Supporting Investment in Alcohol and Other Drug Services Across Regional, Rural and Remote Australia in Response to COVID-19

In July 2020, as a coalition of alcohol and other drug service providers, agencies and peak bodies, we provided a policy submission to the Australian Government titled *Urgent Policy and Funding Needs in the Alcohol and Other Drugs Sector in Response to COVID-19.* This short paper expands on this work.

The impacts of alcohol and other drug (AOD) use have been amplified in regional, rural and remote Australia during COVID-19 because:

- Regional, rural and remote areas have fewer services – both generally and specifically in relation to AOD treatment – creating long-term access barriers that make it much harder for any problems associated with the increase in alcohol and other drug use driven by COVID-19 to be met;
- People living in regional, rural and remote areas, including Aboriginal and Torres Strait Islander communities, often need to travel 500+ km to access treatment services. This can be costly and include considerable hardship, and will simply be inaccessible for many. It also makes it very difficult to follow up with clients once they leave the treatment services; and
- Smaller communities can make it more difficult for people to seek help when they need it, due to concerns around stigmatisation, confidentiality, and privacy.

There is a significant opportunity to increase access in regional, rural and remote areas to AOD treatment services, and to stimulate economic and community recovery, by: investing in treatment facilities and other community services infrastructure – such as community centres, community and neighbourhood houses – that can be leveraged to support place-based service delivery models; and, utilising and building upon new treatment models that have emerged during COVID-19.

Ongoing solutions to regional, rural and remote access issues should support a community's capacity to respond to its needs through locally-based and tailored approaches. Access to AOD services through multi-purpose community centres based in regional, rural and remote communities can ameliorate the impact of issues such as stigmatisation and privacy. Additionally, they can provide a safe space for people to access digital services where they're unable to do so from their own home for various reasons, or are unable to afford access to the necessary data or devices.

Regions are struggling to cope with demand

People who live in regional, rural or remote areas use drug and alcohol treatment services at a higher rate than those in major cities, and they generally travel for longer to do so.

- More than 25% of people accessing drug and alcohol treatment from regional, rural and remote areas travel at least an hour to do so, compared with 10% of people in major cities.[1]
- Over half of people seeking drug and alcohol treatment services indicate that a lack of available services in their area is the main barrier to them accessing treatment.[2]
- In many communities access to detox facilities for AOD services means that people have to travel to larger towns/cities to detox. In addition, people can to wait up to 3-4 months before being able to access this support.[3]

These impacts are more pronounced among smaller, more closely connected communities. Substance use can adversely impact family life, and in aggregate can also impact on community life through its connection with damaging behaviours including domestic violence, child abuse, family relationship breakdown, homelessness, child sexual exploitation, disability, and unemployment or employability.[4] Harms among Aboriginal and Torres Strait Islander people are similarly high and can affect physical, social and emotional wellbeing, and weaken connection to family and community.[5]

---

1 Australian Institute of Health and Welfare, *Alcohol and other drug use in regional and remote Australia: consumption, harms and access to treatment 2016–17*

2 Australian Department of Health and Ageing, *Barriers and Incentives to Treatment for Illicit Drug Users*, 2004

3 Aboriginal Drug and Alcohol Council South Australia

4 Submission by the Department of Family and Community Services to the House of Representatives Standing Committee on Family and Community Affairs Inquiry Substance Abuse in Australian Communities, 2000.

5 National Indigenous Drug and Alcohol Committee, Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples, 2014.

Regional, rural and remote communities also experience higher mortality rates based on problematic substance use.[6] Since 2010, the rate of unintentional drug-induced deaths in rural and regional Australia has increased by 24%, which is greater than the increase of 5% in capital cities. In 2017, there were 7.3 unintentional drug-induced deaths per 100,000 people in regional areas, compared with 6.3 per 100,000 in the capital cities.[7]

Stigma and discrimination is a major barrier to treatment[8] and is even more material for people in regional, rural and remote areas where communities can be closer-knit. Additional investment is required for community development programs that support community-level, co-designed projects and capacity building.

There have been **important changes in the sector in response to the COVID-19 that has potentially increased access within regional, rural and remote communities,** among them:

- Enabling regional, rural and remote services to access digital access, telehealth and tele-mentoring services as part of a suite of services to be delivered in response to need, and based on consumer choice and the principles of person-centred care. The best approaches to digital access have focussed on local connectivity, adapting approaches to cultural needs and the digital capabilities of communities and individual clients. This requires flexibility in commissioning practices that enables creativity and capacity building within communities at the local level.
- Increased flexibility of opioid pharmacotherapy, including reducing the barriers for takeaway doses, third-party pick-up, longer scripts and reducing restrictions on prescription. It has been suggested that enabling the use of longer acting opioid substitution therapy may also be of significant value.

However, **more can be done to increase access in regional, rural and remote communities:**

- Access to life-saving opioid reversal medicines Naloxone or Nyxoid remains patchy in rural, remote and regional areas. The Northern Territory does not have a funded-free take home program. There is limited geographical availability, with the drug only accessible in Darwin, Alice Springs and Palmerston. Tasmania's program is limited to free provision only in primary needle and syringe programs; we recommend this be expanded to increase access via other service points and across a wider geographical area.
- In Western NSW and other parts of Australia it is currently impossible to access depot buprenorphine products, a weekly or monthly subcutaneous injection that treats opioid dependence. This treatment is a game changer as it reduces withdrawal symptoms and cravings with the added benefit of removing daily dispensing and the associated cost and disruption this creates.
- Dispensing daily means consumers are faced with costs of more than $35 a week or close to $2000 a year. This imposes a substantial affordability barrier that has a marked impact in regional, rural and remote communities. Dispensing costs are in stark contrast to people with other chronic health problems, where costs of treatment are much lower. A move to a model where treatment is aligned with other chronic illnesses, reducing the cost to the client, will improve engagement.
- The alcohol and other drugs workforce has experienced significant changes to the way they work and require ongoing support to continue to respond to increased demand and need. This is heightened in regional, rural and remote areas, where 36% of the AOD workforce is based.[9]
- Telehealth and digital access, while a support, may pose challenges to developing an effective consumer-centred relationship, and does not replace face-to-face services, which must still be funded. Nor do these services represent an adequate platform for in-depth counselling work, outreach, psycho-social or group interventions, as it is difficult to identify high risk people and build rapport with consumers who are new to the service.

---

6 International Journal of Drug Policy, *Patterns of alcohol, tobacco and cannabis use and related harm in city, regional and remote areas of Australia,* Amanda Roxburgha, Peter Miller, Matthew Dunna, 2013.

7 Australia's Annual Overdose Report 2019, A Pennington Institute Report, http://www.ourphn.org.au/wp-content/uploads/20190829-Australias-Annual-Overdose-Report-2019.pdf, page 40.

8 Australian Department of Health and Ageing, *Barriers and Incentives to Treatment for Illicit Drug Users,* 2004

9 Skinner, N., McEntee, A. & Roche, A., 2020. *Australia's Alcohol and Other Drug Workforce: National Survey Results 2019-2020.* Adelaide, South Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University

Economic and community benefits of alcohol and drug services

As the government seeks to generate economic activity and community support as part of a COVID-19 recovery, development of rehabilitation facilities and investment in AOD services should form an important part of that stimulus.

This is also an investment much needed by the sector and by people who use alcohol and other drugs, as demonstrated in the 2014 *New Horizons* report.

Investment in drug treatment is highly cost effective – for every $1 spent on treatment, the government could save over $7.[10] Other studies in Australia, such as by Odyssey House Victoria, found that each person treated in residential rehabilitation generates an average benefit to the community of $1 million based on economic output, reduced public spending on social security, lower property crime, and reduced loss of life.[11]

Alcohol and other drug services in regional, rural and remote areas often act as important community hubs, with examples being:

- Bridges Health & Community Care in Bundaberg[12];
- Drug ARM, which operates counselling services of all kinds across central Queensland[13];
- Barkly Region Alcohol and Drug Abuse Advisory Group (BRADAAG), which provides AOD services as well as non-AOD supports in response to community need from Ti Tree to Katherine and the Queensland border[14].

These services are models for community building post COVID, but they need policy changes and additional funding to flourish.

Investment in community infrastructure to enable service access in regional, rural and remote communities would provide valuable jobs and economic stimulus during construction phases as well as ongoing operational jobs, with the further stimulus effect that this would have on commerce in the broader regions.

Many communities are working with ageing and deteriorating infrastructure that fails to meet community need or standards, where it exists at all. There is an opportunity to invest in construction of dedicated AOD treatment facilities, for communities experiencing a shortfall in this area; and upgrades to existing and new community infrastructure – for smaller communities with more diverse infrastructure needs – that can be leveraged in the delivery of AOD treatment services and other forms of service access.

We are aware of many services in regional, rural and remote communities that are seeking to increase or improve service infrastructure. Just one example is in Dubbo, which is over 140km away from the closest detoxification service and more than two hours from the closest residential rehabilitation service. The Dubbo Regional Council has a proposal to construct a facility with 15 residential rehabilitation beds and eight detoxification beds at an estimated capital cost of $5 million and annual operational cost of $2.7 million. Based on the council's modelling, this would inject an estimated $17.5 million into the local economy. While funds and land have been committed to building the facility, further investment is required to cover its operating costs. Securing this investment would deliver not just a much-needed service, but also create ongoing jobs in the area.

Similar arguments can be made for multiple other investments in AOD services, including but certainly not confined to youth-specific AOD services in the Lismore-Tweed area and the Central Coast in NSW, where arrests in relation to amphetamines have surged by 400% over the past 10 years; and the NSW Far North Coast which has a rate of methamphetamine-related hospitalisations of more than 25% above the state average.[15]

We would encourage a formal commissioning process that would enable all regional, rural and remote communities to submit proposals for funding of their community infrastructure needs, as part of the post COVID-19 economic rebuild.

---

10 Ettner, S., Denmead, G., Dilonardo, J., Cao, H., & Belanger, A., 2003, *'The impact of managed care on the substance abuse treatment patterns and outcomes of Medicaid beneficiaries: Maryland's HealthChoice program',* Journal of Behavioral Health Services and Research, 30(1), 41-62

11 Odyssey House Victoria, *Economic Impact of Residential Treatment for Alcohol and Other Drug Addiction in a Therapeutic Community,* June 2013.

12 https://www.bas.org.au

13 https://www.drugarm.com.au

14 www.bradaag.org.au

15 North Coast Primary Health Network, 2017, *Lismore Local Government Area Health Check.*

What is needed

State, Territory and Commonwealth governments must respond to the pandemic with policy changes and additional funding for the treatment sector to help stimulate regional, rural and remote communities and enable COVID-19 enhancements – already made to the delivery of Australia's AOD services – to be built upon and rolled out in regional, rural and remote areas on an ongoing basis. This includes:

1. Continuation and expansion of regional, rural and remote telehealth, digital access and tele-mentoring practices to increase connectedness and access to services by these communities, as an adjunct to, and not a replacement of, face-to-face services.
2. Continuation of the removal of barriers to accessing pharmacotherapy, including takeaway doses, changes to dispensing fees, and access to maintenance programs such as depot buprenorphine products.
3. Planned investment in service infrastructure and the AOD workforce to support access to AOD treatment services for regional, rural and remote residents. There is considerable need for service expansion across the entire country, as identified by the *New Horizons* report.
4. Providing access to longer-term funding for the scope of community supports that enable access to AOD services.
5. Increased flexibility to internally reallocate funding across core AOD services to better respond to fluctuations and changes in client demand.
6. Jurisdictionally appropriate investments in workforce capacity and capability.
7. Investment into a properly funded AADC national peak body to ensure the needs and issues of regional, remote and rural Australian services are identified and opportunities to promote and implement service integration, quality and professional development initiatives are maximised.