National AOD Workforce Development Strategy

Submission By:
The Rural Doctors Association of Australia (RDAA)

RDAA response to NCETA consultation on the National Alcohol and Other Drug Workforce Development Strategy

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About RDAA

The Rural Doctors Association of Australia (RDAA) is the peak national body representing the interests of doctors working in rural and remote areas and their patients and communities.

RDAA's vision for rural and remote communities is simple – excellent medical care. This means high quality health services that are: patient-centred; continuous; comprehensive; collaborative; coordinated; cohesive; and accessible, and are provided by doctors and other health professionals who have the necessary training and skills to meet the needs of their communities.

Introduction

It is well recognised that inequity of access to health professionals and services, including for the prevention and treatment of alcohol and other drug (AOD) issues, is a persistent problem in rural[1] Australia. Thus far policies and programs to redress these access issues, including in relation to workforce development, have had limited success.

People with AOD issues interact with many different areas within the health system especially if they have co- or multi-morbid conditions or issues that increase complexity and levels of need. They also often interact with a range of other government and non government services, including homelessness, housing, justice, education and employment services. Fragmented and silo-ed approaches to funding, organising and delivering AOD treatment and support is characteristic of the system and coordination between types of care and service is rarely, if ever, seamless.

The lack of understanding about the complexities of the rural health and social and community services sectors – including about the role of rural doctors within the AOD sector and the scope and circumstances of rural medical practice – contributes to the poor design and implementation of policy and program initiatives which, in turn, compromises their effectiveness.

While RDAA's comments focus on the medical workforce as part of the rural AOD sector, there is considerable overlap of issues in relation to the broader AOD workforce. RDAA notes that Australian and jurisdictional governments rely on the non-government sector to meet needs but with insufficient funding, resources and support, including in relation to workforce development.

[1] Within this document the term 'rural' is used to encompass locations described by Modified Monash Model (MMM) levels 3-7. Rural doctors are rural GPs, Rural Generalists and consultant specialists (resident and visiting) who provide ongoing medical services in these areas.

Key Issues

The role of rural GPs and Rural Generalists in preventing and treating AOD issues and co- and multi-morbid conditions (including alcohol-related accidents, injury and violence) is often under-recognised and poorly supported.

These doctors and their practices most often provide first point of contact with the health system, whether it be in community or hospital settings, and provide ongoing coordination of treatment. They are also called upon to respond in emergencies, including those necessitating retrieval. This extended scope of practice can also include coordinating and supporting their patients through their treatment journey and connection with other social and community services. They also provide treatment and support for the partners, families and others who may be negatively impacted by an individual's alcohol and/or other drug use.

Continuity of care is essential for patients who have alcohol and drug dependence issues. The success of AOD dependence programs is maximised with a long-term therapeutic relationship with a clinician who is able to oversee their condition and care over weeks, months and years. In rural areas, an adequately resourced Rural GP/Rural Generalist is extremely well placed to make a lasting influence to change the life trajectory of an alcohol or drug dependent patient, that of their family, their workplace, and their community. A Rural GP/Rural Generalist who lives and works in a rural community, supported by rural allied health, mental health workers and nursing staff can influence a lasting positive change with excellent outcomes in a financially viable way, often avoiding protracted hospital admissions and recurrent relapses.

Education, training and continuing professional development that is mindful of the rural context and the unique needs of people from specific population groups within rural communities, must be provided to enable these doctors to provide high quality care. Training must be properly targeted with rural doctor oversight, not controlled by city-based AOD consultant specialists with no rural experience. Because the degree of remoteness can create significant access barriers, a range of delivery modalities will be necessary.

Rural doctors must have clear referral pathways to be able to escalate care if necessary. In particular, the lack of access to mental health clinicians in rural areas exacerbates the inequities that exist for rural people in relation to AOD care. Many patients have underlying mental health issues which lead to their addiction as a coping mechanism. Improved outcomes for people experiencing AOD issues could be achieved by referral to psychiatrist, Rural Generalist with advanced skills in mental health, or to psychologists before AOD use becomes a coping mechanism. It is critical that these referrals are acted upon in a timely way (in person care or via telehealth supported by their general practice team). Rural AOD patients should have access to care when they when they present for help, not have to wait weeks or months to get that help and support. This has implications for workforce development and distribution not only for consultant specialists, but also for the broader workforce in relation to attracting, educating, training, recruiting and retaining qualified personnel. Short term, cyclical service funding and contracts can result in insecure employment arrangements that disincentivise recruitment and retention of AOD professionals in rural areas, and impacts on referral pathways and continuity of care.

Rural doctors also have an important role in public health as was highlighted during and in the aftermath of the 2019-20 bushfires, and by the continuing response to the COVID-19 pandemic. Beyond providing care for their patients and others during crises, they often: advocate for public health policy and measures; act as a conduit for public health information; provide community education; and represent their communities and/or the rural medical sector on committees and in forums at local (such as liquor accord meetings),

state/territory and national levels. In order to adequately address AOD issues in rural communities, they must be supported to develop the skills needed to fulfill these public health roles.

Investment in rural medical workforce initiatives continues to be inadequate.

Funding and incentives for attracting, educating, training, recruiting and retaining a medical workforce with the skills needed by rural people and communities, continue to be inadequate to mitigate the maldistribution of doctors across Australia[2,3] This maldistribution means that there is a critical need for proactive strategies to recruit and retain Rural Generalists and consultant specialists with advanced skills in disciplines relevant to care for those experiencing AOD issues (such as addiction, mental health care and Aboriginal and Torres Strait Islander health) to live and work in rural communities.

Industrial arrangements can have an impact on service provision. For example, fee-for-service models or bulk-billed Medicare Benefits Schedule (MBS) appointments may not allow for the consultation time and follow up needed by people experiencing complex AOD or co- or multi-morbid issues. A continuing reliance on fly-in-fly-out and locum workforces that do not return regularly to the same area is also problematic and impacts on the capacity to provide best practice continuity of care. Consideration should be given to developing models of care and funding models that allow rural doctors to better support their AOD patients.

Full implementation of the National Rural Generalist Pathway, including addressing industrial arrangements that currently act as a disincentive to choosing rural GP/Rural Generalist training is essential.

Non-job-related factors often influence a person's choice of position and location and must be addressed as part of any workforce development strategy. For example, opportunities for partner employment are an important, but often neglected, part of workforce development.

RDAA is advocating solutions-based initiatives to address these and other identified issues (RDAA Rural Workforce Plan https://www.rdaa.com.au/documents/item/1364 and RDAA Pre-budget 2022-23 Submission https://www.rdaa.com.au/documents/item/1844).

Generalist models of care that are based on multi-disciplinary teams are critically important in rural areas to meet individual, family and community needs, including in relation to AOD issues.

These models of care should respect the skills and scope of practice of each member of the team and be underpinned by robust communication mechanisms to ensure effective functioning as a team. Workforce skills development is essential to make this happen.

Safety is a key concern for rural doctors providing AOD treatment and support.

[2] Australian Government Department of Health. 2018. Medical Workforce Factsheet. Table 7. p5. Viewed 28 February 2022. https://hwd.health.gov.au/webapi/customer/documents/factsheets/2018/Medical%20Workforce%20Summary%20Factsheet%202018.pdf

[3] General Practice workforce providing Primary Care services, Australia, Remoteness Area - Statistics by calendar year 2. Aust and remote summary GP FTE per 100,000 population. Viewed 28 February 2022. Available at https://hwd.health.gov.au/resources/data/gp-primarycare.html.

Safety issues are also of concern to all professionals responding to or providing treatment and support for those experiencing AOD issues and their partners, families and others. They include possible harassment, threats or violence not only of the professional but also their families.

Initiatives that can bring together different workforces to address an issue of common concern have the potential to provide much needed personal and professional networks and support, and should be supported with adequate and ongoing funding. For example, the Working Safe in Rural and Remote Australia – a joint initiative of the Rural Doctors Association of Australia (RDAA), the Australian College of Rural and Remote Medicine (ACRRM), the then Australian Nursing Federation (ANF), the Police Federation of Australia, the Queensland Teachers' Union and CRANAplus – sought to respond to growing concern about workplace violence in rural and remote areas, including violence resulting from AOD use. Unfortunately this project did not attract ongoing funding and, as organisations have limited capacity, did not realise its full potential. RDAA understands that CRANAplus is continuing work on remote nurse safety that can inform workforce development for other groups. This should be supported.

Rural communities comprise a range of workforce groups who may have unique needs but there are significant overlapping priorities.

These overlapping issues include but are not limited to:

- Recruitment and retention in rural areas, including financial and non-financial incentives
- Training and professional development, including the development and provision of accessible resources to support training, continuing professional development and clinical practice for generalist and specialist workforces.
- Capacity to develop and maintain personal and professional networks and support.

Telehealth is an important mechanism to facilitate access to care.

Telehealth can be a very useful tool which can allow clinicians to safely treat clients/patients in their own communities in a culturally safe way. Support for telehealth as a mechanism to improve access to more distant consultant specialists and other AOD treatment and support is needed.

Telehealth consultations should be complementary to in person care. This requires that the policy settings supporting telehealth (including the Medicare Benefits Schedule) are targeted and balanced appropriately, and that the workforces supporting these consultations have the requisite clinical and digital skills, technology and infrastructure.

Australia continues to experience the effects of significant climate-related events and the COVID-19 pandemic.

Responses to these events have had, and continue to have, a major impact on the training, recruitment, retention and movement of rural GPs, Rural Generalists and consultant specialists, including the locum workforce.

There has also been a considerable impact on the health and wellbeing of already over-stretched and under-resourced practitioners. Workforce development strategies to better support the health and wellbeing of these practitioners and enable improved recruitment, retention and distribution to mitigate against practitioners choosing to move to more urban locations are necessary to maintain and improve AOD services in rural areas.

This has had a considerable impact on the capacity to provide health care for people in rural areas, including those experiencing AOD issues and must be considered within a national workforce development strategy. National approaches to credentialing of doctors, and to movement of health professionals during emergencies and disasters are necessary to alleviate these issues.

Conclusion

Rural GPs, Rural Generalists and rural consultant specialists are critical to the provision of equitable AOD services across Australia. Targeted initiatives to enable these doctors to provide the range of services needed by those experiencing complex AOD issues in rural communities (where there is limited access to more specialised AOD care) must be central to a National AOD Workforce Development Strategy to help to redress the health care inequities that exist for these communities.