National AOD Workforce Development Strategy

Submission By: Australian College of Rural and Remote Medicine (ACRRM)

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

COLLEGE SUBMISSION

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

Organisation	Australian College of Rural and Remote Medicine (ACRRM)
Name	Marita Cowie AM
Position	Chief Executive Officer
Location	Level 1, 324 Queen St, PO Box 2507 Brisbane Qld 4001
Email	
Phone	

Initial Comments

The College welcomes the opportunity to provide feedback on the review and revision of the National Alcohol and Other Drugs (AOD) Workforce Development Strategy.

As one of two professional Colleges recognised by the Australian Medical Council to provide vocational training towards Fellowship in the specialty of general practice, ACRRM's programs are specifically designed to provide its Fellows with the extended skills required to provide the highest quality care in rural and remote communities, which often suffer from a dearth of face-to-face specialist AOD services.

With funding support from the Federal government, the College has successfully developed and delivered incentivised training for rural and remote GPs, with non-incentivised access to some components of the program available for students and other health professionals[1]. ACRRM views this training program as a key component of the AOD workforce development strategy. With funding due to end in December of this year, it would be beneficial if the Strategy could consider the work already carried out by ACRRM in this space, the training courses which have already been written and consider ways to continue to fund this project to allow ongoing delivery and continuous improvement.

We have restricted our feedback to responding to the consultation questions pertinent to the work of the College.

[1] The College has been funded by the Commonwealth of Australia, Department of Health to develop and deliver the Education Package and Training Grants for GPs in Drug and Alcohol Addiction, announced as part of the 2018-19 Budget Measure: Preventative Health – support for alcohol and drug abuse

Response to Discussion Questions

PRIORITY GROUPS

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?

Many of the factors which make rural communities attractive and rewarding places to live and work, are also those that can present the biggest challenges for health professionals, and particularly for those working in the AOD sector.

In addition to their professional capacity, these people and their families are also community members who have several other roles within their community. They will meet their patients in a range of other capacities and the separation of roles can be difficult for both patient and practitioner and create another barrier to seeking treatment. This creates additional stresses on the personal life and general well-being of health professionals in this sector in rural and remote locations.

There are also significant safety issues for doctors, nurses and other health professionals that need to be considered. They should not have to visit patients who have potential for violence alone or be exposed to patients without appropriate safety mechanisms.

A relatively high profile in a smaller community also means that health professionals and their families can be subject to threats and harassment if there is conflict regarding the treatment they provide, or the decisions (e.g. in cases of family violence) that they are forced to make.

In rural and remote locations, health professionals be they general practitioners, Rural Generalists in hospital EDs, nurses, Aboriginal Health Practitioners or others in rural and remote locations are likely to be working without local availability of a range of support specialist resources, staff and services for AOD issues. They are likely to be working with minimal professional colleague support, and minimal resources within their local area. To meet the needs of people with addiction issues in their communities, they are often called to provide services that would normally in cities to be considered outside of their scope of practice.

We must ensure the rural and remote AOD workforce has access to personal mentoring and support structures to assist them maintain their physical and mental safety and wellbeing.

Rural and remote communities often have significant Aboriginal and Torres Strait Islander populations and caring effectively for people in these communities involves providing access to culturally safe and responsive services. The Strategy needs to be cognisant of the differences in providing safe practice in this area. Doctors and other health professional may benefit from support in terms of training or working in teams with cultural advisors, Aboriginal health practitioners and AOD staff from Aboriginal and Torres Strait Islander backgrounds.

In addition, the strategy must take cognisance of migration and ensure that people from culturally and linguistically diverse backgrounds can access services which are culturally appropriate, with providers positioned to respond to their specific needs. The necessary interpreter and translation services must be made available.

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

The importance of practitioner health and wellbeing must be recognised by the strategy, alongside a commitment to caring for and supporting a rural and remote workforce which is geographically

dispersed and often working in more challenging circumstances than their urban counterparts. Setting quality standards and developing innovative models of care to support practitioners at all stages of their career and enable them to 'thrive' in rural and remote practice will be key to the strategy's success.

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

Rural Generalists and other General Practitioners are often the first, and sometimes the only, port of call and service providers in rural and remote areas. These doctors are often called upon to work to an extended scope of practice to support patients in cases of health emergencies, to provide in-patient services in hospital and facilities, and to arrange retrievals in emergency situations.

These practitioners will be critical to the success of the AOD Workforce Development Plan in rural and remote areas, as they have the capacity to deliver a greater range of services within the community; provide continuity of care for patients at all stages of their treatment and have the necessary skills and training to provide intervention to those in need.

Rural Generalists and rural general practitioners and especially those with specialist AOD training, will often be in the best position to deliver and coordinate a range of services, especially in those communities which lack the critical mass to employ a full health care team, including mental health and AOD workers.

ACRRM has been funded by the Department of Health to develop and deliver incentivised AOD training for General Practitioners.

The College has developed the following training activities:

- Online learning courses which cover the foundations of AOD, and provide a more in depth look at each of the common drug groupings i.e. alcohol, benzodiazepines, methamphetamines etc. This course is self-paced and incorporates a number of tools and resources that GPs can utilise.
- Virtual Workshops which give participants the opportunity to discuss case examples and learn from experts in the field of AOD.
- Webinars covering a variety of AOD topics, identified through feedback on the program.

The College is also currently developing additional activities as a result of the project being extended to December 2022. These include:

- An online course with live webinar covering brief interventions and motivational interviews.
- A short online course covering smoking cessation.
- A short online course covering medico-legal considerations and AOD.

Some of the key findings from Program feedback highlight that AOD initiatives need to:

- Be more accessible to a wider number of people and should easy to engage with for General Practitioners, practice nurses, health professionals, and practice administration staff
- Provide GPs with the opportunity to access formal training in AOD
- Highlight the resources available to health professionals to utilise within their practice
- Reinforce basic concepts such as brief interventions and motivational interviewing
- Consider how to include and support families and carers of patients with AOD problems and coach them on how to have difficult conversations
- Assist GPs to develop a better understanding the context in which patients use AOD and why.

The College addresses these concerns through its AOD training and with funding due to end in December of this year it would be beneficial if the Strategy could consider the continued funding of this project to allow ongoing delivery and continuous improvement.

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?

It is important that the strategy take cognisance of the differences between delivering alcohol and other drug services in rural and remote settings, and in Aboriginal and Torres Strait Islander communities as compared to urban settings.

The Strategy needs to be cognisant that the delivery of support and treatment, and who is best placed to deliver it can be different in the rural and remote context. Likewise, in defining the AOD workforce, it is important to note that the needs of Australians in rural and remote areas, and the barriers to accessing AOD treatment can differ from the urban experience.

Rural Generalists and General Practitioners are in a unique position to provide holistic care, crossing the siloes of mental health care and providing care across the illness spectrum and the lifespan, and work with an extended scope of practice.

Recruitment, training, and support of more Aboriginal and Torres Strait Islander healthcare professionals is a component of the Close the Gap effort, and the strategy should aim to increase workforce numbers from this population. Engaging with the implementation of the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031* and the corresponding Sector Strengthening Plan will be of importance for the workforce development strategy to ensure alignment with both plans and collaboration/partnerships with Aboriginal and Torres Strait Islander peak bodies.

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?

The College notes and supports the Productivity Commission statement that "*Services should be delivered by a skilled workforce, supported by technology and comprehensive governance arrangements, to ensure that they are responsive to local needs and can be readily ramped up and down as needs change".*

In rural and remote areas, this necessitates developing and supporting a skilled workforce which can provide as many services as possible, as close to home as possible, with the local General Practitioner/Rural Generalist being integral to the process as a central part of a local health team. The provision of appropriate AOD services for patients and support for practitioners and caregivers via telehealth and other mechanisms to complement face-to-face services would be an important component of workforce support.

Better access to appropriately skilled and locally based service providers would moderate some of the need for patients and caregivers to travel to seek services, thus minimising resultant barriers to accessing services.

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?

Employment insecurity is a particular issue for rural and remote areas, with many State and Federally funded programs being funded on an annual or contractual basis. This further hinders recruitment and retention of staff to AOD programs in rural and remote areas.

There is a continuing reliance on locum and FIFO workforces in rural and remote areas. Locums and FIFO staff are paid at higher rates than permanent locally based staff and may not offer the continuity of care or out of hours, emergency response capacity of permanently based staff. We are not aware of any systemic approach to measuring the economic costs of these appointments against the cost of creating a more attractive value proposition to permanent staff.

Longer term funding would create security for practitioners in this sector and developing effective personal and professional supports will be key to workforce development. Funding should be directed toward sustainable long-term services and provision of resources in the local communities. This provides the certainty to enable practitioners to upskill if not sufficiently and to stay in the area when they are training. This in turn gives people in rural and remote communities with addictions confidence that they will continue to be supported in their treatment programs.

Rural Generalist practitioners and especially those with advanced skills in AOD, will be in the best position to deliver and coordinate a range of services, especially in those communities which lack the critical mass to employ a full health care team.

In the view of the College, the current funding models do not adequately reflect the important role played by GPs and Rural Generalists in providing AOD services. These doctors may experience layers of financial disadvantage: they have limited access to subsidised courses; they earn less per hour, and the patients they manage generally experience high levels of disadvantage so GPs tend to bulk-bill these patients in order that they can access care. Despite this, GPs continue to provide AOD services and care in some of the most disadvantaged areas of Australia.

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.

It is critical that Rural Generalists and rural General Practitioners, particularly in under-served communities, can access the training they need to deliver care to vulnerable AOD patients in these settings. This training needs to be relevant to the rural and remote context and their specific needs and circumstances.

Rural and remote doctors have significant needs in terms of training and upskilling to meet the broad scope of services they are often called upon to provide in the absence of alternative local specialised services, and many struggle to meet these needs. The Strategy needs to address how these doctors wishing to upskill or undertake training can access appropriate incentives, funding, and support to do so.

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?

ACRRM welcomes the increasing role of data and digital technologies to value-add healthcare provision, particularly toward improved access to services in rural and remote areas. ACRRM views it as critical to assert the importance of continuity of care and human relationships in the delivery of healthcare.

New technologies have the potential to greatly enhance care but should also support rather than replace human-driven, continuous care relationships. There is a risk of information technologies driving a trend toward low value, high convenience healthcare. There is also risk that the interpersonal human relationships that are at the centre of effective primary care may be lost to the efficiencies of easy-to-access care. The pandemic lockdowns, highlighted for many of our members, how vital they were to the support and well-being of their vulnerable patients, for whom their telehealth consultations with their GP became a vital opportunity for human contact. It is important that this most critical element of healthcare is not lost going forward.

The College sees value in further exploration of options for appropriately financing other potentially valuable telehealth/digital health models of care that can enhance healthcare, particularly in remote settings. These should be supported by appropriate funding mechanisms.

FINAL: Are there any other questions or comments?

Summary of ACRRM Recommendations

- In defining the AOD workforce, it is important to note that the health service needs of Australians in rural and remote areas, and the barriers to accessing AOD treatment can differ from the urban experience.
- Funded models of care for rural and remote AOD services should prioritise solutions that are sustainable and support strong locally based services, staff, and resources.
- Rural Generalists and rural general practitioners and especially those with specialist AOD training, are strongly positioned to deliver and coordinate a range of services, especially in those communities which lack the critical mass to employ a full health care team, including AOD workers.
- Telehealth and new data and digital technologies have the potential to greatly enhance care but should support rather than replace human-driven, continuous care relationships.
- The importance of rural practitioner health and wellbeing must be recognised by the strategy, alongside a commitment to caring for and supporting a rural and remote workforce which is geographically dispersed and often working in more challenging circumstances than their urban counterparts.
- Similarly, the safety of doctors and health professionals in remote settings in caring for potentially violent patients and/or patient families must be considered, and appropriate supports put in place
- Cultural safe and effective care for Aboriginal and Torres Strait Islander people in remote and rural areas, may require support for the local doctors and health

professionals in terms of cultural training or opportunities to work in teams with cultural advisors, Aboriginal health practitioners and AOD staff from Aboriginal and Torres Strait Islander backgrounds.

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is *the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care.* It progresses this through the provision of quality vocational training; professional development education programs; setting and upholding practice standards; and through the provision of support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of face-to-face specialist and allied health services.

ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the traditional owners of lands across Australia in which our members and staff work and live and pay respect to their elders past present and future.