# National AOD Workforce Development Strategy

## Submission By:
## The Pharmacy Guild of Australia (the Guild)

The Pharmacy Guild of Australia

# SUBMISSION

## National AOD Workforce Development Strategy 2015-2018: Review & Revision

7 March 2022

**National Secretariat**

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# ABOUT THE PHARMACY GUILD OF AUSTRALIA

The Pharmacy Guild of Australia (the Guild) is the national peak organisation representing community pharmacy. It supports community pharmacy in its role of delivering quality health outcomes for all Australians. It strives to promote, maintain and support community pharmacies as the appropriate providers of primary healthcare to the community through optimum therapeutic use of medicines, medicines management and related services. Community pharmacies are the most frequently accessed and most accessible health destination, with over 462 million individual patient visits annually and the vast majority of pharmacies open after-hours, including on weekends[1].

Owned by pharmacists, community pharmacies exist in well-distributed and accessible locations, and often operate over extended hours, seven days a week in urban, rural and remote areas. They provide timely, convenient and affordable access to the quality and safe provision of medicines and healthcare services by pharmacists who are highly skilled and qualified health professionals.

In Australian capital cities, on average, a person is located under 1 km from the nearest pharmacy. Outside the capital cities, Australians are 6.4 km on average from their nearest pharmacy[2]. The network of over 5,800 equitably distributed community pharmacies plays a pivotal role in the delivery of the National Medicines Policy, by ensuring timely access to safe, effective and affordable medicines under the Pharmaceutical Benefits Scheme (PBS) for all Australians. Quality Use of Medicines is an important pillar of Australian National Medicines Policy, with community pharmacy having a vital role supporting ageing Australians who are at high risk of medication misadventure due to multiple co-morbidities and complex medicine regimens.

This accessibility to community pharmacy and to the PBS is underpinned by the regulatory arrangements under a variety of Commonwealth, State and Territory laws. One of these regulatory requirements is that pharmacies are unable to open for business unless a registered pharmacist is present, which means an available and sustainable pharmacist workforce is vital to the operation of community pharmacies. Currently 20% of pharmacies are in rural and remote Australia, approximately 400 of which are one-pharmacy towns, where the patients' access to community pharmacy is most impacted depending on the workforce availability.

# THE ROLE OF COMMUNITY PHARMACY IN THE ALCOHOL AND OTHER DRUG (AOD) WORKFORCE

The community pharmacy workforce has long been involved in reducing AOD-related harm. Following is a list of some of the AOD-related activities that community pharmacists regularly undertake:

- Providing specific drug-related services such as:
    - Needle, syringe and other injecting equipment supply;
    - Safe collection and disposal of syringes;
    - Opioid dependence treatment programs;
    - Benzodiazepine reduction programs with supervised doses;

1 PBS Date of Supply, Guild Digest, https://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0
2 Geospatial analysis, MacroPlan, Dimasi 2016

    - Staged supply programs;
    - Recording of the sale of pseudoephedrine-based products through the Project STOP online real-time monitoring system;
    - Smoking cessation advice and treatment;
    - Supply of naloxone as a Pharmacist Only medicine, including as part of a Take-Home Naloxone Pilot[3] running until June 2022; and
    - Reviewing real-time prescription monitoring systems, where available, to aid in harm minimisation.
- Interprofessional collaboration activities such as:
    - Inter-professional liaison and referral of drug users to appropriate treatment or agencies, usually through their GP; and
    - Referral to appropriate support services
- Providing information and educational resources such as:
    - Information on drug-related conditions (hepatitis C, HIV/AIDS etc) to prevent overdose deaths and reduction of infections;
    - Providing information to family and friends of illicit drug users; and
    - Implementing public health campaigns.

Community pharmacies are a major provider of opioid dependence treatment (ODT) services, needle and syringe programs and other drug and alcohol services and therefore, pharmacists and pharmacy assistants are acknowledged as important contributors to the Alcohol and Other Drugs (AOD) workforce. As such, workforce development for the pharmacy workforce is important. Such support should build on the existing prevention and harm minimisation strategies and ensure up-to-date education, resources and training is provided to pharmacy staff. This will in turn improve the information and support provided to consumers.

There should also be an overarching national real-time prescription monitoring system so that community pharmacists can identify and support patients to use prescription medicines safely and to help minimise the risk of harm. This is essential to deal effectively with opioid abuse and misuse in Australia. In 2019, the Commonwealth committed to developing a National Data Exchange (NDE) to enable jurisdictional systems to connect to a national data repository, which is a central clearing house for all states to exchange data on Schedule 8 medicines. However, not all State and Territory governments are utilising the NDE.

The community pharmacy workforce must be considered in any strategies relating to AOD harm, so that we can maintain a highly skilled workforce to deal with the issue of abuse/misuse of medicines and ensure that patients have access to best-practice evidence-based care within a Quality Use of Medicines (QUM) framework[4].

[3] Take home naloxone pilot | Australian Government Department of Health

[4] Department of Health, Quality Use of Medicines, https://www1.health.gov.au/internet/main/publishing.nsf/Content/nmp-quality.htm

# SUBMISSION QUESTIONS

Please note that we have responded only to questions from the Discussion Paper where we have particular interest and which we believe should shape the next phase of the Strategy from a community pharmacy perspective.

## General Workforce Development questions

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

Important issues could include (but aren't limited to):

- Changing service delivery models including as a result of COVID-19
- The need for more specialised skill sets to address complex presentations
- Growth in the proportion of the service delivery system provided by the NGO sector
- Growth in digital and online service provision
- The need for greater capacity building to support the Aboriginal and Torres Strait Islander AOD (alcohol and other drug) workforce
- Stronger emphasis on integration of the peer/lived experience workforce into service provision
- Increasing recognition of the importance of consumer representation and participation in service delivery
- A larger number of early career workers in the AOD sector and the concomitant ageing of the workforce
- The need to address AOD workers' wellbeing, and strategies to address stress and burnout
- Ongoing challenges related to stigma of AOD work, which may impact worker wellbeing, recruitment and retention

### Guild response

Community pharmacists provide a variety of services to their communities in the AOD space, and some community pharmacists have a special skill set or focus on AOD.

The Guild wishes to highlight the following high priority workforce development issues that have emerged since the previous 2015-2018 Strategy:

- **Changing service delivery models including as a result of COVID-19:** The COVID-19 pandemic has meant community pharmacies have had to consider how to maintain ODT and other AOD services whilst adhering to public health measures such as lockdowns, social distancing, capacity restrictions, isolation or quarantine requirements and most importantly, infection control. Dosing patients isolating due to being a positive case or close contact was one issue that required considerations of logistical, clinical and regulatory implications to ensure an appropriate solution such as delivery of takeaway doses, provision of doses to responsible people, or referral of the patient back to the public clinic.
- **The need to address AOD workers' wellbeing, and strategies to address stress and burnout:** The COVID-19 pandemic has negatively impacted community pharmacists through increased fatigue and stress due to being on the frontline during the pandemic, and little respite

due to increased workload. Also, border closures have restricted the movement of the workforce to provide much needed locum services to pharmacies in other states.

The pharmacy workforce has been on the frontline of the pandemic and community pharmacies remained open to ensure access to primary healthcare services and medicines. Staff came to work each day despite concerns for their own personal health and safety and those of their families. This anxiety and dealing with angry and abusive consumers due to medicine shortages or supply restrictions has had significant impact on pharmacists. Additionally, many rural community pharmacists were unable to take leave during 2020 and 2021 as border closures prevented locum workers from travelling to relieve them.

There has also been anecdotal evidence of pharmacists leaving the profession due to stress and burnout, which has further impacted existing workforce shortages. Pharmacist shortages are evident across all areas. Raven's Recruitment Pharmacy Market Report in November 2021 states that pharmacy is facing significant workforce challenges, and that during 2021, the number of positions available and time taken to fill has increased considerably across all regional, rural and metropolitan areas. They also note that the continued shortages in finding pharmacists for permanent roles has increased demand for locums to backfill these roles, and that including community pharmacists on the Priority Migration Skilled Occupation List (PMSOL) has not yet alleviated the current shortages within the pharmacy workforce[5].

The community pharmacy workforce is also currently suffering from additional duress due to a critical shortage of rapid antigen tests, increased workload from providing COVID-19 vaccinations, and staff being required to isolate after testing positive for COVID-19.

- **Increased treatment and access options**: The treatment and access options for various AOD conditions is continually expanding including Pharmacist Only (or S3) supply of naloxone, recent scheduling of nicotine vaping products (NVPs) as prescription only, and the availability of long-acting injectable buprenorphine (LAIB). Professional development for these is required for the AOD workforce, especially pharmacists who will be dispensing or supplying these to patients and providing important counselling on their use. This professional development must be delivered nationally and in a coordinated, harmonised way to avoid inequities in access between jurisdictions.

  Commonwealth and State Governments must also adopt and expand patient access to take-home naloxone, which is currently part of a pilot that is only running in select states and is due to end in June 2022.[6] The community pharmacy workforce must be utilised to supply naloxone to at-risk patients and their families in an ongoing and comprehensive way.

  In recognition of the workforce shortages of the specialist AOD workforce, particularly prescribers, the Guild supports all health professionals working to their full scope of practice. As such, the Guild recommends the increased role of pharmacists in managing the ongoing treatment of their patients by being given the legislative authority to prescribe and administer relevant medicines. Prescribing would entail a collaborative arrangement with the patient's prescriber to adjust, monitor and maintain their ODT therapy. Victoria has led the way in authorising pharmacists to administer Long-Acting Injectable Buprenorphine (LAIB) and this should be replicated in all jurisdictions.

[5] Raven's Recruitment (2021), The Pharmacy Salary and Market Report 2021

[6] https://www.health.gov.au/initiatives-and-programs/take-home-naloxone-pilot/about-the-take-home-naloxone-pilot

Governments should also invest in collaborative prescribing models for Schedule 8 medicines for opioid replacement therapy (ORT), to allow pharmacists to undertake dose titration, treatment continuation and screening under a shared care plan with the patient's prescriber. This increased activity by pharmacists is within their scope of practice and would reduce the burden on the specialist AOD workforce, particularly in regional, rural and remote Australia.

- **Greater recognition of the variety of workers involved in reducing AOD-related harm:** Since the previous Strategy there has been increasing recognition of the role of community pharmacies in the AOD space, and there has also been greater recognition of the need for true multi-disciplinary care, to ensure that patients can access the most appropriate care from the right health professional through effective referral pathways. Pharmacists are well placed to identify patients accessing at-risk medicines inappropriately and refer them to the appropriate medical practitioner or alternative specialised clinical service centres.

  Pharmacists in community pharmacies provide a range of medicine review services involving consultations with patients. These consultations provide an opportunity for a health professional to enquire about alcohol and other drug use with a view to identifying people with potential problems requiring additional help and support. Consideration should be given to specialist AOD workers within the community pharmacy sector and training pharmacists to incorporate this into their current services.

  We also highlight that in the community setting, pharmacists are often overlooked by other health practitioners as important participants in multi-disciplinary case conferencing; however, it is essential to include pharmacists in these kinds of activities to provide expert advice on medicine related issues in the context of Quality Use of Medicines (QUM). Technology such as shared care plans between GPs and drug and alcohol services should form part of patient treatment and the patients' community pharmacist should be able to contribute to these shared care plans.

  There also needs to be consideration for clinically managing patients that are already in the health system who have not responded to their management, or who have not been managed satisfactorily and have problems with medicine abuse/misuse. For these patients, appropriate clinical responses should focus on improving access to support programs, involving:

  - Increasing the number of access points, particularly through community pharmacy;
  - Developing and supporting appropriate training for relevant health professionals;
  - Improving communication channels between supporting health professionals; and
  - Adequately funding services to ensure cost is not a barrier to at-risk patients and that supporting health professionals are adequately compensated.

  The updated Strategy should reflect this greater recognition of the variety of workers involved in AOD-related activities, including community pharmacists and pharmacy staff, so that they are adequately considered as part of workforce development.

## 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?

Important issues could include (but aren't limited to):

- Reviewing and improving funding models to ensure AOD services have optimal support for capacity building and effective service delivery
- Addressing remuneration and other employment conditions for AOD workers to achieve parity with similar sectors (e.g., mental health)
- Development of a national AOD workforce census to guide workforce planning and WFD
- Development and promotion of recruitment pathways into the AOD sector from related fields (e.g., public health, community services)
- Building and supporting structured career pathways within AOD organisations and the sector in general, including pathways into leadership and management roles
- Implementing programs and strategies to increase the accessibility of professional development, clinical supervision and practice support for the AOD workforce
- Developing and implementing public campaigns to address stigma associated with AOD use and AOD work

## Guild response

The Guild believes the following should be priority actions to improve the workforce development into the future:

- **Reviewing and improving funding models to ensure AOD services have optimal support for capacity building and effective service delivery:** Community pharmacies regularly undertake many AOD-related services for consumers, however funding for these services is often inconsistent.

  For example, community pharmacies provide opioid dependence treatment (ODT) services which involve the supply in instalments for the daily dose management of methadone or buprenorphine to at-risk patients. Currently, ODT medicines are dispensed on a private (non-PBS) prescription, with the patient payment for dispensing and dose management. Current operations vary between jurisdictions and there are limits with the number of participating pharmacies and supported patients. The establishment of a nationally subsidised ODT service would provide a more affordable and accessible treatment program and would create a financial safety net for those undergoing treatment.

  The Guild recommends that the Federal Government funds a National Opioid Dependence Treatment Program under the PBS. Prescribing and dispensing of prescriptions for ODT medicines should be aligned with that of other PBS medicines, to ensure that treatment is accessible and affordable for the patient cohort. Approved pharmacists would be remunerated for dispensing the prescription as a pharmaceutical benefit, inclusive of daily dose management for oral ODT or in-pharmacy administration (or delivery to the patient's clinic) of injectable ODT. Patients would pay the relevant PBS co-payment for one month of treatment.

  The introduction of LAIBs in 2019 offered a significant opportunity to patients accessing ODT, however this has been hampered by a lack of uptake by prescribers. New models are required to

manage the prescribing and administration of LAIBs, and the current treatment framework must adapt to increase patients' access to these newer treatment modalities. There is a significant opportunity to train community pharmacists to prescribe and administer LAIBs as part of a person's ODT treatment plan, and this training should be provided nationally in a coordinated and harmonised way.

- **Harmonisation of State and Territory regulations for dispensing S8 prescriptions:** Currently community pharmacists are unable to dispense prescription medicines in certain situations where the medicines have been prescribed in another jurisdiction. For example, a patient who is prescribed a Schedule 8 medicine (i.e. methadone, buprenorphine) in Victoria is unable to have the prescription filled out in Tasmania. This access issue would be addressed by State and Territory regulations being harmonised to remove these barriers for at-risk patients. Real-time prescription monitoring, which we have covered in other areas of this response, is also essential to this solution.

  More broadly, there is an opportunity for harmonisation of the general management of the ORT program and the approach to pharmacists dispensing take-away doses for ORT. Pharmacists should also be able to undertake dose titration, treatment continuation and screening under a shared care plan with a prescriber, in all jurisdictions.

- **Implementing programs and strategies to increase the accessibility of professional development, clinical supervision and practice support for the AOD workforce:** Professional development must be made more accessible for the community pharmacy workforce. This includes not only strategies to ensure training around AOD issues is covered in undergraduate pharmacy courses, but also ongoing funding for continuing professional development courses (CPD) for pharmacists and pharmacy staff at a national level. This will enable the community pharmacy workforce to support other AOD workers to its full scope of practice[7].

  The Guild recommends the development of a contemporary, standardised training program for the AOD workforce that can be adopted by all jurisdictions and is agnostic of practice setting and clinician. A standardised training program would ensure the quality of training and content being delivered to the AOD workforce. State and territory training could then focus on jurisdictional differences.

[7] Scope of Practice of Community Pharmacists, https://www.guild.org.au/__data/assets/pdf_file/0023/106178/Scope-of-Practice-of-Community-Pharmacists.pdf

## Discussion question 3: Thinking about specialist AOD workers:

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

*Priorities for specialist AOD workers could include (but aren't limited to):*

- *Access to clinical supervision and practice support*
- *Increased accessibility and support for accessing advanced training (e.g., funding support for backfill costs)*
- *Programs to address wellbeing (e.g., burnout), including addressing secondary stigma that may be associated with AOD work*
- *Strategies to build and improve career development pathways*

## Guild response

Please refer to our response to Discussion Question 4.

In regard to the need for increased access to training, we reiterate our recommendation for the development of a contemporary, standardised training program for all AOD workers that can be adopted by all jurisdictions.

## 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 we be aiming for?)

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

Priorities for generalist workers could include (but aren't limited to):

- Integration of AOD content into pre-employment training at vocational and tertiary levels
- Increased accessibility to AOD-related training and professional development for established workers
- Strategies, programs and support to facilitate integrated care that incorporates AOD professionals and organisations
- Targeted professional educational campaigns to address stigma and discrimination that may be associated with AOD use and AOD work

## Guild response

The Guild believes that it should be a priority to develop strategies, programs and support to facilitate integrated care for patients with AOD problems. There is a need for the following:

- A range of evidence-based treatment options to support AOD users to reduce harmful patterns of use;
- Continuous improvement of the knowledge and skills of health professionals, including pharmacists, in regard to the harms associated with illicit drug use, the management of dependence, and any treatment options available;
- Programs which enhance the capacity of health professionals to undertake effective interventions and support clients with drug dependence issues;
- Programs that recognise community pharmacists as being part of the primary health care team, and in particular, programs that involve community pharmacists in any coordinated care planning with GPs or AOD workforce for patients to address their substance misuse. For instance, where no in-patient services are available, especially in a rural area, the prescriber may consider provision of an appropriate medicine(s) via Staged Supply through a community pharmacy as a short-term measure until a suitable managed facility in the community is found; and
- Jurisdictions may currently provide training to pharmacists on the ODT programs in their state or territory, however, the Guild recommends that further opportunities for interprofessional training or networking between the specialist and generalist AOD workforce would increase the quality of service provision to patients. A national, contemporary, standardised training program for all AOD workers that can be adopted by all jurisdictions should be developed.

In cases where health or addiction concerns are apparent, pharmacists can refer patients to access their local GP or a drug and alcohol service for appropriate treatment as available in the area. In many circumstances, particularly in rural and remote Australia, the local community pharmacy may be the only available health care facility. Community pharmacists in these situations should be enabled to develop their skills and be more involved in providing AOD services to their communities. This may involve changes to legislation to enable pharmacists to prescribe relevant treatments according to standard treatment protocols, with access to specialist support to manage complex cases. Patients in

these communities can participate in three-way (or more) communications involving their community pharmacist and a distant AOD support clinic.

In an acute or emergency situation, a prescriber could provide an emergency prescription to the community pharmacy to supply the family, a carer or a designated person a limited supply of emergency anti-psychotic medicine to relieve the immediate effects of drug withdrawal until appropriate health care can be instigated.

These are some examples of integrated care that should be implemented through a coordinated strategy or program to ensure that community pharmacists are utilised to their full capacity.

## Priority Groups

### 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?

### (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?

Important issues could include (but aren't limited to):

- Culturally safe training and support mechanisms
- Availability and accessibility of education, training and professional development for new and established workers
- Programs and actions to address the wellbeing

### Guild response

The Guild acknowledges the need for greater capacity building to support the Aboriginal and Torres Strait Islander AOD (alcohol and other drug) workforce. We support increased national investment in developing and delivering culturally safe training and support mechanisms, and any initiatives that will improve workforce development outcomes for Aboriginal and Torres Strait Islander AOD Workers.

Any such initiatives should be developed in partnership with Aboriginal and Torres Strait Islander AOD Workers as the primary stakeholders in regard to setting goals and implementing programs.

## Discussion question 6: Thinking about other 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?

Important issues could include (but aren't limited to):

- Availability and accessibility of education, training and professional development for new and established workers
- Strategies needed to support the recruitment and retention of workers
- The need for training and professional development to develop particular knowledge, skills or abilities
- Programs and actions to address the wellbeing of these workers that meets their unique needs

## Guild response

Currently there are difficulties in recruiting community pharmacists in rural and regional areas. The Guild is receiving almost daily reports from its members in both regional and metropolitan areas about their recruitment difficulties, sometimes having job ads up for close to a year. Skilled migrants on regional visas are often used to fill workforce shortages.

We recommend that the Commonwealth Government makes changes to the Skilled Migration Program to increase the current cap of 79,600 places.[8] This would allow pharmacies in rural and regional areas to recruit a greater number of overseas trained pharmacists, addressing the challenge of uneven population growth and economic development between urban and regional areas. It would also ensure that rural and regional community pharmacies remain a strong primary healthcare provider delivering better health outcomes and reducing AOD-related harm in their communities.

The updated Strategy should aim to reduce the workforce shortages in rural and regional areas as much as is feasible so that the shortages do not impact the ability for the workforce to provide adequate care to people with AOD problems.

Remuneration arrangements should also take into account additional costs associated with service provision in rural and remote regions. An example of this is the remuneration for administering COVID-19 vaccines by GPs and pharmacists which included an additional fee for providers located in Modified Monash regions 2 to 7.

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[8] Department of Home Affairs, Migration Program planning levels, https://immi.homeaffairs.gov.au/what-we-do/migration-program-planning-levels

We also highlight the need for skilled migrants in the AOD sector including community pharmacists to receive adequate training on Australia's health system and the specific programs they will be delivering to clients such as Staged Supply and ODT programs, to reduce the possibility of stigma and discrimination of clients with AOD issues. This is particularly important for health practitioners migrating from countries where health practices and cultural practices differ from Australia's.

## 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?

Important issues could include (but aren't limited to):
Systems, organisational and individual strategies that meet the requirements of the Australian Commission on Safety and Quality in Health Care National Standards for Working with Aboriginal and Torres Strait Islander People (hereafter 'Aboriginal') and promote:

- Recruitment and retention of Aboriginal staff
- A welcoming and safe environment that quickly establishes if clients identify as Aboriginal
- Flexible service delivery options
- The use of practice strategies that engage Aboriginal people and their families
- Community consultation and engagement and understanding local history and protocols

## Guild response

Please refer to our response to Discussion Question 5.

Ninety four percent of community pharmacies are accredited by the Quality Care Pharmacy Program which is the recognised Clinical Governance Framework for community pharmacy. As such, there is requirements for pharmacies to provide culturally safe services by engaging with local communities and organisations to codesign services, and for staff to undertake cultural safety training.
Support should be provided to the AOD workforce at national, and local levels, to undertake tailored cultural safety training that addresses all aspects of AOD use in the Aboriginal and Torres Strait Islander population.

## 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?

Important issues could include strategies that (but aren't limited to):

- Encourage awareness of additional barriers to accessing AOD services these groups experience
- Promote access and equity to services
- Prioritise diversity in the recruitment of workers into the AOD workforce
- Ensure the comprehensive implementation of diversity training in AOD organisations
- Collect data about diverse populations

## Guild response

The Guild is supportive of any professional development opportunities that focus on how best to support and ensure effective service delivery for client groups with specific or unique needs. However, there must be pathways in place for community pharmacies to assist patients with complex needs to access specialised clinical treatment.

Difficulties in accessing specialised clinical treatment centres can have a significant influence on medicine abuse/misuse. Healthcare workers should have clear, concise and uniform resources to support them in providing professional clinical support, with a clear referral pathway for complex cases. Delays in referrals may result in at-risk patients being managed within more limited scopes of practice which can have consequences such as medicine misuse or abuse.

This issue includes the need for patients to access specialised pain clinics, specialised sleep clinics or mental health clinics, for example. In addition, health professionals need to have a readily available reference to know what specialised health service centres are available in their area, or alternatively, how to access remote or distant services when they are not locally available.

## 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?

Important issues could include (but aren't limited to):

- Upskilling AOD workers in responding to other health issues and upskilling generalist and specialist workers from other sectors to respond to AOD problems
- Promoting within-service holistic wrap-around client care and / or improving collaboration between AOD and other health services (no wrong door)
- Promoting and supporting client empowerment, individualised, client-driven treatment and being comorbidity-prepared
- Screening at health system entry points for substance use problems

### Guild response

Our response to Question 8 is relevant to this response. We have also noted in our responses to other questions some examples of how integrated care can be implemented to better incorporate the community pharmacy workforce.

Community pharmacists are a highly capable and adaptable workforce that routinely treat patients with multiple and complex needs, including those with comorbidities and with mental illness. However, there are opportunities to provide training on a national scale to the community pharmacy workforce in specific areas to enable integrated care.

For example, national mental health first aid (MHFA) training for the community pharmacy workforce would better enable community pharmacy staff to identify and assist patients with concomitant mental health and AOD issues and refer them to other specialised treatment providers as appropriate. Funding should be dedicated to providing MHFA training to the national community pharmacy workforce.

# 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?

Important issues could include (but aren't limited to):

- Activity-based funding models adversely impacting WFD resources (particularly the additional WFD costs associated with providing services in rural and remote areas)
- WFD implications of funders moving to outcomes-based funding approaches
- Meeting e-health and enhanced service integration challenges
- Approaches to reduce the stigma experienced by AOD clients attending specialist and non-specialist services

## Guild response

We note that there are currently a variety of funding models that enable the community pharmacy workforce to contribute to reducing AOD-related harm in their patients. These include the following:

- Pharmacy Needle and Syringe Programs (NSPs) funded through State and Territory governments[9][10]. The involvement of community pharmacies in Needle and Syringe Programs has made a significant contribution to the prevention of blood-borne diseases among people who inject drugs and within the wider community. It has also made it possible to access people who inject drugs and provide a gateway to other treatment and drug rehabilitation programs.
- The Staged Supply Program is funded through the Seventh Community Pharmacy Agreement (7CPA) and allows pharmacists help patients with drug abuse/misuse issues[11]. Staged Supply services can also help to prevent the diversion of at-risk medicines and enable pharmacists to help patients with adherence issues (e.g., those with mental health problems) by facilitating self-management of their medicines.
- Medicine Reviews including the Home Medicines Review (HMR)[12] and MedsCheck programs are funded by the Australian government through the 7CPA. These programs support the quality use of medicines and help to minimise adverse events and misuse of medicines. These services could be extended for more targeted pharmacist interventions for people at risk of unintentional or intentional medicine misuse or abuse.

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[9] Queensland Needle and Syringe Program, https://www.guild.org.au/guild-branches/qld/professional-services/pharmacy-needle-syringe-program

[10] NSW Pharmacy Needle and Syringe Program, https://www.guild.org.au/guild-branches/nsw/professional-services/needle-and-syringe

[11] Pharmacy Programs Administrator, Staged Supply, https://www.ppaonline.com.au/programs/medication-adherence-programs-2/staged-supply

[12] Pharmacy Programs Administrator, Home Medicines Review, https://www.ppaonline.com.au/programs/medication-management-programs/home-medicines-review

However, there are gaps in the various funding models, and one immediate priority that we wish to highlight is with the opioid dependence treatment services that involve the supply in instalments for daily dose management of methadone or buprenorphine to at-risk patients.

Currently State and Territory based ODT programs operate in a complex environment with varied service delivery, funding models, distribution and effectiveness. The Commonwealth Government does not currently directly fund nor administer ODT programs, nor does it have a direct role in how States and Territories manage the delivery of these services. As a result, there is significant variability between the jurisdictions regarding the operations of ODT services, pharmacy remuneration, patient costs and ultimately patient access and success.

States and Territories operate varied remuneration/funding models for community pharmacies providing ODT services; leading to pharmacies not participating due to remuneration being insufficient to cover the cost of providing the service, and many opioid-dependent people not participating due to the financial burden incurred by having to bear the full cost of the service.

The Guild's 2021-22 and 2022-23 pre-budget submissions called for the Commonwealth government to fund the dispensing and daily dose management for opioid dependence treatment to make the service more affordable and accessible for patients, and many consumer and professional groups have supported this proposal[13].

There are also issues with capped funding for the Staged Supply program, as many pharmacies provide Staged Supply to a greater number of patients than the program cap renumerates them for. Additionally, many pharmacies are unable to offer this service to all eligible patients who could benefit from it because of the funding caps. As a result, patient access to Staged Supply is significantly constrained, and governments should consider whether additional funding sources should fund a greater number of Staged Supply patients. The current funding caps are not allowing pharmacists to provide this service to all patients who require it, and this must be addressed.

[13] Pharmacy Guild of Australia, Support for Changes to ODT, https://www.guild.org.au/news-events/news/forefront/v11n04/support-for-changes-to-odt

## 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?

Priority actions could include (but aren't limited to):

- Reviewing and addressing remuneration, especially for frontline workers, to achieve greater parity with similar sectors (e.g., mental health)
- Supporting and increasing the capacity of AOD organisations to ensure adequate resourcing and staffing
- Developing and promoting clear AOD career steps and pathways
- Developing and promoting entrance pathways into AOD work, incorporating training and credentialling pathways
- Supporting programs to orientate, train and develop workers new to the AOD sector
- Increasing availability and accessibility of professional development opportunities
- Implementing strategies and programs to reduce stigma associated with AOD work

## Guild response

The Guild is supportive of any initiatives to reduce stigma associated with AOD work, and any training programs to upskill healthcare workers on AOD-related care, that incorporate the community pharmacy workforce (including pharmacy assistants and other pharmacy staff).

We reiterate our recommendation to develop a standardised training program for the AOD workforce that can be adopted by all jurisdictions and is agnostic of practice setting and clinician. Please refer to our response to Question 15.

## 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?

Important issues could include (but aren't limited to):

- The impact of enhanced real time monitoring of Schedule 8 and relevant Schedule 4 medicines on treatment demand
- Increased cocaine use, either on its own or in combination with alcohol (the cocaethylene effect)
- Increased supply and use of drugs such as Ecstasy which may have been stockpiled as a result of Covid 19-related reduction in demand
- Increased use / misuse of gabapentinoids in response to concerns related to prescribing opioids
- Increased use of fentanyl, fentanyl analogs and other novel synthetic opioids on their own or to adulterate heroin
- Gamma Hydroxybutyrate (GHB) (and its precursors, gamma-butyrolactone [GBL] and 1,4-butanediol [1,4-BD]).

## Guild response

The nature of drug dependency is changing with increasing prevalence of the misuse, abuse, and diversion of prescription opioids such as oxycodone and fentanyl. The growing number of people dependent on opioids is a cause of concern, both internationally and within Australia. Between 2016 and 2017 in Australia 3.1 million people had one or more prescriptions dispensed for opioids, over 40,000 people used heroin, and about 715,000 people used painkillers/analgesics and pharmaceutical opioids for illicit or non-medical purposes.[14]

There are nearly 150 hospitalisations and 14 emergency department presentations involving opioid harm every day in Australia, and 3 people die from drug induced deaths involving opioid use daily.[15] This data represents a massive growth in opioid related harm over the last 20 years, and this trend is continuing to have an impact on our communities.

We highlight the importance of an overarching national real time prescription monitoring (RTPM) solution to assist AOD workers in monitoring their clients' access to high-risk prescription substances including opioids. The list of prescription substances monitored by RTPM systems should be continually reviewed to ensure high risk prescription substances, particularly those with an increased trend towards misuse, abuse and diversion are captured for monitoring to prevent harm.

The Guild has long supported the introduction of a national RTPM solution, as a vital clinical tool to enable prescribers and pharmacists to identify and support patients to use prescription medicines safely and to help minimise the risk of harm. A national RTPM system will equip prescribers,

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[14] Opioid harm in Australia: and comparisons between Australia and Canada, Summary - Australian Institute of Health and Welfare, https://www.aihw.gov.au/reports/illicit-use-of-drugs/opioid-harm-in-australia/contents/summary, 9 Nov 2018

[15] ibid

pharmacists and other AOD workers with accurate and timely information so that they can provide better care for their patients.

In the Guild's 2018 submission to the Therapeutic Goods Administration's consultation paper on the opioid use and misuse in Australia, we stated that a nationally co-ordinated real-time monitoring system is essential to deal effectively with opioid abuse and misuse in Australia and welcomed the commitment made by all State and Territory health ministers to achieving a national RTPM solution. In 2019, the Commonwealth committed to developing a National Data Exchange (NDE) to enable jurisdictional systems to connect to a national data repository, which is a central clearing house for all states to exchange data on Schedule 8 medicines. However, currently not all State and Territory governments are integrated and utilising the NDE yet.

Combined with adequate treatment programs and AOD workforce capability, a national RTPM solution is key to reducing the harms from prescription medicine misuse.

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

Important issues could include (but aren't limited to):

- What level should minimum educational qualification standards for specialist AOD be at?
- Should minimum educational qualification standards for specialist AOD workers be nationally consistent?

## Guild response

The Guild recommends the development of a contemporary, standardised training program for the AOD workforce that can be adopted by all jurisdictions and is agnostic of practice setting and clinician. Please see our response to Question 15 for our recommendations in regard to consistency in training.

## 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?

Important issues could include (but aren't limited to):

- How accessible are the current AOD vocational qualifications (Cert IV/ Diploma I AOD, AOD skills set)
  - What are key barriers to workers gaining these qualifications?
  - How can accessibility be improved?
- What are the major gaps in the current set of AOD qualifications that impact on workers' capacity and effectiveness?
  - Are there particular skill sets that need to be added?
  - Are there particular areas of knowledge that need to be added?
- How well is competency-based training meeting the needs of the AOD sector and consumers?
  - Are there other training approaches/modalities that are needed to complement a competency-based approach? What might this look like?

## Guild response

Please refer to our response to Question 15.

## 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.

Important issues could include (but aren't limited to):

- Strategies to increase accessibility of PD, for example:
  - Scholarships and other programs to reduce financial burden on workers and organisations
  - Increasing the availability of online delivery
  - Funding programs to support regional and remote workers to access face-to-face training (e.g., travel, accommodation and backfill costs)
  - Development of a centralised register of professional development opportunities
- Development and support of other approaches to PD that extend beyond training, such as professional placements, conference attendance and mentoring
- Conduct of a national review of AOD professional development programs and opportunities to identify major gaps and strategies for improvement

## Guild response

Professional development for community pharmacists and their staff should encompass AOD-related care. We recommend funding greater opportunities for community pharmacy staff to collaborate with other health practitioners who are also working in the AOD space. Training opportunities should provide opportunities for a variety of health practitioners to collaborate with each other in both formal (face-to-face training sessions) and informal (i.e., conferences) settings.

This collaborative approach to training should be complemented by a new model of care incorporating community pharmacists as part of a multi-disciplinary care plan with other health practitioners. This will require governments to appropriately fund and recognise the contribution of community pharmacists within this new model of care. Please refer to our responses to Discussion Questions 1 and 4 in regard to community pharmacists being important participants in multi-disciplinary case conferencing.

We also agree with the recommendation in the Discussion Paper that "undergraduate and pre-registration education and training are key sites for the inclusion of AOD-related content. Embedding training in AOD issues at these levels would have numerous benefits, including not only increasing the knowledge and skills of health workers, but also establishing the legitimacy of AOD issues (and de-stigmatising them)." To complement this recommendation, the Guild recommends the development of a contemporary, standardised training program for the AOD workforce that can be adopted by all jurisdictions and is agnostic of practice setting and clinician. A standardised training program would ensure the quality of training and content being delivered to the AOD workforce. State and territory training could then focus on jurisdictional differences.

We also recommend consideration is given to how AOD related assessment and support can be incorporated into existing and future pharmacy services. This would provide another opportunity for interaction with a health professional and potentially earlier identification of problems requiring further support.

## 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?

Important issues could include (but aren't limited to):

- Elements of service delivery that work particularly well (or particularly poorly) when delivered remotely
- Specific client/consumer groups for whom remote service delivery is particularly beneficial (or particularly inappropriate)
- The ideal ratio of remote: face-to-face service delivery and how this should this be established for different groups
- Key infrastructure changes/upgrades that are needed to support increased remote service delivery
- Training priorities for upskilling staff to effectively utilise new technologies
- The barriers preventing more effective use of new technologies, and how they can be addressed

### Guild response

Any strategies to support AOD services, workers and clients to engage with digital and online service provision must acknowledge that many services delivered by community pharmacies cannot be effectively undertaken remotely (i.e., online or through remote delivery). Such services include ODT, Staged Supply, NSPs, and generally any services related to medication provision. These services are best delivered when community pharmacists and their staff can support patients in a face-to-face environment.

Community pharmacies can play a role in supporting patient access to remote services. Many pharmacies have consultation rooms that can be used to conduct telehealth interactions between AOD workers and patients who may not have access to adequate technology. Community pharmacies, especially in regional, rural and remote areas, can act as a health hub using existing infrastructure to support patients' access to AOD services. Appropriate funding mechanisms to support this service would need to be considered.

Please also see our response to Question 4.

## Data Systems, Monitoring and Evaluation

### 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?

Important issues could include (but aren't limited to):

- The current gaps in workforce data at a national and jurisdictional level that impact on WFD planning and implementation
- The extent to which a national data collection could add value to existing jurisdictional data collections
- The potential for greater coordination across jurisdictional data collections to enhance comparability of data
- The parameters and scope of a potential national data collection (e.g., frequency of data collection, essential data to be collected)

### Guild response

The Guild is supportive of collecting national data on the AOD workforce and recommends that any such collection includes data showing the number of community pharmacies providing ODT services. This data collection could take place through a workforce survey at the time of pharmacist registration and would indicate a minimum number of pharmacists who are involved in AOD work, which would inform AOD workforce planning more broadly.

Information on ODT statistics currently relies on individual state/territory data, whereas national data relies on surveys conducted by support agencies or the AIHW. Implementing a national ODT program as part of the PBS would provide more reliable data for all Governments, as PBS dispensing data is captured in real time. This more reliable data includes prescriber and pharmacy data, state and territory related data, and regional data.

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

Priority actions could include (but aren't limited to):

- Development of an implementation plan
- Development and implementation of a monitoring and evaluation plan
- Additional consultations with national and jurisdictional stakeholders to address monitoring and implementation

## Guild response

The Guild would welcome an opportunity to participate in any consultations at a state or national level in relation to the development of the revised Strategy and implementation plan, to represent the community pharmacy sector as a critical element of the AOD workforce.

# Final

## Are there any other questions or comments?

## Guild response

The Guild does not have any additional questions or comments.