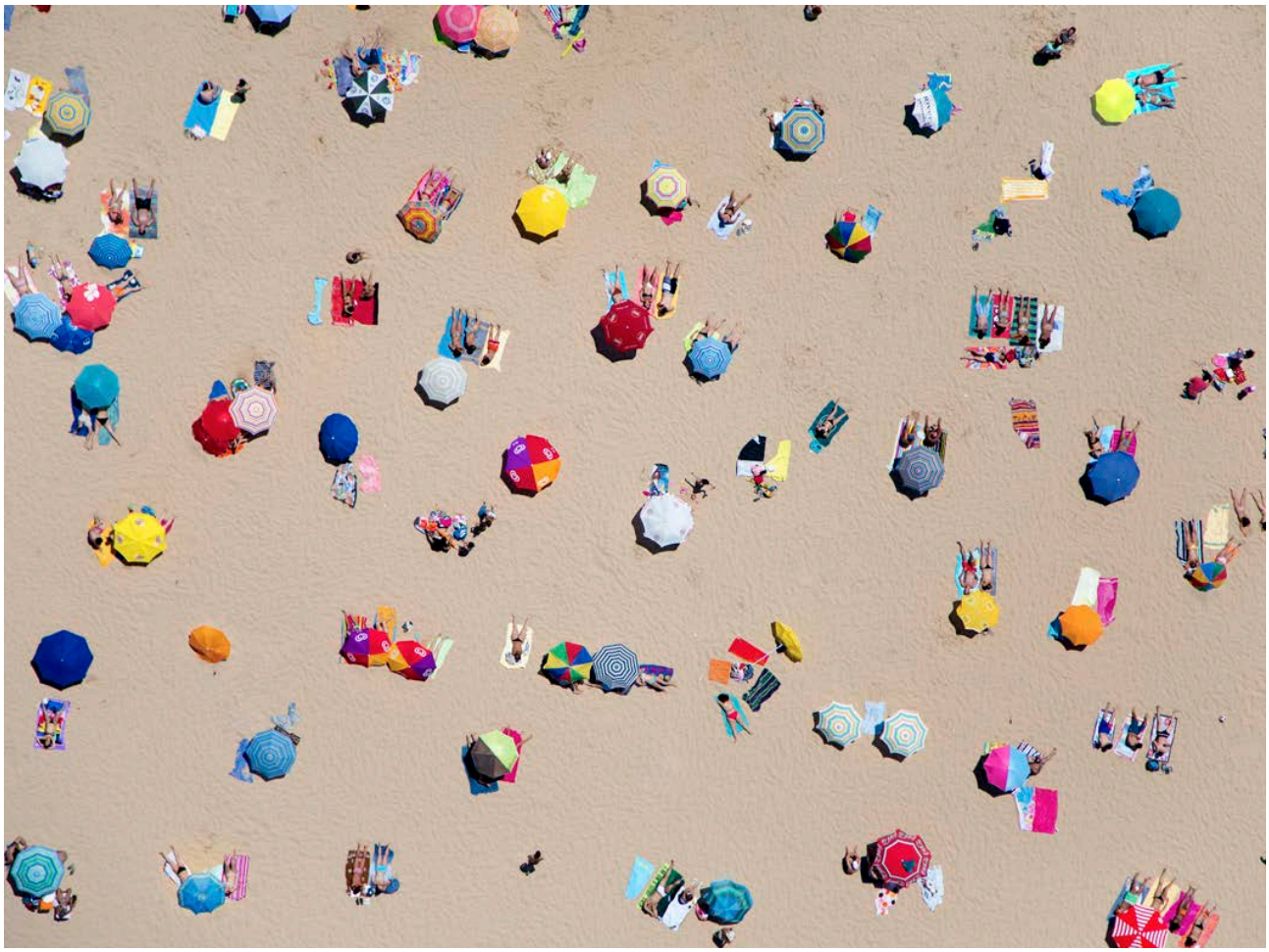
National AOD Workforce Development Strategy

Submission By: Alcohol and Drug Foundation

Alcohol and Drug Foundation



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Submission

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Level 12, 607 Bourke Street, Melbourne
PO Box 818, North Melbourne, 3051
03 9611 6100
adf.org.au
ABN 66 057 731 192

ABOUT THE ALCOHOL AND DRUG FOUNDATION

The Alcohol and Drug Foundation (ADF) delivers evidence-based approaches to minimise alcohol and other drug harm. We recognise the power of strong communities and the important role they play in preventing problems occurring in the first place. A community-centric approach is at the heart of everything we do.

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

The impact of the global pandemic cannot be overstated, and we expect to continue seeing the long-term impacts on mental health and alcohol and other drug (AOD) harms to emerge over the coming years. We are concerned about a potential increase in demand for treatment, and how changes in patterns of AOD use and a possible rise in mental health issues may increase both the number of people overall requiring support as well as the complexity of their cases, thus necessitating a workforce well equipped to managed clients who may present with a dual diagnosis.

The pandemic has increased pressure on the health system overall including the treatment system, and we've heard from treatment sector stakeholders that pressures from lockdown, isolation, and social distancing requirements were a significant challenge. Other issues are ongoing such as staffing shortages, including due to illness and isolation requirements.

The provision and uptake of telehealth options has increased, and as expressed in the discussion paper this has benefited some groups more than others. In order to ensure that the potential benefits of telehealth as an option are enjoyed by all Australians the existing technology gap will need to be addressed. While telehealth represents a positive increase in the diversity of options to meet healthcare needs, it cannot be over-relied on and expected to be a magic bullet to solve existing issues in access to treatment and support.

The ADF is particularly concerned to see increases in alcohol retail turnover in 2020 and again in 2021.[1] The more alcohol is consumed, the higher the rates of alcohol related harm in our communities. The pandemic has also affected Australian drug markets, and as the world returns to 'normal' – both the slow resumption of global supply chains and the return of social opportunities including clubs, bars and festivals – the impact on the availability and use of drugs is emergent.

Tragically, there is the increasing likelihood of climate crisis-related extreme weather events. Droughts, intense storms, bushfires and floods are likely to increase in frequency and severity. These events impact mental health and AOD use and place an additional strain on services. The pandemic has demonstrated how we urgently need to reduce pressure on the health system overall, including through supporting people to avoid, reduce or cease their use of AOD.

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?

The ADF support the introduction of a national AOD workforce census and recognises the usefulness of such data to guide planning and development. The ADF is also pleased that the importance of prevention was acknowledged in the discussion paper, and we recommend that the value of a prevention workforce be recognised in the final Strategy as well.

The growing focus on prevention in Australia is an opportunity to increase the capacity of the prevention workforce to amplify our impact and ensure the most effective and efficient delivery of AOD prevention programs. This includes building capacity for prevention in the untapped resource provided by those who influence young people – teachers, youth workers, coaches, and other role models.

International experience provides examples of robust training programs that ensure AOD prevention efforts are effective and do not inadvertently increase AOD related harm. The EU drugs agency (EMCDDA) developed a training program and handbook for AOD prevention specialists that provides a template suitable for adaptation and delivery in the Australian context. The aim of this work was to advance the professionalism of the drug prevention workforce in Europe and to implement a standardised prevention training curriculum in Europe that improves the effectiveness of prevention.

Importantly, while the handbook is based on international standards it has been tailored to European AOD circumstances. It covers a wide range of topics (e.g., aetiology, epidemiology, monitoring and evaluation) as well as prevention in diverse settings (e.g., family, school, workplace, community, media and the broader environment). As part of this, the EMCDDA has developed an EUPC "European Master Trainer" course which enables successful participants "to cascade evidence-based prevention knowledge through courses in their own country and language".[2]

Adapting such a resource to the Australian context would enable us to reach a primary target audience of AOD and mental health prevention practitioners with further opportunities for modification in order to increase knowledge and understanding and strengthen skills in AOD prevention amongst key secondary target audiences including teachers, youth workers and preventative health influencers in local government and community coalitions. Adopting this kind of 'train the trainer' approach could help to cascade knowledge and skills through communities, creating a web of expertise and knowledge transfer. It could also contribute to a greater understanding of and confidence to invest in AOD prevention, including by local government.

The European model for delivery includes trained master trainers and could also be adapted into online modules. Providing accreditation via various agencies could be explored as a way to increase awareness about and uptake of such a program.

The ADF strongly agrees that the stigma associated with AOD use and AOD work needs to be addressed. Reducing stigma makes it more likely that a person who uses drugs will

reach out for support when they want it, as well as making the pursuit a career in AOD work more appealing.

Including AOD content in pre-employment education and training curriculum and through ongoing professional development opportunities could contribute to reducing stigma by educating the broader workforce and increase awareness of AOD work opportunities.

We can also leverage existing resources for professionals, such as The Power of Words resource suite.[3] These resources can be promoted to existing staff, and organisations could be encouraged to include them in onboarding for new staff across a range of professions (e.g., primary care, media outlets, hospitals, emergency services, corrections).

There is also an opportunity to investigate opportunities to embed contact-based programs that involve direct involvement with people with lived and living experience of AOD issues, within undergraduate, post-graduate and professional development training opportunities as a way to increase understanding and decrease stigma.

There is also an opportunity to engage with values-based messaging to improve the effectiveness of advocacy and communications work, such as through working with organisations such as Common Cause Australia.[1]

Discussion question 4: Thinking about generalist workers:
(a) What are the priority WFD issues for generalist workers?
(b) What WFD goals should be set for improving WFD outcomes for this group (i.e., what should be we aiming for?)
(c) What are the major steps in the short-medium and longer term to achieve these goals?

Generalist workers, such as GPs, are well positioned to provide regular AOD screening for their patients that can help to identify and address patterns of AOD use that may result in harm. Primary care is usually a person's first encounter with the health system, and the one which will manage the majority of their health needs across their lifetime. Because most people will engage with primary care at some point in their life this represents an opportunity to consistently provide screening and early intervention for alcohol and other drug use.

The regular provision of screening, brief intervention, and referral to treatment (SBIRT) through primary care would enable people to get information about their AOD use, including steps they can take to reduce harm and how to access treatment if they want it. SBIRT is a flexible intervention that determines if an individual's AOD use patterns merit a brief intervention, such as an individual who is at risk of developing dependence, or a referral to more intensive treatment if the person is already experiencing dependence.

[1] http://www.commoncause.com.au/

This can facilitate people accessing support at an earlier stage then they otherwise might, which can prevent their AOD use from becoming entrenched or prevent them developing a dependence that may require a more intensive intervention.

Supporting primacy care practices and practitioners to use AOD screening tools as a regular element of primary care can also help normalise discussions around AOD between patients and practitioners, building trust and making it more likely that a patient will speak to the health care provider about AOD-related issues.

The RACGP runs the Alcohol and Other Drugs (AOD) GP Education Program, which offers courses for essential, treatment, and advanced skills.[4] Encouraging and supporting GPs to engage with these programs is a great opportunity to continue building the knowledge and skills in primary care to strengthen how GPs can support people who use drugs as well as other clients in their care who may be worried about a loved ones AOD use.

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?
(b) What WFD goals should be set for improving WFD outcomes for this group (i.e., what should be we aiming for?)
(c) What are the major steps in the short-medium and longer term to achieve these goals?
(d) Are there Australian or international examples of effective WFD for these groups that could be replicated/adapted?

While outside the scope of this Strategy, it is important to acknowledge that for law enforcement and corrections workers, their engagement with people who use AOD is within a framework focused on the criminalisation of the use of illegal drugs and often other offences, such as public intoxication. Drug law reform could contribute to changing this framework and may support a shift in both public and law enforcement attitudes towards providing a health-based response to AOD use.[5]

We would need to ensure that workers are being supported through such changes. For example, as public intoxication is being decriminalised in some jurisdictions we need to ensure that appropriate health responses (e.g., 'sobering up/ wet shelters') are in place to support police and emergency services workers to avoid conflict and suitably respond to incidents in a way that ensures the best care possible for the person who is intoxicated.

To support corrections workers and ensure the best health outcomes for people in prison, it's critical that we are providing AOD treatment and support for people who want to access it, including in the lead up to and the period following a person's release from prison. This is an important way to help people break cycles of offending. Specific support for people who inject drugs in prison is another critical need. International data indicates that people who inject drugs are overrepresented in justice systems around the world.[6]

Australia is no exception, with almost half of the people in prison reporting having injected drugs at some point in their life and two-thirds having injected drugs in the past year.[7]

As such, providing harm reduction services in prisons, such as needle and syringe programs, is necessary considering that more than 1 in 5 (22%) prison entrants tested positive for hepatitis C antibodies, and 8% of all prisoners reported that they injected drugs while imprisoned.[7]

Including AOD curriculum as part of pre-employment training for law enforcement and corrections workers could help to increase understanding and empathy about AOD use and dependence, and support future workers with the skills to optimally engage with people who use drugs. This could include promoting existing resources and investing in training around stigma to help raise awareness and shift attitudes among current law enforcement and corrections employees.

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 remains the most commonly used drug in Australia, and alcohol sales data suggests that Australians have been drinking more in 2020 and more again in 2021.[1] The increasing availability of alcohol, particularly through the expansion of online sales and home delivery, also remains a concern. While the availability and use of other drugs is likely to be impacted by the resumption of global supply chains and social opportunities such as festivals and nightclubs, we expect that alcohol will remain the primary drug of concern and the drug causing the most harm.

References

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