National AOD Workforce Development Strategy

Submission By:
National Drug Research Institute, Curtin University (NDRI)

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

Submission from the National Drug Research Institute, Curtin University (NDRI)

February 2022

Professor Simon Lenton
Director
National Drug Research Institute
Curtin University
Building 609 (Level 2), 7 Parker Place
Technology Park, Bentley WA 6102
(08) 9266 1600
ndri@curtin.edu.au

INTRODUCTION

The National Drug Research Institute's (NDRI) mission is to conduct and disseminate high quality research that supports evidence informed policy, strategies and practice to prevent and minimise alcohol and other drug-related health, social and economic harms among individuals, families and communities in Australia.

Since its inception in 1986, the Institute has grown to employ about 30 research staff, making it one of the largest centres of alcohol and other drug research and public health expertise in Australia. NDRI researchers have completed more than 500 research projects, resulting in a range of positive outcomes for policy, practice and the community. For example, NDRI research has significantly informed and contributed to policy and evidence-based practice such as the National Alcohol Strategy, National Amphetamine-Type Stimulants (ATS) Strategy, and National Drug Strategy; contributed to Australia's involvement in international strategies, such as WHO Global and Regional Strategy to Reduce Harmful Use of Alcohol; directly contributed to Australian and State government alcohol and illicit drug policy, including cannabis policy and naloxone availability; contributed to international evidence-based school interventions; influenced NHMRC guidelines to reduce alcohol health risks; and been cited in development of policy documents for Aboriginal Australians.

ABOUT THIS SUBMISSION

This brief submission outlines some general principles for consideration as well specific points around Service Development which, while not specifically focussed on workforce development, are important considerations for program and service development and effectiveness. The submission was co-authored by Professor Steve Allsop and Associate Professor Nyanda McBride, who leads NDRI's *Prevention and Early Intervention* research program. NDRI's researchers are available to provide further information or verbal evidence on request.

GENERAL PRINCIPLES

- We need to build workforce capacity to respond to people who are affected by alcohol and other drugs (AOD) who may not necessarily use or use in a risky way themselves, for example parents, children and siblings.
- The workforce in AOD is ageing and in a very short space of time we will have a significant number of people leaving the sector, with all their expertise. It is critical a strategy is in place to address this imminent gap.
- We need a reinvestment in AOD education and training in secondary and tertiary education along with post qualification training for all relevant professions – health, social work, law enforcement, etc. Elective courses and curriculum infiltration (getting alcohol into obstetrics and paediatrics, for example) is critical along with more specialist programs. We have seen such courses diminish in the past 15 years or so.
- AOD workforce development must jointly focus on general health and other settings (hospitals, primary health care, mental health, corrections, etc.) as well as specialist services because a large proportion of people affected by AOD use never come into specialist services and the sheer number of issues would not be able to be managed in AOD specialist services alone.
- An effective workforce is totally reliant on funding quantum and certainty. Short funding periods with low wages make it difficult to recruit people into these domains and retain them. It is hard enough to recruit people into the sector but if wages are low and continued funding uncertain, it is unlikely we will build a quality workforce. How would our hospitals and our mental health services flourish if we put them on one, two or three year funding cycles where they had to

competitively apply for funding? If a staff member leaves an organisation in the second year of a three funding year cycle, how can an agency competitively attract quality staff? This does not mean services should not expect to have to set and meet quality assurance guidelines (as do our hospitals) but ability to plan and offer secure employment is critical.

- An effective workforce is reliant on a quality supervision and staff development investment.
- A specialist medical workforce is critical. This means supporting the training and support that currently exists with meaningful reward for specialism through access to specialist items in Medicare that support AOD work for addiction medicine consultants across all medical domains.

SERVICE DEVELOPMENT

Incorporating evidence/proof of impact, and using a systematic approach to intervention/program develop both have empirical evidence for behaviour change. Although not content specific to workforce development, these are important considerations for program and service development and effectiveness.

It is important to note there are three levels of evidence that inform the behavioural effectiveness of an intervention:

1. **Evidence-based programs** that have been developed and informed by past knowledge in the field (i.e. systematic literature reviews) and, when this is not available by current best practice which has been informed by practice, wisdom and experts. This approach does not provide any evidence of behavioural impact.
2. A program with **proof-of-impact** is one that has undergone rigorous longitudinal impact assessment and shown statistically significant behaviour change in the target population. This outcome provides a good level of evidence of behavioural impact.
3. A program has **well established proof-of-impact** when it has been replicated in another jurisdiction under the lead of another research team, with statistically significant behaviour change that supports the original study. This outcome provides a high level of evidence. [1]

If a program is solely evidence-based (Level 1 above), there is no proof that behaviour change will result from implementation. However, if a program has well established proof-of-impact (Level 3), then there is a general understanding that if it is delivered as intended, with the intended target group, by trained staff, then a level of behaviour change can likely be expected [2, 3].

Service Development Approach

A systematic approach to service development can increase potential for behavioural change [4]. A systematic process ensures that the most pertinent evidence is captured and applied to service development. A systematic approach to service development goes beyond attempting to incorporate findings from a systematic literature review.

The SHAHRP empirical model for developing interventions to increase the potential for behaviour change [5] uses a systematic approach to service and program development and includes:

1. Relevant finding from past literature. Identifying components, strategies, content and mode of delivery from service and program selected for inclusion in systematic literature reviews which have demonstrated some potential for behavioural effectiveness. If past literature provides limited findings, review of similar literature may help uncover possible aspects that can guide service and program methodologies.
2. Relevant theory. Relevant theories can help to conceptually identify the range of factors that impact the behaviour. Identification of these factors can be used to help build a comprehensive list of factors that may help to modify behaviour.

3. Expert advice. The range of experts who can provide guidance to service or program development include content, intervention and setting experts comprising academic researchers, policy/practice professionals, and others who work directly with the consumer group/s. Expert involvement should occur from the inception of program development to optimise potential for behavioural impact and to optimise the adequate measurement of behavioural impact (so that future programs will be accepted into systematic reviews and provide guidance to future programs).
4. Consumer group involvement in development and pre-assessment of services and programs. Consumer involvement in service and program development is critical for behaviour change as it ensures that strategies, content and mode of delivery are meaningful and relevant to the consumer groups. If consumer involvement is not included then the possible behavioural effectiveness of the program is reduced [4]. Several steps are required to ensure that consumer experiences guide service and program development. These include asking consumers about their experiences, knowledge, values and beliefs; asking consumers about their recommendations for program components, strategies, content and mode of delivery; systematically incorporating consumer identified detail in a pilot of the service or program; piloting the service or program with the consumer groups to refine.
5. To ensure the inclusion of all relevant findings from the systematic service or program development process, methodically table all key findings and plan placement of findings into services, projects, recommendations and guidelines. Maintain a table noting where placement has occurred by element (systematic review, theory, target group input, expert input) so that regulation is more readily achieved, and is documented in detail for evaluation, future reporting, for replication purposes and to enable a clearer understanding of inclusions that contribute to behaviour change (when analysis is linked to fidelity of implementation data).
6. A systematic approach to service and program development needs to be teamed with appropriate evaluation methodology. Evaluation design should be established before the conduct of the service or program as pre-assessment of, for example, knowledge, attitudes, previous experiences, behaviours and behavioural intentions, is required to statistically analyse against post service and program measures to identify change. Evaluation design and methodology is complex and requires expert input to reduce bias and increase the reliability of evaluation findings. Quality evaluation design and methodology will result in acceptance into systematic literature reviews and help build the knowledge base of the field.

REFERENCES

1. McBride N. School drug education: intervention development and research. Springer: Singapore. 2016.
2. McBride N, Farringdon F, Midford R, Meuleners L, Philip M. Harm Minimisation in School Drug Education. Final Results of School Health and Alcohol Harm Reduction Project (SHAHRP). Addiction. 2004;99:278-91.
3. McKay M, McBride N, Sumnall H, Cole J. Reducing the harm from adolescent alcohol consumption: results from an adapted version of SHAHRP in Northern Ireland. Journal of Substance Use 2012;Early Online:. 2012:1-24.
4. McBride N. Intervention Research: A practical guide for developing evidence-based school prevention programs. Springer: Singapore. . 2016.
5. McBride N. School Health and Alcohol Harm Reduction Project Empirical Model for Developing Interventions to Increase the Potential for Behaviour Change. National Drug Research Institute, Curtin University: Perth. 2020.