similarly, an increase of peer workers within community based AOD services (with appropriate training and part of a multidisciplinary team) can provide effective support. People with lived experience of mental illness have a valuable role to play in supporting the recovery of others by providing empathy, insight, advocacy and hope, and would improve the efficacy of AOD services.

Embracing already available technology would provide innovative solutions to improve service access, education opportunities, supervision, and workforce and trainee support. The RANZCP has developed professional practice guidelines for telehealth in psychiatry, and such innovation can aid the AOD workforce.

The need to support workforce wellbeing is another short-term priority, whilst also being critical to the long-term sustainability of the AOD WFD. To encourage workforce retention, initiatives to improve the working lives of addiction psychiatrists and reduce the pressure on the existing AOD workforce are required. The provision of basic psychotherapy and counselling, in addition to group supervision for practical care coordination and self-preservation of all mental health workers should be considered.

Discussion question 3: Thinking about specialist AOD workers:

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

The RANZCP recognises and acknowledges the priority issues identified in the discussion paper, noting the shortage of addiction medicine specialists. The existing cohort of addiction medicine specialists are close to retirement, and many will soon retire or reduce their working hours. This will impact the provision of AOD services, particularly to clients with complex needs.

AOD WFD must recognise the distinction between addiction medicine specialists and addiction psychiatrists - as being complementary but different skillsets. Increasing the numbers of both types of specialist will add value to the workforce.

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

The RANZCP will consider this question and provide responses to future consultations of the review.

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

Currently psychiatrists are remunerated less compared to other specialists (including in full-time roles), potentially resulting in psychiatry appearing a less attractive option. There is also lack of investment in training pathways in addiction (with not enough trainee positions), and in public addiction psychiatry therapy. The RANZCP recommends extending long term effective funding models for in demand specialists such as addiction psychiatrists.

Discussion question 4: Thinking about generalist workers:

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

The RANZCP acknowledges the priority issues identified in the discussion paper. Using generalist workers to play an important role in responding to AOD demand is a priority issue. This can be achieved by providing referrals to specialist services, delivering information and brief interventions, and providing treatment and/or support for treatment and recovery.

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

In light of poor staff retention, the RANZCP advocates for AOD WFD to focus on upskilling existing workers. Allowing nursing and allied health staff to access addiction psychiatrists if needed, would be key to upskilling existing staff, particularly as full day education courses are not feasible for busy clinicians.

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

The RANZCP will consider this question and provide responses to future consultations of the review.

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?

The RANZCP recognises and acknowledges the priority issues identified in the discussion paper, that the recruitment and retention of Aboriginal and Torres Strait Islander AOD workers is a crucial and ongoing challenge, due to unique WFD needs. Aboriginal and Torres Strait Islander peoples are currently underrepresented within Australia's medical workforce, specialist training positions, and in positions of leadership. There are several obstacles to the recruitment retention of Aboriginal and Torres Strait Islanders, including:

- lack of experienced/trained mentors (including Aboriginal heritage mentors)
- lack of financial support to complete university courses, including income and family supports that are reflective of cultural challenges
- insufficient university Aboriginal mental health worker courses and course places nationally
- assessments being too pathologising, with too much emphasis on clinical questioning and risk rating scales rather than active listening to accounts of severe personal, family and communal trauma rekindled by transgenerational loss and trauma.

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

Any AOD workforce development strategy should aim to increase Aboriginal and Torres Strait Islander representation in the mental health workforce. This includes improving the number of Aboriginal and Torres Strait Islander peoples in senior positions as a priority.

Ensuring that workplaces are culturally safe will also assist in the recruitment and retention of Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander peoples should be involved in the development of job descriptions, recruitment, and retention strategies 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?

To achieve an increase of Aboriginal and Torres Strait Islander representation, a coordinated and consistent investment in appropriate staffing and retaining of Aboriginal Mental Health workers is required in both mainstream and Aboriginal Medical Health Services.

Strategy should include specific workforce plans to create new education and training pathways for Aboriginal and Torres Strait Islander people interested in a career in the AOD sector. This includes actions that will support the development of Aboriginal and Torres Strait Islander people throughout the different stages of their career in health (from school, through to higher education and into the workforce). Continued support for professional mentoring in specialist trainee years is also 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?

The RANZCP notes WFD issues within rural and remote areas. The majority of the AOD workforce is based in metropolitan areas, contributing to staff shortages and difficulties accessing professional development. These shortages compound the already complex working conditions of regional, rural and remote areas.

Attention should also be paid to the unique needs of the peer workforce, who can offer vital lived experience to AOD treatment. Efforts should be made to appropriately train peer workers with the relevant

skills to succeed in the AOD workforce, making them subject to the same retention and wellbeing strategies discussed earlier (Question 1).

The RANZCP also highlights the needs of LGBTIQ+ staff. Staffing outcomes could be improved through appropriate education and training for staff, including an awareness of LGBTIQ+ services and the presence of LGBTIQ+ staff and role models. This would support staff retention by creating an environment where LGBTIQ+ staff are comfortable working.

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

To improve WFD outcomes for groups with unique needs, targeted recruitment and retention strategies should be put in place with a clear outcomes-based assessment surrounding their recruitment and retainment. Strategies such as recruitment targets and initiatives to support newly recruited workers would recognise the unique risk factors for turnover that such groups face.

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

To improve WFD for Australians living in rural and remote areas, a locally integrated health workforce is required. The RANZCP advocates for incentivising psychiatrists in regional and rural areas through a variety of schemes:

- funding new psychiatry supervisor positions in rural areas to allow trainees to remain
- expanding the Specialist Training Program
- funding dedicated rural and remote postgraduate psychiatry programs
- establishing opportunities and incentives in rural and remote areas for local educational institutions to provide courses in AOD services
- developing networked arrangements to expand rural training opportunities, and leverage and enhance connections with the rural private sector.
- funding for additional rural supervisors and support, including dedicated time for supervision
- enabling training to be primarily undertaken in rural areas where possible; allowing greater flexibility in how supervision, accreditation, and assessment requirements are met
- collaborating with state and territory medical workforce planners, local health regions, postgraduate medical councils, universities and, where appropriate, regional training hubs
- increasing service funding for additional training posts or specialist teams in high-need locations

For further information, please see the RANZCP's Rural Psychiatry Road Map.

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

The RANZCP will consider this question and provide responses to future consultations of the review.

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?

The RANZCP is strongly supportive of Aboriginal and Torres Strait Islander mental health workers, who provide insights into communities, and actively engage with Elders and community members to enhance service quality and provide holistic care to consumers. However, AOD service delivery is hampered by difficulties translating mainstream work practices to meet the specific needs of Aboriginal or Torres Strait Islander clients, with a lack of cultural understanding and support from non-Indigenous health workers. There must be system-wide recognition of the role of culture and community in the healing process.

Community-controlled organisations play a vital role in the integration of culturally safe services within communities. This will support continuous quality improvement of an integrated health system that is Aboriginal and Torres Strait Islander-led.

To develop and maintain a skilled Aboriginal and Torres Strait Islander AOD workforce, there is need for secure funding, job security, pay equity and ongoing opportunities for training and support. Training should be provided for culturally informed care to all the workforce. Culturally relevant tertiary/vocational qualifications to Aboriginal students, Aboriginal worker placements, traineeships and scholarships, are all key stages to develop a workforce effectively trained to deliver culturally relevant AOD services that utilise Aboriginal and Torres Strait Islander ways of working.

Discussion question 8: What are the key WFD strategies for the AOD workforce that 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?

The AOD population is ageing and is increasingly "older" (50-64 years). The AOD workforce increasingly requires training that encompasses physical and cognitive comorbidity and people with needs familiar to aged care services. Highly comorbid cases are often complicated by the workforce's knowledge of such comorbidities, affecting practitioners' ability to reach out to other agencies.

People presenting to AOD services are likely to have a pre-existing mental health comorbidity. Those with mental health conditions must be recognised as having complex needs, with the expertise of both general and addiction psychiatrists key to any treatment plan.

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?

The RANZCP supports the greater integration of services providing care in collaboration with other AOD and specialised practitioners, including psychiatrists. AOD treatment should come as part of a multi-focal treatment pathway. To achieve this, a well-integrated and coordinated AOD care system is required, underpinned by the psychiatric education of AOD staff and the involvement of addiction psychiatrists.

Addiction psychiatrists can play an important, leadership role in building the capacity of other health professionals and providing advice, so consumers receive continuity of care and evidence-based treatments when treated both the substance use disorder and any mental health comorbidity. The RANZCP therefore encourages the strategy to incorporate more clinical input from psychiatrists when considering how to redesign the architecture of AOD treatment in Australia.

See RANZCP Position Statement: Principles for mental health systems for further information regarding system design.

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

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

Please see above (Question 1).

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

Please see above (Question 1).

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

Please see above (Question 1).

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

a) What are the key issues and challenges?

Please see above (Question 1).

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

Please see above (Question 1).

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

Please see above (Question 1)

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?

Alcohol abuse and its relevant mental health comorbidities are of particular concern to RANZCP. Alcohol's seemingly socially acceptable nature means that it is often overlooked as an AOD concern, despite the potential detriment to one's mental health. The RANZCP's Report 'The economic cost of serious mental illness and comorbidities in Australia and New Zealand' highlights that drinking alcohol is riskier for people with mental health problems than people without. Mental health issues can increase a person's risk of problematic alcohol use and risk the outcomes of treatment. Co-occurring alcohol and mental health problems can result in a broad range of negative outcomes, including more severe symptoms, suicidal ideation, poorer social functioning, and increased healthcare costs. Workforce training of the psychiatric element of problem drinking is required to educate employees within the AOD sector. This will allow staff to educate patients on the dangers of alcohol misuse, and relevant treatment options.

Cigarette smoking amongst people with mental health issues, impacting their physical and psychosocial health, is also of concern to the RANZCP. People living with mental illness are more likely to smoke tobacco but are offered treatment at lower rates than the general population. The AIHW highlights that Tobacco remains the leading cause of preventable illness and death across AUS, and people with mental illness smoke at higher rates than the general population, with higher levels of nicotine dependence.

Within psychiatric units, patients may be advised to quit smoking, or be provided nicotine replacement therapy (NRT) on discharge, but this currently does not translate into reduced rates. Professional development can provide AOD staff with the appropriate training to advance smoking cessation in inpatient settings, alongside challenging the culture of smoking within in-patient settings and prevalent myths surrounding smoking's efficacy and patient aptitude. Those with mental illness are a priority population in this regard and require psychiatrists within the AOD workforce to effectively manage their care.

Methamphetamine and its related mental health comorbidities are also of concern. Methamphetamine use causes a significant public health burden, acute (ED and psychiatry inpatient unit) burden, and is associated with the highest level of psychological distress and mental illness compared to any other drug of concern. A response to methamphetamine use on a national level needs to include systemic investment in psychiatry workforce to identify and assertively treat MH comorbidity in a coordinated manner. Please see

the RANZCP's Position Statement: Recognising and addressing the harmful mental health impacts of methamphetamine use, for further information.

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

The RANZCP acknowledges the benefits of minimum qualification standards for specialist AOD workers across all jurisdictions. Minimum qualification standards can be a useful WFD strategy to establish a baseline level for AOD skills and competencies, and allow for transportability of skills between jurisdictions and organisations. Such an approach would facilitate a co-production of services across jurisdictions, through a workforce with transferrable skills. This in turn would support the ongoing professionalisation of the AOD specialist workforce and contribute to the consistency and quality of service delivery.

Such standards should be implemented with a consideration of disadvantaged groups, who due to attainment gaps, may be restricted from joining the AOD workforce. It is also critical to ensure that other, generalist members of the workforce, are supplied with the opportunity to join the AOD workforce, despite the lack of minimum qualification.

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 vocational education system partly meets the needs of the AOD workforce sector. Specific training can be crucial to providing the AOD workforce and other involved generalists the advanced clinical skills to deal with clients' complex needs. The RANZCP recognises the discussion paper's assertion that promoting more AOD content within relevant training courses, and supporting organisations to upskill new workers where necessary, is an important WFD priority. As many early career AOD workers have been exposed to relatively little AOD-specific training, with these skills often being taught on-the-job, it is important to promote the merits of vocational training.

Formal qualifications require a substantial investment of time and resources for workers and their employers. Demands for vocational training for the AOD workforce must not come at the expense of people suffer socio-economic disadvantage. Shorter, more targeted courses and programs may be beneficial for experienced AOD workers looking to upskill in particular areas, minimisng the restraints that these groups face.

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 RANZCP acknowledges the challenges for professional development within the discussion paper. These include the financial costs involved, insufficient time or staff, unsupportive organisations or managers, and access difficulties.

Whilst the RANZCP welcomes the recognition of technology and social media as a new means to providing PD in the face of these aforementioned constraints, managers should be aware of the barriers of entry to those unable to access such technology, either through logistical issues or socio-economic disadvantage.

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?

Online and digital programs are an effective option for AOD services. Telehealth is something that people with mental ill-health may find extremely useful. Telehealth services may also be a vital resource for AOD services in rural and remote communities, where there remain issues with staffing and accessibility.

A report by Lived Experience Australia identified the additional benefits of this technology which included convenience, significantly cutting down travel and waiting time, and that it is particularly helpful for those who might have difficulties travelling to a psychiatrist's office either due to mobility/transport barriers or anxiety triggers when leaving the house.

The RANZCP advocates for the need to continue telehealth psychiatry services long-term, as an available option in addition to face to face consultations. As with psychiatry consultations, AOD services should utilise telehealth options, to allow clients to undertake rehabilitation treatments.

In order to successfully utilise Telehealth appointments, the RANZCP recommends that the AOD workforce is effectively trained on best practice and professional standards, outlined in the RANZCP's Professional Practice Guidelines for telehealth in psychiatry.

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 national AOD workforce data collection is a significant priority. There is currently no comprehensive national AOD workforce data collection system that provides accurate and representative data on the Australian AOD workforce. The RANZCP welcomes the discussion paper's acknowledgment of this significant gap, as high-quality workforce data is essential for effective workforce, education and training planning at a national and jurisdictional level. The RANZCP advocates for psychiatry data to be prioritised, particularly in under-resourced specialities such as addiction.

The RANZCP submission to the National Mental Health Workforce Strategy 2021-2031 highlights the importance of a single source tool for workforce data to underpin workforce planning. Tools such as the HeaDS UPP Tool, could act as this single source of data.

Data collection should be consistent and coordinated and be used to inform system improvement and research purposes. Systems must ensure that workforce groups who may be less likely to register for data collection initiatives (e.g., CALD patients, patients with cognitive disabilities) are captured in these data, so that it is representative of the workforce. Doing so will ensure that care services do not overlook key socio-cultural groups of staff, in particular Aboriginal and Torres Strait Islanders.

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

The development of a framework for ongoing monitoring and implementation of WFD programs and initiatives is a priority area. This will help support the wider sharing of information and data across systems to assist health workforce planning.

Any reform should include clear Implementation Action Plans that guide activities across short, medium and long term. An implementation, evaluation and refinement process charting foundational, short-term expectations (within 12 months), medium-term expectations (within three years), and long-term expectations would be an effective development. This would enhance the ability to evaluate workforce systems changes and cease services where appropriate. These Action Plans would also allow a degree of flexibility to be able to accommodate necessary changes or unexpected needs.