National AOD Workforce Development Strategy

Submission By:
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SUBMISSION

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

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Introduction

Lived Experience Australia (hereafter LEA) is a national representative organisation for Australian mental health consumers and carers, formed in 2002 with a focus on the private sector. Our core business is to advocate for systemic change, empowerment of consumers in their own care, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion.

LEA is pleased to provide this Submission into the Australian Government's Review and Revision of the National Alcohol and Other Drug (AOD) Workforce Development (WFD) Strategy: Discussion Paper LEA has focussed on the main areas we consider most critical to the people we represent.

Given there is close alignment between mental ill-health and AODs, LEA is keen to provide this Submission as the people we represent are often treated in both settings but experience a lack of integration of focus on their needs by these systems. There has been a great deal of discussion as to what comes first, i.e., mental health issues where people us AODs as a coping or soothing strategy, or whether AODs cause or add to their mental ill-health. We also know that many people with mental ill-health including those with severe or complex mental illness also have issues relating to heavy AOD use.

AODs seems to be treated separately from mental ill-health in several settings, most particularly noted in community mental health settings. There seems to be little interaction or information sharing, which sees people being treated via medications for mental illness, also consuming medications for AOD withdrawal. These two areas seem to treat the person in separate silos, with each area taking responsibility for medication management according to the setting and focus. We are aware from our members that mental health clinicians, for example, do little to monitor the medications for AOD treatment, and the necessary reduction in medications needed for people to withdraw their dependence.

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

a) systems

Anecdotally, LEA refers to our members' responses, and therefore believe that as a priority action, integrated, holistic care where the consumer is at the centre of care is urgently needed.
Greater integration between mental health and AOD is urgently needed. This includes not only secondary and tertiary mental health services but must also include primary care systems to ensure prevention and early intervention for these enmeshed conditions, which have proven causal relationships[1] and shared pathways.

b) Organizational

LEA is of the view that greater communication, cooperation and collaboration are urgently required between AOD and mental health systems when a consumer is being treated by both areas.
Formal protocols are urgently needed to ensure who is accountable for what, where both have a role that is shared, and who ultimately takes responsibility for the best outcomes for the consumer.

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

3-5 years: A basic understanding of both aspects of care, i.e., mental health and AOD should be a skill and expertise of any clinician working in both areas, with clear systems for ongoing professional development as part of core workforce skill maintenance, given new evidence and treatments are appearing all the time in both areas.

[1] Hahad O, Daiber A, Michal M, et al. Smoking and neuropsychiatric disease: association and underlying mechanisms. International Journal of Molecular Sciences. 2021;22: 7272-7295.

Discussion question 3: Thinking about specialist AOD workers:

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

Workforce recruitment and retention, despite the stigma associated with working in this area, is needed. AOD is a growing area affecting many Australians, many of whom do not consider they are affected or addicted. More needs to be done to attract people into this profession. A stigma reduction campaign within the various professions would help in encouraging people to think about this area in a professional light. We've witnesses clinicians doing some of their most rewarding and skilled work when working with people with mental health and AOD issues.

Private psychiatric hospitals provide most of the inpatient hospital withdrawal and rehabilitation services across Australia. More needs to be done to expand inpatient AOD rehabilitation in a hospital setting where people experiencing adverse events of withdrawal can be more closely monitored and supported ensuring that the treatment will have positive outcomes in the long term.

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

There is a clear need for professional development skills requirements now. Credentialing is also needed to ensure the scope of practice aligns best with the treatment and supports being provided.

Discussion question 4: Thinking about generalist workers:

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

LEA continues to draw attention to the stigma attached to working in this area. Unless workers feel that their efforts are making a difference, work satisfaction declines. Working in the AOD area should be highlighted in educational programs providing opportunities for people to work in an area not only of need, but also toward giving people a chance to have a contributing life.

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):

Peer workforce

In terms of peer workers, LEA undertook a scoping study in 2019[2] to develop a member based national organisation for the peer workforce, and in the consultations, a narrow view was expressed as to whether peer workers from the AOD should be included in the mental health peer workforce.

A narrow view has also been expressed as to whether peer workers employed within alcohol and other drugs, NDIS, other areas or volunteers engaged in a peer support capacity should be eligible for membership. These views were not representative of what the consultations highlighted. In terms of applicability of a national peer organisation to peer workers in the alcohol and other drug area, it should be noted that the National Qualification Certificate IV in Mental Health Peer Work CHC43515 is the same for A&OD peer workers with AOD electives.

Further, given this strong view from the Victorian consultation, the Project Team determined that a question as to membership should be included within the online survey which asked people:

Membership: If we have an organisation who should it represent?

[2] Toward Professionalisation: Community of Peers Project; A Project to undertake a feasibility study into the establishment of a member-based organisation for the peer workforce in Australia; 2019

Respondents believe that any organisation should represent all lived experience workers 48.8% (n=63 of 129) and both consumer and carer peer workers 29.4% (n=38 of 129) with only 9.3% responding to applicability for consumer peer workers exclusively (n=12 of 129).[3]

This result clearly indicates to LEA that the AOD peer workforce is just as valued as is the mental health peer workforce and should be seen to be as crucial to this area as to any other.

Over the last 3 years, LEA has offered sponsorships to 36 people to undertake the Cert IV, Mental Health Peer Work[4]. We are seeing an increase in applications from people from the AOD areas. LEA is of the view that this is encouraging as we know that the value of peer worker interaction is something that consumer really appreciate. In our 2021 research Report, the Missing Middle[5], when asked who they would want to re-engage with after disengaging from mental health services, *the fourth most prevalent response in both the consumer and carer responses, was engagement with a peer worker.*

Rural, Regional and Remote areas

These areas are noted for lack of access to services, whether it is mental health or AOD. Protocols are needed to enable access to training clinicians whether this is via telehealth or other means to ensure people can access clinicians when needed.

Support is crucial in the area of AOD as is mental health. People with AOD should be able to access these through mental health community teams or other mechanisms available to people with mental ill-health.

Non-regulated AOD support providers

LEA is aware that there is a huge profitable industry being established in the 'private' rehab space, with $30,000 per program, for example for Meth programs. Families are selling up assets to fund what they see are last hope options after being failed by the health system due to lack of availability or unreasonable wait times. These options seem to have ex-addicts and supporters as founders and key staff with light association to health professionals. We query the level of regulation required for these programs and their workforces. Often, their appeal is they attempt to tackle the challenge from a social problem rather than a health problem perspective, offering additional value adds such as personal development through to spiritual awakening. Sadly, these unregulated offerings will fill a void for many desperate people and families impacted by AOD.

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?

LEA has addressed the close association and needs between mental ill-health and AOD throughout the earlier responses.

Integrated care with clear protocols to guide that integration are needed as a matter of urgency. Drug interactions between AOD use and mental illness can present a risk to a consumer. Also monitoring the reduction of medications overtime as the consumer's health improves is crucial so that the person is on the least number and amount of medications possible, to avoid the adverse long-term impacts of physical health of many of these medications. LEA is very aware of the close association between psychotropic medications and health risks and advocate for the minimal number and amount of medications necessary to keep a person stable on their recovery journey.

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[3] Toward Professionalisation: Community of Peers Project, https://www.mentalhealthcommission.gov.au/getmedia/97a154cd-7b72-4577-9562-4077c33820d2/Towards-Professionalisation-literature-review p.36.

[4] Cert IV Mental Health Peer Work; Report to Department of Health, Canberra.

[5] The Missing Middle, Lived Experience Perspectives, Kaine C, Lawn S, (2021) https://www.livedexperienceaustralia.com.au/missingmiddlemedia P.16.

It is a known fact that people with mental illness die 20 years younger, are more at risk of homelessness and poor physical and dental health, have little opportunity for meaningful work or study, are isolated and disengaged with the community and rely heavily on family and/or friends and Carers.
This is similar in the AOD area where relationships break down, with lost employment, homelessness and poor physical health that can also result from their AOD use.
Clearly, closer integrated care is urgently required, with clear communication, and collaboration between settings.
GPs are often the first and last port of call, and the GP should be at the heart of information sharing between systems.

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

LEA has discussed this in the preceding questions.

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 is the 'hidden' substance which is generally seen as acceptable and often not associated with AOD dependence, however, it can be as devastating as any illicit drug taking and causes as much damage to relationships, employment etc.
A clear message is needed to ensure Australians are more aware of the devastating effects of alcohol misuse.
Clearly methamphetamine (ice) is at present the number one substance of concern. We know that people using ice can experience psychosis which they may or may not fully recover from. The interaction between ice and known psychotropic medications is of great concern with many consumers not being aware of the danger.
More needs to be done in the mental health sector to educate consumers of the grave risk to their mental health both in the short and long term in taking illicit drugs, most particularly ice.
Injectable illicit drugs are also of concern as the sharing of needles and thoughtless disposal poses risks to the community and seems to be increasing. We are horrified by reports of used syringes being found in children's playgrounds for example, on beaches, or other areas where we can find pleasure in barefoot recreational pursuits.
To ensure effective responses to people with illicit drug substance abuse, we are supportive of dedicated injecting facilities where people can safely use clean and dispose of used syringes despite the seeming controversy held by many of the public. Location of these facilities is the key to consideration, and it is more about where they are located than what they are offering.
Cigarette smoking is also an insidious issue for people with mental health issues, impacting their physical health and multiple aspects of their psychosocial health. Service cultures continue to 'accept' it as the 'norm' for these populations, despite it being the major contributor to cardiac disease in this group, and cardiac disease being the leading cause of mortality and morbidity in this group. Little has changed in this regard for these populations, even though it is clear that doing so makes clear clinical, social and economic sense.[6]
We would have hoped to see some mention of cannabis and other organic drugs such as Ayahuasca mentioned as we are aware that they are now being used as withdrawal options in some of the

[6] RANZCP (2016) The Economic Costs of Serious Mental Illness and Comorbidities in Australia and New Zealand. https://www.ranzcp.org/files/resources/reports/ranzcp-serious-mental-illness.aspx

unregulated AOD retreat environments. Both have potentially devastating effects for people living with psychosis that can lead a person into the mental health domain.

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 filling a key place for those in the mental health sector. Telehealth is something that people with mental ill-health find extremely useful[7]. Amongst the key findings were:

Feedback regarding access to and use of telehealth psychiatry services was largely positive. Many identified that without access to this technology during COVID-19, they would have had no other support available. Many 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. Many respondents advocated for the need to continue telehealth psychiatry services long-term to make it a permanently available option in addition to face to face consultations.

As with psychiatry consultations, services via telehealth for AODs must also be a long-term investment if we want consumers to undertake permanent withdrawal, rehabilitation and be free of addiction.

LEA also refers to the work the Royal Australian and New Zealand College of Psychiatrists (RANZCP) are doing in the alcohol area[8] on which LEA has a representative. This is a campaign that should be elevated by the Australian government to bring the message home about the interconnection between alcohol harm and their mental health wellbeing. LEA supports a fully funded campaign to support the work of this project of the RANZCP.

Contact

We would be very pleased to provide further clarification around any of the points raised or further inform the discussion from our research undertaken over the last 2 years.

Please feel free to contact:

Professor Sharon Lawn
Board Chair and Executive Director

Janne McMahon OAM
Founder and Strategic Advisory

[7] Telehealth Psychiatry Consultation, Kaine, C; Lawn, S (2021) Lived Experience Australia. https://www.livedexperienceaustralia.com.au/telehealthpsychiatry

[8] RANZCP Alcohol harm and mental health campaign (2021-2022)