

**Victorian Department of Health
AOD Workforce Development Strategy
Consultation Paper**

SUBMISSION FROM ANEX

Consultation questions

Please complete this response form and return to Ms Jo Norman at jonorman@kpmg.com.au by October 7.

Please note, not all questions may apply to you or your organisation.

For the AOD Workforce Development Strategy as a whole:

Do you believe that the overall approach of the AOD Workforce Development Strategy provides clear direction to develop the AOD workforce?

This Submission from Anex pertains to the staffed engaged in Needle and Syringe Program (NSP) delivery.

According to the National Needle and Syringe Program Strategic Framework 2010-2014, which was developed following Victorian-driven initiatives, the NSP

“seeks to facilitate access for IDUs to preventive care as well as primary health services. IDUs are a group who often experience poor general physical health, mental health as well as medical problems associated with injecting.”

The Draft for Discussion prepared by KPMG generally provides a sound basis on which to move forward. It would be further improved, significantly, by also providing clear direction on how the workforce development needs of people providing sterile injecting equipment for blood borne virus prevention can be a) conceptualised, and b) integrated into the broader vision for the AOD sector.

While the Draft for Discussion states that NSP workers are part of the AOD Workforce, in fact they are not formally considered to be part of the AOD workforce at all. This is discussed in Section 2.1.

Inclusion in the Victorian AOD Workforce Development Strategy 2012-2015 of measures to fully incorporate ALL elements of the health sector workforce involved with assisting people affected by illicit drug use¹ is a necessary step for the Strategy to be considered comprehensive and to fully leverage the resources deployed to the AOD sector.

¹ Defined as those people also misusing licit drugs as prescription opioids.

Do you believe that the AOD Workforce Development Strategy will help improve the AOD workforce and the organisation that employ them? Do the themes and strategies address the needs of the workforce?

As it stands, the Draft for Discussion document offers no prospects of improving the ability of people performing NSP and related tasks, especially in relation to Secondary NSPs which now account for more than half the Department's distribution of sterile injecting equipment.

As discussed in this submission, it does not yet address the needs of the NSP workforce.

See discussion below.

Do you have any suggestions for improving/strengthening the Strategy as a whole?

Yes.

The formulation of the Victorian AOD Workforce Development Strategy (particularly with regards to NSP delivery) should take into consideration fundamental documents released at both State (Victoria) and Federal levels.

These policy documents include:

- National NSP Programs Strategic Framework 2010-2014.
- Third National Hepatitis C Strategy 2010-2013.
- The National Hepatitis B Strategy 2010-2013.
- Sixth National HIV Strategy 2010-2013.
- Second National Sexually Transmissible Infections Strategy 2010-2013.
- Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010-2013.
- The National Drug Strategy 2010-2015.
- Victorian Public Health and Wellbeing Plan 2011-2015.
- Victorian Pharmacotherapy Review 2011-10-06.
- Integrating Care: Victoria's Needle and Syringe Program.
- Department of Health Evaluation of Needle and Syringe Programs in Victoria and the Role of the Council of Australian Governments (COAG) supporting measures.²

National NSP Strategic Framework

In particular, there are a number of "Key Results Areas" specified within the National NSP Programs Strategic Framework 2010-2014 that should be reflected in the forthcoming Victorian Department of Health AOD Workforce Development Strategy 2012-2015.

² (Note: this is with the Department, but not yet released).

These Key Results Areas need to be factored in during formulation of the Victorian AOD Workforce Development Strategy are:

1. National standards.
2. Increased availability (of NSP services, including referrals to treatment).
3. Improved data collection.
4. Implementation of national core training areas for NSP workers.
5. Improved access to referral to health services.

Recommendations

- The Victorian AOD Workforce Development Strategy recognise the important role that NSP staff have in referrals and counselling.
- As discussed in Section 2.2 of this submission, the Strategy should formally state that staff who perform NSP duties that involve interacting with clients are classified as part of the Victorian AOD workforce.
- The Victorian AOD Workforce Development Strategy indicate that NSP workforce capacity building, including creation of minimum training levels, be formulated in conjunction with outcomes to flow from the National NSP Strategic Framework.

For each theme:

Theme 1: Workforce planning

What are your suggestions for improving / strengthening the strategies under this theme? What barriers may need to be overcome?

Please note discussion in Section 2.1 before reading comments in this section.

Initially, there should be development of required minimum training levels for all people providing NSP services where it involves client contact.³ This could be a first step in a longer term goal of moving toward a qualifications framework and building a career path within this sub-sector, including for the large numbers of Administration Staff who perform NSP work in health settings.

This element of AOD workforce planning – where it relates to NSP service delivery – should be conducted in the context of the goals outlined in the National NSP Strategic Framework, particularly with regard to referral of clients.

The National NSP Strategic Framework states that:

Program services should be non-judgemental and accept the lived experience of IDUs some of whom may be marginalised as a result of their injecting drug use and associated activities.

The NSP workforce should be skilled in offering evidence-based services and engaging with

³ This is a requirement in Tasmania for example

IDUs. The availability of a consistent and high standard level of education and training of all NSP workers will maintain a professional and effective workforce;

Please identify who should have responsibility for each strategy.

See discussion in 2.2

Theme 2: Workforce design and structure

What are your suggestions for improving / strengthening the strategies under this theme? What barriers may need to be overcome?

For most of the workforce, NSP service provision is not the primary focus and is not funded. This significantly constrains the ability of many staff to access workforce development and training opportunities.

This is further exacerbated by there being no minimum training requirements for providing NSP services.

The Victorian Alcohol and Other Drugs Workforce Development Strategy 2004-2006 outlined five strategic directions, and minimum qualification standards. However, the accompanying "Minimum Qualifications Strategy" notes (Page 18) that:

"Needle Syringe Program Workers are not required to meet the Minimum Qualification Strategy as they do not fall within the definition of an AOD Drug Treatment Services Worker. However, Primary Needle Syringe Program Workers are able to access any of the free training offered under the Victorian AOD Workforce Development Strategy."⁴

On Page 3 of the Draft for Discussion paper by KPMG, it includes needle and syringe program staff as officially part of the "six key categories of workers" under the Victorian public AOD system. In doing so, the Draft For Discussion refers to the 2009 Victorian Alcohol and Other Drug Workforce Census which was published in 2011.

However, that Workforce Census, which was conducted by the Department of Health, specifically states on Page 4 that "employees of the Victorian Needle and Syringe Program, were excluded from this project".

Therefore, it should be assumed NSP workers (Primary and Secondary)⁵ still remain outside the formal definition of the AOD workforce.

Recommendation

⁴Victorian Government. 2009 Victorian Alcohol and Other Drug Workforce Census. In. Melbourne: Victorian Department of Health; 2011.

⁵ Primary refers to those NSP services that are funded for their work, for example a Primary Health Service such as Innerspace. Secondaries are not funded and include hospitals and some community health centres.

- The Victorian AOD Workforce Development Strategy, and all other relevant Victorian strategies, (including minimum qualification guidelines) should categorically state that all people working in an NSP role in Victoria, whether full or part-time, should be considered part of the AOD workforce.
- In addition, this Strategy should recommend that all future workforce development planning and support for the AOD sector specifically recognise the unique role that NSP frontline staff play – and can potentially increasingly play – in counselling and referral as envisaged through funding allocations under the Illicit Drugs Diversion Initiative.
- As such, the Strategy should foreshadow development of appropriate minimum levels of training requirements and/or qualifications for people performing duties in accordance with the Victorian NSP.

Recommendation

- It is recommended that creation of minimum training requirements for people in the NSP within Victoria be undertaken with cooperation of, and support from, the Australian Government Department of Health and Ageing.

2.2 Please identify who should have responsibility for each strategy

Anex is the organisation best placed in Victoria to project manage the scoping, research/consulting and development of minimum training standards for people performing NSP tasks in Victoria.

Responsibility for ensuring this occur and is delivered should rest with the Victorian Department of Health, notwithstanding the possible integration with the Australian Government Department of Health and Ageing via the National NSP Strategic Framework discussions and actions.

Theme 3: Workforce supply and distribution

What are your suggestions for improving / strengthening the strategies under this theme? What barriers may need to be overcome?

We need a network of NSP workers across the sector, rostered to spend time at unfunded outlets, so that all NSP clients have access to the education, information and referral that needs to be available to this neglected population. Furthermore, there is opportunity for productivity and effectiveness gains by combining forces, remodelling a work force appropriately trained to assist injecting drug users across the full range of services they need on their journeys out of their injecting drug using careers.

These practitioners could be seen as outreach primary health service providers, delivering primary health services across larger catchments, where the concentration warranting fixed-site primary health services is not present. Such an approach clearly lends itself to supporting pharmacotherapy and referrals to other health services, particularly mental health.

Recommendation

- The Strategy should signal Government intention to commit additional resources to secondary NSPs, either directly on a service-by-service basis or through additional means

such as resourcing support workers who could help tap the latent potential for the unfunded services to enhance their 'all of government' role through referral to other services. Such an investment strategy should ensure that population distribution is factored in so as to reduce eliminate existing regional disparities in service availability.

Please identify who should have responsibility for each strategy.

Theme 4: Workforce skills and competencies

What are your suggestions for improving / strengthening the strategies under this theme? What barriers may need to be overcome?

The Victorian NSP Operating Policy and Guidelines state that "Staff education and training is mandatory before the agency can commence as an NSP".⁶ This refers only to when an agency is first establishing the service, so does not cover the situation in which an existing service requires "new" staff members to begin performing NSP duties or an existing member taking on an NSP role.

As such, there are essentially no minimum training requirements applying to workers within the NSP. This means that any established NSP service, from a Primary health service to a rural hospital, can require a staff member (eg: an administration worker) to dispense sterile injecting equipment, Behaviour Change Communications materials or referral information without that person having been trained in any of the following areas, for example:

- illicit drugs, including safer routes of administration and trends in drug markets;
- misuse of 'harmaceuticals' (prescription drugs);
- working with people affected by illicit drug use;
- referrals to other health and social services;
- understanding and responding to people affected by drug use who also have other health problems;
- the role and value of Needle and Syringe Programs;
- opportunities for clients to access drug treatment, including pharmacotherapy;
- pregnancy and drug use.

The NSP workforce can potentially play a much more important and effective role in the area of demand reduction, which is one element of prevention. Additional support is required for

⁶ Department of Human Services (Victoria), 2001 and updated 2008. Victorian Needle and Syringe Program Operating Policy and Guidelines.

secondary NSPs so that they may play a far greater role in brief counselling interventions and referral to other services, particularly drug counselling and treatment.

It is clear that additional and improved workforce development strategies are required, particularly for those in rural and regional secondary services that have less opportunity to network and learn from already experienced frontline staff.

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It is important to understand the significance of the secondary NSPs sector to the overall savings that the Victorian program has achieved. It was estimated in the 2009 Return On Investment study that net savings from the NSP over the 10 year period to 2009 was \$153 million in Victoria.⁷

NSP data indicates that secondary outlets accounted for 39 percent of the equipment distributed through the program during that period. However, these outlets receive no specific funding for the service, not even for data collection and dissemination to the Department.

It can therefore be argued that given that secondary outlets accounted for 39 percent of product throughput across the decade to 2009, and savings across the state were \$153 million, more than \$59 million in healthcare cost savings were achieved via an unfunded health intervention.

That breakdown pertains to the 10 year period examined for the Return on Investment Study. The share of distribution through unfunded services has become even more pronounced in recent years.

Whereas unfunded NSPs accounted for 35 percent of distribution in 2002/2003, by 2010/2011 secondary NSPs accounted for 50.6 percent of distribution.⁸ In other words, more than half the health care cost savings accrued through the Victorian NSP is potentially being delivered by services that receive no specific funding support whatsoever to achieve that return on investment.

Such a situation, in which more than a half of the financial benefits (cost savings) are derived from unfunded activities is uncommon to say the least.

It also represents an opportunity to exponentially increase that benefit with appropriate and targeted investment of funding, particularly in the further development of the NSP workforce.

Recommendation

- That all the short term and medium term 'actions' listed in sections 4.1, 4.2 and 4.3 of the Draft for Discussion document (if they are implemented) specifically include the NSP sub-sector.

Therefore, and as such,

- The Victorian AOD Workforce Development Strategy should foreshadow development of

⁷ Wilson D, Kwon A, Anderson J, Thein R, Law M, Maher L, *et al.* **Return on investment 2: evaluating the cost-effectiveness of needle and syringe programs in Australia.** In. Sydney: Australian Government Department of Health and Ageing, National Centre in HIV epidemiology and clinical research (University of NSW). 2009.

⁸ Based on distribution data provided to Anex by the Department of Health.

appropriate minimum levels of training for people working in an NSP role. This training should be crafted in such a way as the potential for inter-linkages across needs/service areas is emphasised, particularly with regard to drug treatment, law enforcement, mental health services and social welfare services such as housing and family services.

- Consistent with the National NSP Strategic Framework, the Victorian AOD Workforce Development Strategy should provide for greater resourcing for NSP workforce development, including curriculum development, E-learning and for regularised experience sharing through support for state-wide/regional and national networking events.
- That under section 4.4 of the Draft for Discussion document, identification of “financial incentives targeted to the *primary health care* workforce” be broadened so that it is recognised that financial incentives (enablers for organisations) also be made available so that people performing NSP duties but who are not in an organisation categorised as being a “primary health care” provider are also more able to access NSP-related training.

Please identify who should have responsibility for each strategy.

See discussion in 2.2

Theme 5: Workforce leadership and management

What are your suggestions for improving / strengthening the strategies under this theme? What barriers may need to be overcome?

The National NSP Strategic Framework states that a “*nationally consistent training model for NSP workers*” be developed.

It recognises that there is no national standard that ensures that people who provide NSP services have been appropriately trained, and that “availability of a consistent and high standard level of education and training of all NSP workers will maintain a professional and effective workforce.”

A consistent approach to workforce training and development would enhance the quality of service provision. Core training and education of NSP staff should be consistent for staff who work in primary, secondary, and pharmacy NSPs. Training would allow NSP staff to feel skilled and supported to effectively engage with IDUs. This would include an understanding of drug use, a non-judgmental attitude, and a strong knowledge of the broader service system.

Clearly then, all endeavours to improve workforce development opportunities for NSP staff in Victoria should be undertaken in the context of the intentions outlined in the National NSP Strategic Framework.

However, any NSP workforce development improvement in Victoria – including moving toward compulsory minimum training standards for frontline staff – should not necessarily wait until there is national agreement on minimum standards. The danger is that it could take far too long.

Recognition of NSP role

In 2008 Anex completed a thorough review of Victoria's NSP which included a survey of staff.⁹ The report was made public by the Victorian Government in 2011.

The survey, which included secondary NSPs, found that more than 60 percent of respondents (all of whom performed NSP duties) did not perceive NSP service delivery as part of their role.

This is further evidence that NSP duties should be formally recognised as falling within the AOD workforce.

Recommendations

- The NSP workforce, whether full time or as part of a person's overall work duties, should be formally considered part of the Victorian Alcohol and Other Drug Workforce. That this is communicated throughout the health care network at Organisational Management level in order to provide leadership and recognise the important public health benefits that people working within the NSP provide.
- Development of best practice guidelines and service planning for Victorian NSPs should be conducted, part of which would necessarily be formulation of realistic minimum training requirements that are communicated to and supported by health care managers.

Please identify who should have responsibility for each strategy.

Priority groups – Koori AOD workers, dual diagnosis workers and consumer participation

What are your suggestions for improving / strengthening the strategies for these groups? What barriers may need to be overcome?

In the past month alone, Anex has been involved with facilitating four Aboriginal Health Services to become registered as NSPs. There is clearly growing realisation amongst such services that NSP program should be part of their suite of health interventions.

It should not be assumed that Aboriginal injecting drug users will or do only access health services through Aboriginal AOD workers. Therefore, there should be additional emphasis on assisting the entire AOD workforce be in a position to better understand and assist Aboriginals with drug and alcohol problems, including drug injection.

⁹ Voon D, Ryan J, McKinley C, Fletcher K (2008). Integrating Care: Victoria's Needle and Syringe Program. Drugs Policy and Services Branch, Department of Human Services. Released in 2011.

Please identify who should have responsibility for each strategy.

Do you have any other comments?

The formulation of the Victorian AOD Workforce Development Strategy should take into consideration the Integrating Care report (2011) and the as-yet-unreleased evaluation of the Victorian NSP conducted by Health Outcomes International.

In recommending that there be minimum training standards for people doing NSP service delivery in Victoria, we are mindful that this will have budgetary implications for the Department and for service providers. However, it should be borne in mind that the NSP sector in Victoria contributes substantial net cost savings to the Victorian health system.

Therefore, improving workforce capacity should be viewed as partial re-investment of the overall return on investment (estimated \$15 million per year) that the Victorian NSP provides to Government and the community.

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