integrated care

Rural and Remote Areas: Effective approaches to delivering integrated care for drug users

Effective Interventions Unit

SCOTTISH EXECUTIVE

Scottish Executive Effective Interventions Unit

Remit

The Unit was set up in June 2000 to:

- Identify what is effective – and cost effective – practice in prevention, treatment, rehabilitation and availability and in addressing the needs of both the individual and the community.

- Disseminate effective practice based on sound evidence and evaluation to policy makers, DATs and practitioners.

- Support DATs and agencies to deliver effective practice by developing good practice guidelines, evaluation tools, criteria for funding, models of service; and by contributing to the implementation of effective practice through the DAT corporate planning cycle.

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Effective Interventions Unit

Rural and Remote Areas: Effective approaches to delivering integrated care for drug users

What is in this document?

This document contains information on the following:

- Definitions of rural and remote areas.
- The scale and nature of drug misuse in rural Scotland.
- Issues and factors that affect the planning, accessibility, assessment and delivery of integrated care for drug users.
- Approaches to integrated care and examples of effective and innovative practice.
- Key principles and elements of effective practice to plan, deliver, monitor and evaluate integrated care.

Aim

To provide information, evidence and examples to support future development of relevant service provision for drug users in rural and remote areas.

Who conducted the review?

Linsey Duff, David McCue and Patricia Russell of the Effective Interventions Unit prepared this report.

Who should read it?

Anyone involved in planning, designing and delivering drug services in rural and remote areas. This includes Drug and Alcohol Action teams, agencies involved in commissioning services, specialist drug treatment service providers and generic service providers that work with drug users. It is hoped that this guide will also be useful to relevant policy makers and, of course, service users and their families/carers who should remain at the centre of the decision making process about their care.

Agencies and service providers working with alcohol users should also find much of the guide relevant.

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Introduction

Background

In 'Integrated Care for Drug Users: principles and practice' (EIU, 2002), the Effective Interventions Unit (EIU) set out the evidence for an integrated approach to the treatment, care and support for drug users. Over the last two and a half years, EIU has produced a range of documents, and delivered workshops and seminars, to support the development of integrated care.

One of the key elements of effective integrated care is **accessibility.** Factors that influence accessibility include those associated with living and working in rural areas, such as: **the range of accessible and available services, and maintaining anonymity in small communities**. Recent EIU guides on Needs Assessment and Advocacy have each devoted a brief chapter to issues and solutions for rural areas. This review provides further exploration of the issues affecting the implementation of integrated care in rural areas and approaches to overcome any barriers.

The Wider Policy Context

Rural Development is a key cross-cutting priority for the Scottish Executive, who have made a commitment to maintaining strong, prosperous and growing communities.

'*Rural Scotland: A New Approach*', published in May 2000, provides the overall vision for rural development in Scotland, with individual departments of the Scottish Executive and agencies contributing towards realisation of the vision. The Minister for Environment and Rural Development co-ordinates development of policies across the Executive. This includes bilateral and ad hoc meetings with Cabinet Colleagues, attendance at Cabinet Delivery and Sub-Committees, monitoring, and presentation of rural achievements.

The vision statement in '*Rural Scotland: A New Approach*' sets out four key priorities:

- a strong and diverse **rural economy,** harnessing traditional strengths and with an appetite for change;
- a rural Scotland where everyone can enjoy a **decent quality of life**, where the young are not forced to leave their communities to get on and where the vulnerable are no longer excluded;
- a rural Scotland where people **enjoy public services that are accessible**, of the highest possible quality and with the greatest possible choice; and
- a rural Scotland whose **natural and cultural heritage flourishes** in all its diversity.

The Scottish Executive also produces an annual rural report which describes progress against objectives and targets and outlines further challenges. It incorporates a 'Summary of Key Facts on Rural Scotland'. The 2004 annual report can be downloaded at http://www.scotland.gov.uk/library5/rural/anrr04-00.asp

A Partnership for a Better Scotland: ***Partnership Agreement*** (SE 2003) contains a series of targets, across all Scottish Executive portfolios. There is an overarching commitment to ensure that all policies and programmes take account of the needs of rural and remote communities. These include commitments to:

- expand the availability of affordable housing in rural Scotland
- expand the rural transport initiative
- develop the role of community hospitals in rural areas.

Some facts and figures on rural Scotland include:

- There is **more of an ageing population in remote rural Scotland** than in other areas.
- **The unemployment rate** (the number of people unemployed as a proportion of the number of economically active) **is lowest in accessible rural areas.**
- Relative to the rest of Scotland, **a higher proportion of people in rural Scotland rate their neighbourhood as very good.**
- **Nearly 20% of people in remote rural Scotland are more than 15 minutes drive away from their GP.**

Further facts and figures can be found in 'Rural Scotland Key Facts 2004', available at http://www.scotland.gov.uk/library5/rural/rskf04-00.asp

The Executive is committed to **Closing the Opportunity Gap in rural Scotland**. The Executive's targets for tackling poverty and social exclusion are set out in the **Closing the Opportunity Gap targets** announced on 9 December 2004. Many of the targets have rural implications, but a specific rural target - *'By 2008, improve service delivery in rural areas so that agreed improvements to accessibility and quality are achieved for key services in remote and disadvantaged communities'* - has been included to ensure a strong focus on delivery for rural Scotland.

A defining feature of rural areas is the **accessibility - or lack of it - of key services**. This can have a significant impact on quality of life. Research highlights that disadvantage in rural areas is often caused or exacerbated by distance or **the uneconomic nature of providing certain services (due to lower population numbers)** and by **stigma** that can be associated with accessing certain services in a small community. 20 Rural Services Priority Areas (RSPAs) were announced by the Minister for Environment and Rural Development, Ross Finnie, on Thursday 27 January 2004. An illustrative map and further information on the rural target can be found at: http://www.scotland.gov.uk/Topics/People/Social-Inclusion/17415/opportunity.

Methods

As with previous EIU documents, this review draws upon evidence from a range of sources, including: primary research, a literature review, views gathered during consultation events and examples from current practice in Scotland.

The review is informed by:

- A **qualitative research study** into the issues that influence the effective planning, design and delivery of integrated care for drug users in rural and remote areas from the perspectives of service commissioners, service providers and service users. This study was conducted by Clear Plan (UK) Services Ltd and used four case study areas: Dumfries and Galloway, Highland, Orkney and Stirling. A summary report of

the study is included at **Appendix 1**. The interview schedules are at **Appendix 2** and the list of interviewees at **Appendix 3**.

- A **literature review** examining the issues that affect rural and remote areas and their residents. The literature review also looks at drug misuse and the provision of drug misuse services in rural and remote areas.

- A **reference group** with representation from Drug and Alcohol Action Teams, national organisations working with drug misusers, local drug services, the EIU and the wider Scottish Executive (including the Environment and Rural Affairs Department). The remit and membership of the reference group is at **Appendix 4**.

- **The Association of Drug Action Teams' Rural and Remote Areas Sub Group** who provided information, advice and comment as well as service examples.

- Two **consultation workshops** in Stirling and Inverness in October 2004. The seminars included presentations on integrated care and topics specifically related to rurality, but the main activities were workshop discussions on key questions led by facilitators. There were a total of 64 participants at the two events. These were individuals with experience of working with drug users in rural and remote areas. The summary report of the consultation workshops is at **Appendix 5**, with a list of participants at **Appendix 6**.

- **Service examples** on effective ways of delivering treatment, care and support to drug users in rural and remote areas.

Note: in this guide there are many references to the EIU's 'Integrated Care for Drug Users: principles and practice'; and 'Service Provision for Drug Users in Rural and Remote Areas of Scotland: a Qualitative research study'. As shorthand we will refer to them as:

Integrated Care for Drug Users

The qualitative research study

Thank You

The EIU wishes to thank all who have contributed to this guide. In particular, we are grateful to the members of our reference group and the Association of Drug Action Teams' Rural and Remote Areas Sub Group.

Chapter 1: What do we mean by rural and remote areas?

There are various definitions of 'rural' and 'remote'. In this chapter we describe the definitions that we are using throughout this guide. In selecting the definitions to use we have followed Scottish Executive advice on defining rural and remote areas.

Scottish Executive Urban Rural Classification

The primary definition of rural and remote areas that we use in this guide is the **Scottish Executive Urban Rural Classification 2003-2004.**

The Scottish Executive Urban Rural Classification (previously called the Scottish Household Survey Urban Rural Classification) was first released in 2000. It is consistent with the Executive's core definition of rurality which **defines rural as a settlement of 3,000 or less people.** The classification also **distinguishes between 'accessible' and 'remote' rural areas, based on drive time to a settlement of 10,000 or more people.**

Based on these **two criteria of settlement size** (as defined by the General Register Office for Scotland) and **accessibility**, the Scottish Executive have developed 6-fold and 8-fold urban rural classifications which are intended to provide a consistent way of defining urban and rural areas across Scotland. For simplicity this guide uses the 6-fold classification. This comprises:

Scottish Executive Urban Rural Classification	
1 Large Urban Area	Settlements of over 125,000 people.
2 Other Urban Areas	Settlements of 10,000 to 125,000 people.
3 Accessible Small Towns	Settlements of between 3,000 and 10,000 people and within 30 minutes drive of a settlement of 10,000 or more.
4 Remote Small Towns	Settlements of between 3,000 and 10,000 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.
5 Accessible Rural	Settlements of less than 3,000 people and within 30 minutes drive of a settlement of 10,000 or more.
6 Remote Rural	Settlements of less than 3,000 people and with a drive time of over 30 minutes to a settlement of 10,000 or more.

The six categories can be collapsed down to the Scottish Executive core definition or rurality, with **categories 5 and 6 being rural and categories 1 to 4 urban.**

Core Definition of Rurality	
Urban	Large Urban Areas, Other Urban Areas, Accessible Small Towns, Remote Small Towns
Rural	Accessible Rural, Remote Rural

The Scottish Executive Urban Rural Classification 2003-2004 can be downloaded at **http://www.scotland.gov.uk/library5/rural/seurc-00.asp**

A map of the urban rural classification is available at www.scotland.gov.uk/library5/rural/seurc-03.asp. Appendix 9 gives urban rural classification statistics 2003-2004, by local authority and health board area in Scotland.

According to the core definition above, 98% of Scotland's landmass and 18.7% of its population is classified as rural.

One of the limitations of the official Scottish Executive definition of rurality is that **data is not always available at this level of disaggregation.** Where data is not available at this level the Randall Definition is used.

The Randall Definition

The Randall definition is based upon population density within a unitary authority. Where a unitary authority has a population density of **less than one person per hectare it is considered Rural.** On this basis there are 14 rural unitary authorities. These are:

- Aberdeenshire
- Angus
- Argyll and Bute
- Dumfries and Galloway
- East Ayrshire
- Highland
- Moray
- Orkney Islands
- Perth and Kinross
- Scottish Borders
- Shetland Islands
- South Ayrshire
- Stirling
- Western Isles (Eilean Siar)

Unitary Authority data is readily available and it is therefore very easy to apply this definition to a wide range of data sources. One disadvantage, however, is since it is Unitary Authority based, some urban areas, including Stirling and Inverness, are classified as rural.

Using the Randall definition of rurality 89% of Scotland's landmass and 29% of its population is classified as rural.

Chapter 2: The scale and nature of drug misuse in rural Scotland

This chapter sets out evidence on the scale and the nature of drug misuse in rural Scotland. There is no one single source of reliable information on rural drug misuse in Scotland. However, it is possible to build a picture of rural drug misuse using **information from a number of sources**. These include: information on local attitudes to, and experience of drug misuse from national surveys, such as the Scottish Household Survey; routinely collected data from treatment and care services, for example, the Scottish Drug Misuse Database (SDMD); and findings from research, such as the national drug misuse prevalence studies.

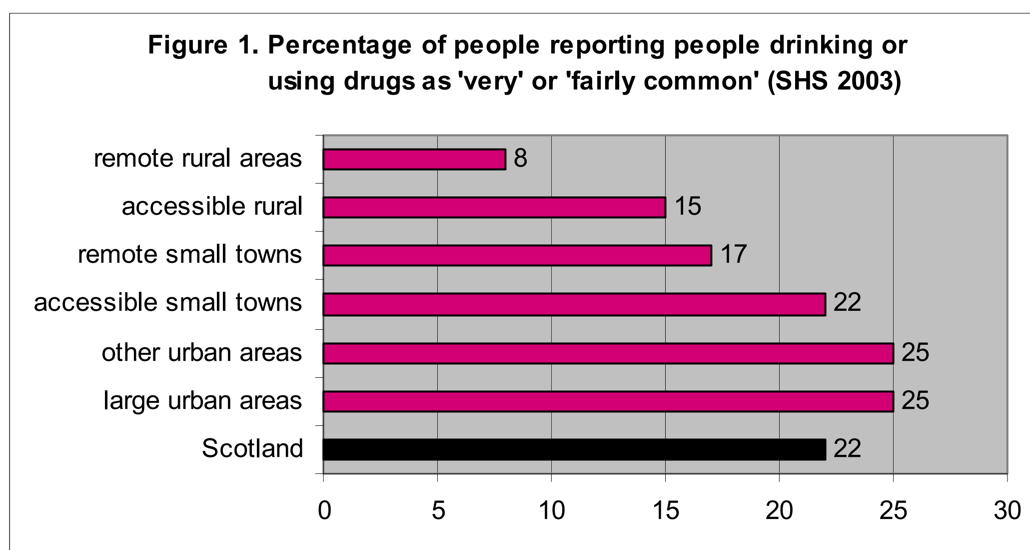
Overall, the data shows **lower levels of drug use in rural, compared with urban areas**. There is, however, **evidence of a narrowing of the gap between urban and rural** areas in terms of drug use. There are also variations in drug use across rural areas in Scotland.

Evidence

It is widely believed that drug use in rural areas is increasing, and that there is also a growing incidence of problematic use (Cragg A 2003).

Experience of neighbourhood drugs problems

According to the 2003 Scottish Household Survey, people living in rural areas were the least likely to report people drinking or using drugs as being 'very' or 'fairly common' in terms of neighbourhood problems.



The full report of the 2003 Scottish Household Survey (Martin C et al 2005) is available at http://www.scotland.gov.uk/library5/housing/shsar03-00.asp

The prevalence of drug misuse in rural and remote areas

The second National Drug Misuse Prevalence Study (Hay et al 2005) was funded by the Scottish Executive to produce **national and local estimates of the prevalence of problem drug misuse in Scotland for the calendar year 2003.** The definition of problem drug misuse used in the study is individuals aged 15-54 years using opiates and/or benzodiazepines.

The study provides prevalence estimates down to LHCC level. This is not sufficient geographical detail for the Scottish Executive Urban Rural Classification, but the alternative Randall Definition, based on local authorities (see Chapter 1), can be used.

There were estimated to be 51,582 individuals misusing opiates and/or benzodiazepines in Scotland in 2003. This corresponds to 1.84% of the population aged 15-54. **The lowest prevalence levels were found in the Island local authorities, followed by Moray (another rural area)** whilst the highest levels were in urban authorities – Glasgow City and Dundee City. Dumfries and Galloway, however, had one of the highest rates in terms of Police Force areas.

Overall the prevalence of problem drug misuse decreased in Scotland between 2000 and 2003, from 55,800 (95% CI 1.92 to 2.09) to 51,582 (95% CI 1.84 to 2.01). In contrast, **significant increases were seen in Dumfries and Galloway and South Ayrshire, both rural authorities.**

The full 2003 drugs misuse prevalence study report is available at http://www.drugmisuse.isdscotland.org/publications/local/prevreport2004.pdf

Data from drug treatment services

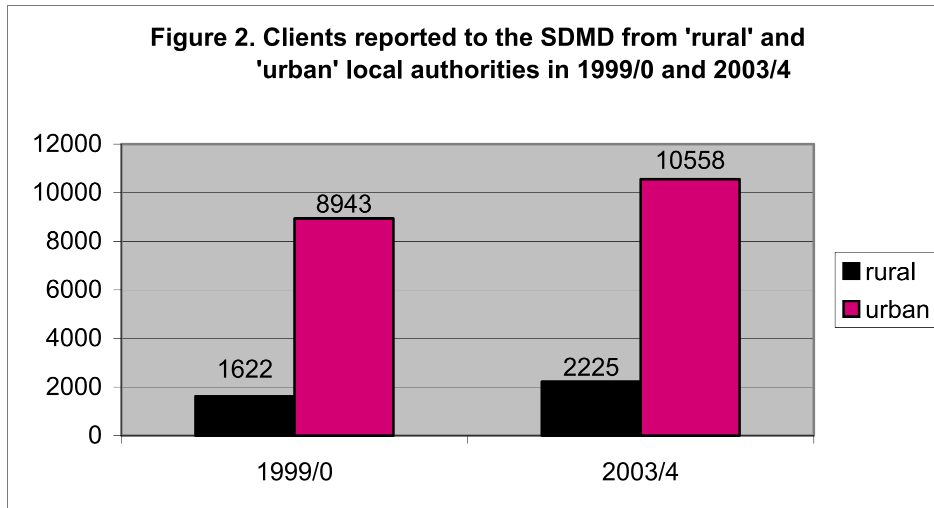
The Scottish Drug Misuse Database (SDMD), established in 1990 at ISD Scotland, offers a profile of drug misuse based on **data about problem drug users attending services for their drug problems**. The information presented relates to new patients/clients[1].

As with the national prevalence study, SDMD data is not available at a sufficient level of geographical detail to apply the Scottish Executive Urban/Rural Classification, but the Randall Definition, based on local authorities, can be used.

In Scotland as a whole the rate per 100,00 population of new clients reported to the SDMD in 2003/4 was 267. **In all but two of the 14 'rural' local authorities (East Ayrshire and South Ayrshire) the rate was below the Scotland average.**

In 1999/00 there were a total of 1,622 new patients/clients reported to the Database from 'rural' local authorities compared with 8,943 from 'urban' authorities. The comparable figures four years later, in 2003/04, were 2,225 and 10,558. This means that urban authorities showed an increase of 18% in new clients/patients over the period, whilst **rural authorities showed an overall increase of 37% (double the increase in urban areas).**

[1] The definition of 'new' is any person who is attending the service for (a) the first time ever or (b) it has been at least six months since the last attendance at the service.



In Scotland as a whole, 37% of all new clients in 2003/4 reported that they had injected drugs in the previous month. Some of the highest injecting rates were in 'rural' authorities such as Dumfries and Galloway, (58%), Aberdeenshire (53%) and Moray (50%).

Statistics from the SDMD are published in the annual Drug Misuse Statistics Scotland publication, available via the Drug Misuse In Scotland website at: http://www.drugmisuse.isdscotland.org/index.shtml

Drugs and young people

A recent study looking at differences in levels of adolescent drug use between adjacent urban and rural communities in Scotland (Forsyth AJ and Barnard M 1999) found that adolescent drug use in Scotland is not particularly concentrated in areas of urban deprivation.

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) has been established by the Scottish Executive to provide a broad based approach to the monitoring of substance use among young people in Scotland.

According to the latest survey, in 2004, (Currie C et al 2005), in Scotland as a whole nearly two thirds (63%) of all 15 year olds reported ever having been offered illicit drugs. **'Rural ' authorities had some of the highest rates of being offered drugs,** for example, South Ayrshire 72%, Stirling 72% and Highland 70%. Meanwhile, nationally, **35% of 15 year olds reported ever having used illicit drugs. Across rural authorities the percentage ranged from 30% to 41%.**

Chapter 3: What influences the design and delivery of services in rural and remote areas?

Many of the issues and factors that influence the design and delivery of services for drug users in rural and remote areas are **not confined to those areas**, or to services for drug users. They do, however, tend to be more common in rural areas, and/or there are particular features associated with rural and remote areas which compound them. It is important to note also that there are both positive and negative factors that will influence services. **All rural and remote areas are not the same and while there are characteristics that they share, there are also differences between areas.** This was highlighted in the qualitative research study which involved four diverse case study areas: Orkney, Dumfries and Galloway, Highland and the Stirling area (see Appendix 1).

We have grouped the issues and factors under some broad headings, but as many of them are inter-related there are several instances where issues are cross-referenced under different headings. We have also tried to identify issues for DAATs, commissioners and service providers to address when planning, commissioning and delivering services.

- **Identifying drug users in rural and remote areas**
- **Community attitudes towards drug misuse**
- **Anonymity and Confidentiality**
- **Travel and transport**
- **Location of services**
- **Range and capacity of services**
- **Staffing issues**
- **Funding**
- **Networking nationally and locally**
- **Housing and employment**

1. Identifying drug users in rural and remote areas

One of the barriers to service provision for drug users in rural and remote areas is **an absence of adequate and accurate information on the numbers of drug users and their needs** (Cragg A 2003, Henderson, S 1998, Lind C 1999).

In chapter 2, we looked at the evidence on the nature and the scale of drug misuse in rural Scotland. While initiatives such as the National Drug Misuse Prevalence Study have undoubtedly improved the information that is available, feedback from the consultation workshops suggests that **more remains to be done at local level on needs assessment in rural and remote areas.**

> **Evidence**
>
> Lack of information about clients' aggregated needs (needs assessment) makes it difficult to plan, commission, deliver and evaluate services. (Consultation Workshops)

It is a particular challenge to find out about the needs of people in rural areas, and to design appropriate services to meet those needs. This is especially true for drug users. Needs assessment should involve getting the views of service users, non-service users and the local community in order to **identify number of users, nature of drug use, what services they are using and not using, the effect of services, gaps and other relevant information** (Guide to Needs Assessment (EIU 2004). A significant factor is that people with drug problems and people experiencing social exclusion/deprivation tend to be dispersed among apparent affluence, rather than concentrated together in problems areas. **Area-based intervention may therefore be insufficient** (Shucksmith M, 2000).

2. Community attitudes towards drug misuse

Compared with larger urban areas, drug misuse is a relatively newer phenomenon to many rural and remote communities. Also, as noted in Chapter 2, levels of drug misuse in rural areas are generally lower than in urban areas. This may result in a **lower level of awareness and understanding of drug misuse** (and of treatment approaches for drug misusers) among rural communities and rural services.

A number of studies have suggested **a tendency towards denial of drugs problems in rural and remote communities.** People may not believe that there is a drug problem in their community, or they may be reluctant to acknowledge the extent of the problem, perhaps through fear of damage to the area's reputation or the perception that drugs are an inner city problem (Cragg, A 2003, Henderson, S 1998). Participants at the EIU consultation workshops described the **stigma attached to drug misuse** in rural and remote communities. Two particular points of interest were that there was a **relative acceptance of alcohol problems;** and that in some areas people **associated drug use with 'incomers'.** It is also important to note that the impact of one drug user on a small community of 20 or 30 is significant.

Evidence

The community does not allow harm minimisation – there may be a zero tolerance attitude

Stigma can be a big issue in rural communities

Alcohol is tolerated, but drug users are stigmatised and associated with incomers

Alcohol misuse is more acceptable, although it results in considerable harm to individuals, families and communities.
(Participants, Consultation Workshops)

The qualitative research study found that, while service providers in the Stirling area believed that rural communities tended to deny the existence of drugs problems, in Dumfries and Galloway providers did not report any difficulties in establishing local community acceptance of drugs issues. This difference may be linked to the more affluent profile of the Stirling area and a wish to maintain a "respectable" reputation. If so, this would appear to support the view, expressed by a number of interviewees, that **acceptance (or not) of drug issues may be associated with levels of affluence in the wider community**.

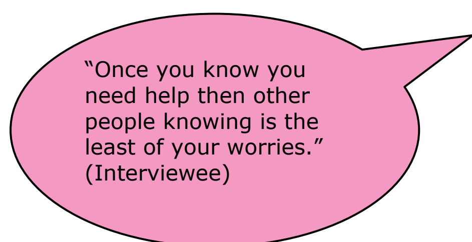
Where there is denial of a drug misuse problem, there are potentially difficulties for **commissioners** in obtaining a true picture of the level and scope of drug misuse; and for **service providers** because the public may be unwilling to support local interventions or services for drug users. However, 'Drugs in Rural Areas' (Cragg, A 2003) suggests that, while the close-knit nature of rural communities may present a barrier to clients accessing rural drug services, it may also provide **opportunities for greater support** to drug users. Cragg cites the example of home delivery of methadone prescriptions by pharmacists who had known drug using clients all their lives. The qualitative research study identified a range of views on the level of support that might be provided by **more close knit rural communities** (compared to urban communities). Some people thought that if you came from the local community, or from the "right family", then you would get support, but incomers, or those from more deprived households may not.

"If you are from the island you will be supported and receive some sympathy. If you are an incomer then things could be different."
(Interviewee in qualitative research study)

The qualitative research study also indicated that **drug users themselves had differing views** about stigma and negative attitudes from the community. Around half of the drug users interviewed lived in the town or village where they had grown up; the other half had moved in as a result of social housing allocation policy. The latter group had little or no contact with the local community. Younger drug users were more likely to be unhappy about **prejudicial attitudes from other members of the community**. "Incomers" who had lengthier drug-using careers were not aware of, or concerned about, community prejudices towards drug users. For others, particularly those who had grown up locally, the revelation that they were "junkies" **and seeking help** had triggered support and encouragement.

3. Anonymity and confidentiality

One of the main issues often raised in connection with negative community attitudes is the **maintenance of client confidentiality and anonymity** in rural and remote areas. Most participants at the consultation workshops felt that it was potentially more of a barrier to accessing services than in urban areas. However, the qualitative research study found that **drug users were actually less sensitive about anonymity and confidentiality than service providers and commissioners**. None of the drug users interviewed for the qualitative research study said that they would **not** attempt to access services for fear of being known as a drug user. This reflects earlier findings in the evidence gathering for 'Integrated Care for Drug Users' (EIU 2002), which indicated that **service providers appeared to be more sensitive** about the sharing of client information between workers and between services than the service users.



It may be that sensitivity to issues of anonymity and confidentiality creates an unnecessary barrier to the development of services in rural and remote areas. **DAATs and their partner agencies may find it helpful to explore the views of both staff and service users** on these issues in more depth as part of the needs assessment, and the subsequent planning and commissioning of services. **Service providers may wish to consider their arrangements for information sharing** including the use of protocols in order to ensure that there are no unnecessary barriers to information sharing which is a key element of effective assessment and planning and delivery of care (EIU 2002, http://www.scotland.gov.uk/health/jointfutureunit/).

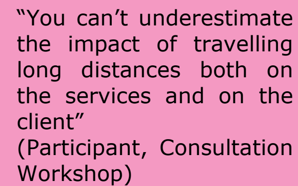
4. Travel and transport

Evidence

The availability of transport for rural inhabitants directly influences the degree of social exclusion and isolation they experience and is vital in determining their opportunities for recreation, employment, services, education and training (Rural Child Poverty Briefing Paper 2003).

Accessibility of services is a key element of integrated care. Drug users in rural and remote areas are more likely, compared with their urban neighbours, to **have to travel long distances to attend services.** Service providers in rural and remote areas may find themselves spending a great deal of time travelling to meetings with clients (who may not be there), meetings with other service providers, DAAT meetings etc. Likewise, the ability of commissioners to visit providers and attend meetings will be restricted.

In the winter months, residents in rural and remote areas will be more likely to find themselves cut-off from roads and services altogether. In the island DAAT areas, there will be particular travel and transport difficulties for drug users living in the outlying islands. On Orkney, for example, the majority of treatment and support services are on mainland Orkney which makes it difficult for those on the isles.



There are 3 main issues for DAATs, commissioners and service providers:

- **Cost of travel**
- **Irregularity of public transport**
- **Inconvenient location of services**

Cost

Many **service users have to rely on public transport** which can be expensive. The qualitative research study highlighted the fact that being on a prescribed methadone maintenance programme (MMT) will often preclude a person from driving. Only if they are complying fully with the maintenance programme, and subject to a favourable medical assessment and (normally, annual) medical review, might the Driver and Vehicle Licensing Authority (DVLA) license them to drive (see http://www.dvla.gov.uk/at_a_glance/ch5_drugandalcohol.htm.)

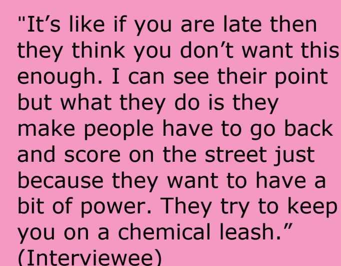
Where services are not located on bus routes, or the buses do not run at convenient times, another, potentially very expensive, option is travel by taxi. Service providers referred, for example, to clients on methadone going by taxi to the pharmacy to collect their prescription. Other transport solutions, identified through interviews with service users included hitch-hiking, and very importantly, **reliance on lifts from family and friends.**

There was some evidence of **help with fares**, although mainly for clients with appointments at criminal justice agencies. There was no universal provision and it appeared that the onus was on the service user to try and obtain reimbursement.

Participants at the consultation workshops also highlighted the costs to service providers, in time and money, when staff had to travel long distances to see a client(s) e.g. a worker might only see 1 or 2 clients in a day.

Irregularity of transport

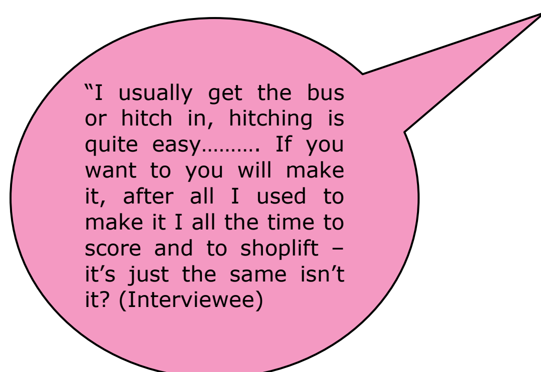
Despite the expense of bus travel, the qualitative research study suggested that the **irregularity and infrequency of public transport** was a bigger barrier to accessing services. One of the consequences raised by service users was that, if they were even five or ten minutes late, providers sometimes refused to see them. Sometimes letters about appointments only come the day before. They felt that this was unreasonable in the light of transport problems, particularly if it was seen as a test of their motivation.



For those with caring responsibilities e.g. women with children who have to fit around nursery or school times or those who have livestock, there are additional problems.

Inconvenient location

Service users also thought that the **location of many services e.g. on the periphery of towns and requiring at least 2 buses, compounded the travel problems**. Sometimes getting to appointments can take all day and, if the client has more than one appointment with different services e.g. housing, the logistics can be difficult.



Our evidence suggests that drug users who are seeking treatment will make a big effort to travel despite the problems although for some it will be a disincentive. It seems clear, however, that, in the design and delivery of integrated services for drug users in rural and remote areas, **travel and transport present commissioners, managers and providers of services with a particular problem**. This can be compounded by issues about **location of services and the timing (and flexibility)** of appointments.

4. Location of services

The way in which location has an impact on accessibility of services goes beyond travel and transport issues. One of the findings of the qualitative research study was that the overall picture in terms of service provision for drug users in rural and remote areas suggested a form of radial diffusion, i.e. **the further away from the physical location of a service that drug users lived, the more limited was the level of services they could expect to receive.** This seemed to reflect the fact that services tended to be located in the larger centres of population. Urban drug users, therefore, because of their location, would be more able to take advantage of them. Some service providers believed that drug users in rural areas received the same level of service as those in urban areas. Others thought that clients probably received a lower level of service. The difference in views might reflect a difference between national services with standard procedures and those offering a particular or local approach to treatment or support. There seemed to be a recognition, however, that **the "package of care" that a client could receive in a rural or remote area would be more limited**. Other services, such as employability, counselling, leisure or sporting activities and debt counselling, were less likely to be readily available.

Difficulties of location in relation to travel and transport may be linked to difficulties for providers in **finding suitable premises**. The qualitative research study found that four strategies were commonly employed by service providers:

- Agencies setting up their own 'satellite points'.
- Agencies using premises controlled by other services.
- Agencies meeting drug users in their homes.
- Agencies meeting drug users in public premises.

The **use of 'satellite points' was rare**. Management decisions had to be made about the relative costs and benefits of obtaining and operating premises in rural areas over the costs and benefits of having a single base in a more central location and sending staff out from that base. In most cases the costs and commitments of obtaining dedicated premises in rural and remote areas were felt to be too high to justify.

For most of the areas in the study, the nature of public transport routes meant that a **single central location** was still easier for rural and remote drug users to access than any other remote or rural area except the one in which they lived.

The most common strategy was to **use premises controlled by other services**. Health Service or Social Work premises were most commonly used but Community Centres, Housing offices and Jobcentre Plus offices were also used. There were some problems with this approach. Social work offices were often unpopular places with service users who also felt that staff in mainstream services could be unsympathetic to drug services staff and to service users. Rooms were often **not suitable for confidentiality, or the provision of counselling or clinical services**. Nonetheless, the qualitative research study found a willingness to make the best of what was available. There could also be an unplanned benefit from the use of premises operated by other services. These services were often in touch with drug users for other reasons and could remind them of appointments with the drug agencies. In most cases, access to premises controlled by other agencies was a matter of **local arrangement and good relationships between individual members of staff.**

Home visits carry some risks for lone workers and there are Health and Safety provisions governing such visits. However, in some areas, there seems to be an acceptance that lone workers would visit clients' homes.

The qualitative research study also found that workers occasionally met with drug users in **public premises** such as cafes and, very occasionally, public houses. Provider interviewees were not unduly concerned about this but acknowledged the issue of maintaining anonymity and the possibility that other services or the media would view this as unprofessional or dangerous.

Participants in the consultation workshops felt that **co-location of services** would be a way to address the problem of finding suitable premises. The result might be similar to a one stop shop offering a range of services under one roof. While some clients may be concerned about this model (because they do not wish one service to know that they are also clients of another), **commissioners, managers and providers could examine the feasibility of co-location in their area as part of a needs assessment.**

5. Range and capacity of services

Integrated care means drug users having access to a **range of treatment, care and support interventions to meet their assessed needs.** The range of services should also offer the possibility for individuals to move on to another, appropriate service when they have made progress.

> **Evidence**
>
> A major problem for those working with problematic drug users in rural areas is **developing a breadth of service sufficient to offer clients a choice of different approaches**. A user in an urban environment who wants to stop using is much more likely to have a choice of different facilities and approaches open to him/her. (Cragg, A 2003)

The responses of participants in the consultation workshops suggest that the range of services available in rural and remote areas **varies considerably** from place to place. A number of participants identified a **lack of local specialist treatment services** such as detoxification, rehabilitation and needle exchange which meant that clients had to travel. This was particularly the case for the Islands. There were also difficulties in accessing other types of services such as employability programmes. In other areas, however, there seemed to be an **expansion of services** accompanied by greater flexibility of ways of delivering such as outreach.

The evidence strongly suggests that one of the main factors influencing the range and level of services in rural areas is that the **funding formula is based on population size**. Where numbers of service users are small, as is the case in rural and remote areas, they attract relatively low levels of funding. The issue of funding is explored in more detail later in this chapter.

The major gaps in service identified through our evidence gathering were:

- general Practitioners willing to prescribe methadone
- pharmacies who will dispense methadone
- needle exchange services
- rehabilitation and detoxification services

Evidence

We have little control over GPs and pharmacies both in terms of the level of service and their attitude to users. In rural areas where choice is very limited this is a serious concern. (Qualitative research study)

If an urban resident finds that their local GP or pharmacist cannot meet their prescribing or dispensing needs, it is likely that they will have less distance to travel to a GP or pharmacist who will than if they were living in a rural area. For example, the Kintyre peninsula, from Campbeltown to Lochgilphead, has no prescribing GPs. There are, however, community pharmacies who will dispense and supervise methadone if it is prescribed from outwith the area e.g. by a consultant in Dunoon.

Some rural and remote areas do not have a pharmacy service. Instead they may have a **dispensing GP or GPs.** This phenomenon of dispensing GPs tends to exist only in rural areas. The result can be no access to either methadone prescribing or dispensing (where the GPs are not willing to prescribe or dispense), so that even if a local specialist drug service were to be set up, clients would not have the option of methadone.

Another potential barrier to clients accessing dispensing services is the **absence of a confidential dispensing area** for clients, particularly in smaller pharmacy outlets.

Evidence

Generic services may not be concerned particularly about drugs or alcohol (Participant, Consultation workshops)

Drug users can get a second-class service round here. A lot of agencies don't know how to deal with them and treat them badly. It's because they are not used to dealing with them and are either prejudiced or ignorant. (Interviewee, Qualitative research study)

In rural and remote areas, drug users are more likely to receive treatment, care and support from **generic rather than specialist services.** The EIU's Needs Assessment Guide highlights primary care teams, including GPs, practice nurses, midwifes and health visitors as having a vital role to play in assessing the needs of drug users and their families in rural areas, as the local GP surgery may be the first point of service contact for many individuals. However, **staff may not have the necessary skills or knowledge** to recognise individual's drug–related needs and/or to know how to respond to them. Both the consultation workshops and the qualitative research study also found that workers in mainstream services sometimes lacked an interest or enthusiasm for working with drug users, or were even prejudiced against them. **DAATs, partners agencies and service providers should consider how to provide awareness raising and training for the range of agencies in contact with drug users, including multi-agency training.**

Finally, there is some evidence that drug users may not know what range of services are actually available to them. This is also a problem in urban areas as well but DAATS and their partner agencies may have to find **more innovative ways of spreading the information.**

6. Staffing

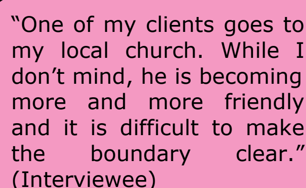
One of the barriers to delivering effective services to drug users in rural areas is **the shortage of adequately trained staff, and volunteers** (Sale, S 2004). This emerged as a major theme from our evidence. As with many of the issues identified in this chapter, the difficulty of recruiting and retaining suitably qualified and experienced staff is not peculiar to drug services working in rural and remote areas. There are, however, particular features of rural areas which impact on **staff recruitment and retention.** The qualitative research study highlighted that there are, almost inevitably, larger pools of labour in more densely populated areas. In addition, rural and remote areas tend to offer lower rates of pay than urban areas and have fewer opportunities for career progression. With the exception of the Stirling case study area (with its city status and central belt location), **interviewees believed it was harder to recruit staff at all levels in rural and remote areas.** One example is the difficulty in getting a consultant / prescriber for 1 or 2 sessions a week as there is no other work in the area to make it worthwhile. One area highlighted the particular challenges where small staff teams cover large rural areas, of providing staff cover for holidays or sickness. Where posts are left unfilled for long periods, this impacts on the workload of the remaining staff.

As noted in the previous section, staff in generic services may not have the skills and knowledge to deal effectively with drug using clients and may be working outside their professional boundaries. There may also be problems with staff attitudes toward drug users. Scottish Training on Drugs and Alcohol (STRADA) provides training for practitioners working with drugs/alcohol misusers, in both specialist substance misuse and other services, throughout Scotland. Some organisations, however, have to pay for the training, for example, staff working in prisons, the police and housing and this is sometimes raised as a barrier. Another, perhaps more fundamental problem is that staff, once trained, often **move on to promoted posts in other areas.** Our evidence shows, however, that there is strong support for **more joint training** to increase the knowledge of staff about other services and to create a multi-skilled workforce.

Evidence

I always think of us as being like the Scottish First Division. We nurture the local talent but those who are good enough can be lured away to Premier League sides with more money and career advancement potential. It's hard to know what to do about it.
(Qualitative research study)

Staff support and supervision can be an issue in rural and remote areas. An example from the qualitative research study was the experience of community psychiatric nurses in Orkney who reported that there was no-one on the island qualified to offer them clinical supervision. They had to rely on supervision from specialist staff off the island in another local authority. The lower numbers of workers in rural areas, and difficulties associated with staff support and supervision, such as the above example, can lead to **feelings of worker isolation and low morale.**



There may also be **difficulties in recruiting, training and supporting volunteers**. 'Advocacy for Drug Users: a guide' (EIU 2004) examines some of the challenges for rural areas. For example, advocacy services in rural areas often attract only a small number of volunteer advocates which leaves service providers with a restricted choice when matching advocates to clients. This is compounded by the fact that in small communities there is a greater likelihood of everyone knowing everyone. Similarly, the qualitative research study highlighted some problems for staff living and working in rural and remote areas in maintaining professional boundaries.

There are also **positive aspects** for staff in working in an area where there are fewer services and where they may have to "multi-task". This can provide **greater diversity of work experiences.** Participants in the consultation workshops suggested that staff in rural and remote areas have to be **more innovative and creative** in finding solutions for clients' needs, including resourcing. One point made by a number of participants was that **lower caseloads means more personalised care for clients**. There was also a view that when there are smaller numbers of service providers, staff get to know each other and build up a trusting relationship, which in turn benefits clients.

7. Funding services in rural and remote areas

Participants in both the consultation workshops and the qualitative research study identified **funding as a major barrier** to developing integrated services.

We have identified the following key issues:

- **High unit costs:** the evidence shows that unit costs of service provision to rural areas are higher than in urban areas because of: staff travel costs; loss of staff time on travel; smaller number of clients; and the availability of premises. The qualitative research study also suggests that, when clients fail to turn up for appointments, it results in an even greater loss of staff time for workers who have to travel to see clients.

- **Short term and competitive funding streams:** which lead to insecurity of services and instability for staff. This potentially has more impact on staff recruitment and retention rural and remote areas where the pool of staff is smaller.

- **National funding formulae:** there was a strong view both from the consultation workshops and the qualitative research study that rural and remote areas are disadvantaged by national funding allocation formulae for public sector service providers. Although some areas of provision have adjustment formula to compensate for this, per capita allocations and inadequate indicators of rural poverty and disadvantage were thought to still impact on the availability of resources in rural and remote areas. This view is supported by recent research for the North West Regional Drug Strategy Team. "Guidance for Commissioners of Rural Drug Services" (Henderson S, 2004) also identifies the higher costs of providing services in rural areas and highlights the problems of applying indicators of urban **deprivation** to the identification of rural deprivation; for example, commonly used indicators such as crime rates.

  > **Evidence**
  >
  > Recognise that providing services in rural and remote areas costs more and a small increase in the number of drug users has a greater impact
  >
  > There is no rural proofing to account for higher service delivery costs in rural areas
  >
  > (Participants, Consultation workshops)

  In Scotland it has been acknowledged that the Scottish Index of Multiple Deprivation (SIMD) may not always identify areas of deprivation in rural areas, due to differences in the nature of deprivation in rural areas and the fact that population density is lower in rural areas. The SIMD does include issues of geographic access to services and these are more likely to be of concern in rural areas. However, the weighting given to this domain in the SIMD is lower relative to the other domains in the index. Recent work on the rural target for Closing the Opportunity Gap has attempted to address this by identifying rural areas that are worst with regards to both the overall SIMD and the geographic access domain in the index.

8. Networking locally and nationally

The qualitative research study found that for most service providers and commissioners, with the exception of respondents in Stirling, **their capacity to network, even at local level, was restricted by the distances and time involved.**

In some rural areas there are problems in getting a mobile phone signal. Also, broadband/internet/email access may not be available. Poor communications can add to the difficulties in networking in rural and remote areas.

Service providers referred to the benefits of networking outside their local area as a way of improving their individual practice and identifying new approaches to service delivery. However, they commonly reported being less likely to attend conferences or seminars or other events, which were often held in the central belt. Despite this, there was a commitment from everyone who was interviewed to give staff as many networking opportunities as the service could support.

Managerial and strategic staff also commented on the additional time involved in networking outside their local area but they believed that it was essential **to avoid insularity** and to give them the opportunity to express their local viewpoint and to influence change.

At the same time, there were some aspects of working in rural and remote areas which made networking easier, particularly at local level. Feedback from the qualitative research study, the consultation workshops and previous EIU workshops on information sharing have all highlighted the fact that the lower numbers of people involved makes it **easier to communicate, share information or work jointly with other individuals or agencies.** Alongside this, there were comments made at the EIU information sharing workshops in the more rural DAAT areas on how they felt they were perhaps **better at communicating with colleagues and sharing information** because, given some of the difficulties they faced, e.g. travel and distance, they had to be.

9. Housing and employment

Two other issues that have an impact on the effectiveness of an integrated care approach are access to **housing and employment related activities.** Around 50% of interviewees in the qualitative research study had not always lived in rural and remote areas but had moved there because of lack of social housing in urban areas compounded by their own difficulties with family breakdown or anti-social behaviour. As "incomers" they may have difficulties in being accepted by the local community (who may perceive them as a disruptive influence) and settling into a new environment.

There are also often limited employment opportunities. Seasonal and low paid work is common. Competition for such jobs tends to be high and known drug users may be excluded. On the other hand, drug users who are part of local families may get jobs. There can be a disadvantage since this can take clients away from services for several weeks or months. Often they will use their wages to buy drugs and renew their habit.

Access to housing and the availability of employability programmes in rural and remote areas may be an issue for DAATs and partner agencies to consider in their needs assessment.

Chapter 4: Approaches to delivering effective integrated care for drug users in rural and remote areas

Overall, the consensus from our evidence gathering was that **integrated care for drug users is a viable approach in rural and remote areas**. There are a number of factors that might make the delivery of integrated care in rural and remote areas potentially more challenging. There are, however, also positive factors: for example, the closer working and communication between agencies identified in the consultation workshops and the qualitative research study. In this chapter, we explore, using case study examples, some of the approaches that can be used to deliver effective integrated care services in rural areas. In doing so, we have drawn on examples from drug misuse and from other client groups.

1. Needs assessment

Needs assessment is crucial to achieving a better understanding of the nature and pattern of drug misuse, which may vary significantly across a wide geographical area.

The EIU's Needs Assessment Guide, (EIU 2004) describes some methods for finding out about the needs of rural populations. Suggestions include: anonymous household surveys or questionnaires, and the use of outreach services and/or snowballing. Also, as the first point of contact for many individuals, primary care teams (including GPs, practice nurses, midwives and health visitors) will have an important role to play in assessing the needs of drug users and their families.

Service Example

The **A-73 project** was set up **in Clydesdale, a rural area of south Lanarkshire,** to provide a comprehensive outreach service, incorporating needs assessment, and needle exchange, to reduce the negative consequences of drug related harm and encourage drug users to make contact with services using an action research approach.

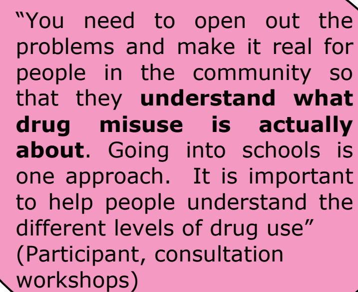
For the purpose of the **needs assessment survey**, data was collected using **two questionnaires, one for 'service users' and one for 'potential service users'.** The former were distributed mainly by clinic nurses and support workers within treatment services, and by the A-73 project on an outreach basis. The questionnaires were designed for self-completion, but where appropriate assistance was given as a semi-structured interview. Questionnaires were returned in a sealed envelope, protecting client anonymity. For the 'potential service users' questionnaire, much of the information was gathered at local events within youth organisations and distributed as a self-completion questionnaire. Most were completed on a one-to-one basis, with some help from A-73 staff.

Contact: **Maureen Woods 01236 437736 or e mail maureenwoods@lanarkshire.scot.nhs.uk**

2. Community attitudes towards drug misuse

A recent study, commissioned by the Drugs Strategy Directorate in England, looking at attitudes towards drug use (Solutions Strategy Research Facilitation 2003) found that **levels of knowledge about drugs appeared to be the main factor in determining people's attitudes.**

'Integrated Care for Drug Users' highlighted the need for substantial efforts to be made, in rural areas, to **engage with communities and improve understanding of the nature of drug problems and their impact.** Participants in the consultation workshops also highlighted the importance of engagement and basic awareness raising as a necessary precursor to establishing effective services. They advocated a joint approach, e.g. Health Promotion, Police and drug agency.



'Rural Drug Treatment and Rehabilitation Programmes' (Sale S. 2004) describes a number of methods employed by projects to educate local people on drug misuse. This includes: meetings with the community to present information on the local drug problem and the project/service's role in tackling it; **door-to-door visits to local homes; and advertising (pamphlets, newspaper advertisements, and television and radio)** as a popular way to communicate the constructive effects of the project.

'Drugs Prevention in Rural Areas', an evaluation report to the Home Office Drugs Prevention Initiative (Henderson S. 1998) suggests that **a broad-based approach** to drug prevention **is more likely to be successful**. This means consulting and linking with the **widest possible number of local agencies and community organisations**, not solely those with a drugs remit, in order to place the work within broader community concerns – perhaps community safety in its widest sense. Such an approach, the report suggests, will help to **overcome the fear of identification** or stigma and capitalise on more readily acknowledged concerns, such as family problems, community safety, alcohol consumption, and threatening or noisy public behaviour. **Supporting and building on existing community structures and networks was also found to be effective.**

3. Travel and transport solutions

In chapter 3, we described some of the difficulties clients faced in travelling long distances to attend services. **One of the solutions is, rather than clients having to travel to services, for services to go to the clients.** Below are some examples of **outreach initiatives,** working with clients in a range of more accessible settings. Some of these examples are from services working with young people, and might involve work in settings such as young people's homes and schools. For adult drug users, the settings may be different. One approach is to use a **mobile service** to reach people, whether for distributing information and advice on drugs and drug-related issues; identifying drug misusers and attracting them into services; or providing ongoing treatment, care and support. In the following sections, we also look at examples of the use of multiple bases, or satellite premises.

Service Examples

Barnardo's Youth Drug Initiative is based in Peterhead and aims to serve the whole of Aberdeenshire, although much of its work is concentrated in the north of the authority, where it has its base. While clients can attend the office base in Peterhead, **the service works usually with young people in their own home or at their school.** The work in schools includes one to one sessions and group work, usually in a guidance department or a unit for children with social, educational or behavioural difficulties. (Working with young people: A profile of projects funded by the Partnership Drugs Initiative EIU 2004)

In recognition of the difficulties of **attracting drug users into treatment,** including the challenge of providing anonymous services, in September 2003 **Shetland Community Drugs Team** established a new **outreach project**. **Community Liaison Outreach Service and Education Resource** (CLOSER) was set up using NOF funding to recruit one part-time Outreach Worker. In its first six months of operation, SCDT's outreach service made contact with 36 new clients i.e. people who had either never been in contact with SCDT's project based services or had not been in contact for longer than 6 months. The majority had in fact not previously accessed drug treatment and information services although 33 of them defined themselves as current drug users. Subsequently, seven clients were keyed into SCDT's prescribing and/or counselling services. SCDT successfully applied for Choose Life Funding to extend the existing service in 2004/2005 by making the worker full-time. Contact: **Linda Gray 01595 696698**, **email: linda.scdt@zetnet.co.uk**

There is no specialist drug treatment & rehabilitation service in the **Western Isles** apart from the "Lifestyle Centre" (Lewis and Harris) and the "Bridge Project Uists" (the Uists, Benbecula and Barra) which provide counselling for people with alcohol and drug misuse problems. These are non-statutory agencies run by CrossReach, the Social Work branch of the Church of Scotland. They are registered charities. Both services can provide outreach to young people aged 12 and over, and will take referrals from any agency involved in working with youngsters. In Stornoway, the ongoing work of the Council's Outreach Project continues to target young people with drug misuse issues through the efforts of street-workers, who may also refer youngsters on to Lifestyle. Lifestyle can be contacted on 01851 701010 – it has premises in the Town Hall in Stornoway. The Bridge Project Uists employs a peripatetic worker, who can be contacted on **01870 610737**.

In the **Borders, a Mobile Information Service pilot (a joint initiative between the Reiver project and the police)** was set up to allow access to information and advice on drug/alcohol misuse in some of the region's smaller and more dispersed communities. It also gives members of the public an opportunity to pass on intelligence information to the police. This was a successful project which is being repeated. Contact: **The Reiver Project, 01896 668811**

Moray mobile information service goes out every evening, providing a range of health information, including sexual health and substance use. Because it **does not just deal with drugs information** it means that for people accessing the service there is not an automatic association with drugs, therefore reducing the potential stigma. The service also has a counselling room for clients. Contact: **Carol Kirkwood, 01343 563375, email: carol.kirkwood@moray.gov.uk**

In rural areas time spent on travelling can place strains on service providers as well as service users, making it difficult to meet service demands. The interim report on the evaluation of the Lloyds TSB Partnership Drug Initiative (PDI) projects for young people includes (EIU 2004) several rural projects. The report describes how the geographic spread of their cases meant that **a lot of the project worker's time was consumed by travelling.** The example(s) above, which involve workers travelling to clients, may be more convenient for the service users, but mean greater travel time for workers. The PDI report went on to describe how some projects sought to address this problem by **undertaking as many client contacts as possible when in a particular area**, or by **maximising the amount of work done at each visit.**

For **service commissioners/planners and service providers**, the establishment of **local planning fora**, **below DAAT level**, as well as providing a more locally responsive planning structure, can help to reduce travel demands. Two examples of this are Highland DAAT, where there are six local drug and alcohol fora covering Ross and Cromarty, Lochaber, Skye and Lochalsh, Nairn and Inverness; and Dumfries and Galloway which has four local fora serving Stewartry, Mid & Upper Nithsdale, Wigtownshire and Annandale & Eskdale.

Another solution to travel and transport problems is to bring clients to services, or to provide assistance (for example, financial help) to get to services. 'Integrated Care for Drug Users' raised the possibility of **subsidising clients' travel**. 'Guidance for Commissioners of Rural Drug Services' (Henderson, S 2004) also refers to travel subsidies and the use of **taxi vouchers**. The qualitative research study found several examples of services using taxis to enable drug users to access services and, on occasion, providing clients with bus passes. With regard to the use of taxis, there was some concern expressed by service providers that this made it hard to assess clients' motivation as they had to make little effort to get there. Other options include the provision of **a bus service to bring clients into services** (as with the service example below which is taken from the qualitative research study), and **collaboration with other providers through a shared transport scheme** (The Countryside Agency 2003).

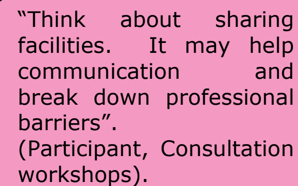
'Services in Rural Scotland' (SE 2000), identified innovative approaches to providing services in rural areas, and gave recommendations on how rural communities might be helped to identify their service needs and to work with providers to achieve these. Among the study's main findings was that, where services can only be provided in urban areas, the provision of good transport links is crucial. **Community transport initiatives** will play an increasingly important role in ensuring that travel services are available to rural, and particularly, remote rural communities.

Service Example

Forth Dimensions, in Forth Valley, which provides an employability focused day programme**, uses a minibus to bring drug users from other areas to their base.** This was not specifically designed to address problems of rurality and remoteness. The service covers three local authorities and has just one base. Therefore, even urban clients can be significant distances from the project base. Rural and remote clients would still have to go to central points to be collected. Contact: **Ken Scott, 01324 579 648, email: ken.scott@dsl.pipex.com**

We have already identified the inconvenient location of services as contributing to travel problems. The issue of where to locate services is explored further in the next section.

4. Location of services



"Services in Rural Scotland' (SE 2000) identified the high unit cost of provision and recommended that service providers in the public, private and voluntary sectors should look for opportunities to reduce costs, including **joint provision of services, either through the shared use of staff, buildings or vehicles, or by making use of agency arrangements.** In the previous chapter we also highlighted the lack of suitable premises as one of the barriers to service development in rural and remote areas.

Co-location of services, or sharing of premises with other services (for example, the local health centre) is one approach to developing services. There are a number of potential benefits, including: **reduced overhead costs, improved communication between agencies, and workers.** For the client, where it works well, co-location should result in improved referral arrangements and access to services, and in agencies working together to meet their needs. The qualitative research study found that all four case study areas had good arrangements in place for utilising existing premises.

Some service users may see co-location as a problem because, for example, they do not wish it to be known that they are clients of a particular service or are concerned about the sharing of information. One way to reduce the such apprehensions is to ensure that the benefits of co-locations are fully explained to clients and to consult them about the working practices.

The **community may be concerned about the use of local facilities** e.g. social work offices or health premises, and the approaches to engagement and awareness raising outlined in the section above may be helpful to address that problem.

The development of **satellite premises** is another means of improving access to services for clients in rural and remote areas. It also addresses problems associated with client territoriality, where clients may be reluctant to attend services in other settlements.

Another approach is the use of **multiple bases** around the area so that clients have a number of points of access. Services provided in those bases may be low level/low threshold e.g. initial assessment and referral or may include interventions such as counselling and ongoing support. Signpost has been running in Forth Valley for over 3 years providing a direct access service organised and run through the community. It is funded by Forth Valley DAAT and was evaluated in 2004. This can be viewed at: http://www.forthvalleysat.co.uk/modules.php?name=Downloads&d_op=viewdownload&cid=7&min=10&orderby=titleA&show=10.

There are a number of complex and inter-related issues about location that may impact on the willingness or ability of drug users to attend services and on the willingness of communities to accept services located in their area. **DAATs, partner agencies and service providers should consider how to develop a range of approaches to consulting service users (and non-service users) and communities.**

Service Examples

All of the **Lloyds TSB Partnership Drugs Initiative (PDI) projects for young people and families affected by substance misuse use a host agency**. The **Web Project, in Angus,** had been operating for around 4 years (as a generic service for children and young people in relation to risk behaviours) and through its work had identified a clear need for a dedicated substance misuse service. The PDI interim report described this as an example of a project strengthening the work of the core agency by introducing a distinctive but complementary provision is the outreach service at the Web project in Angus. In delivering an intensive programme of one-to-one interventions with young people who are at risk of establishing a pattern of problematic drug use, **this project directly complements the more generic work of its host**. (Working with young people: A profile of projects funded by the Partnership Drugs Initiative, EIU, 2004)

The Lochaber Community Mental Health Service has two substance misuse workers (CPNs). There are a number of benefits to locating substance misuse specialists within the mental health service. The incidence of **co-morbidity of mental health and drugs/alcohol problems** means that mental health workers will come into contact with many individuals with substance misuse needs. It also helps to be integrated with the mental health service as **the detox beds are located in the psychiatric hospital** in Inverness, 64 miles away. For the two substance misuse workers, working with mental health colleagues provides them with an important communication **link to the clinical leads and psychiatrists** all of whom are based in Inverness too. There are also close links with Osprey House and Beechwood house residential drug services in Inverness.
Contact: **John Sword, 01397 707060**

Signpost offers a range of practical low-level interventions to service users through one-to-ones, drop-in and harm reduction/needle exchange sessions. This is done at a variety of locations in Forth Valley. Information is distributed verbally and through leaflets and posters. At times staff use mobile phone text to contact clients.
Contact: **Jackie Johnston, 01259 726602, email: Jackie.signpost@btconnect.com**

Effective integrated care for drug users requires arrangements to be in place for **throughcare and aftercare** for clients leaving prison or residential/inpatient services.

Service Examples

Transitional care arrangements in **Dumfries and Galloway** involve in-prison casework and continued care and support following release with **the same worker,** therefore providing continuity of care for the client. This short-term post release low-threshold support lasts for up to 12 weeks.

Drug misusers in **Shetland** who successfully complete treatment often do so after attending a mainland residential service. It has been found that, given the challenges of remaining drug-free after returning to the islands, many of these people have then stayed on the mainland. Using Scottish Executive dedicated funding, **a Full-time Aftercare and Resettlement Worker** was recruited in Shetland in September 2002 and the **Substance Misuse Aftercare and Resettlement Transition Scheme [SMARTS]** was established. March 2003 – April 2004 was the first full year of operation of a service set up to meet the needs of individuals who have experienced significant problems relating to their substance misuse, have addressed these and are seeking to maintain a substance-free lifestyle. SMARTS worked with 30 individual clients in 2003/04, 20 of whom were classed as new to the service. Fifteen clients were 'current' users nearing the end of detox or about to enter in-patient/home detox or rehab. Thirteen clients were ex-users and two were parents of users. Plans for 2004/2005 include the **development of throughcare policies with local housing providers and continued negotiations for second stage accommodation.**

5. Range and capacity of services

In Chapter 3, we highlighted the following specific gaps in service provision in some rural and remote areas: Methadone prescribing by GPs, Methadone dispensing (by GPs and pharmacies) and the availability of needle exchange.

Addressing the problem of **availability of prescribing GPs** is not simply about increasing numbers. DAATs and partner agencies also need to **consider education and training for GPs to provide the right package of treatment, care and support for methadone users**, including the proper testing and monitoring of progress. From 2005/06 The Royal College of General Practitioners (RCGP) will deliver improved training and education for GPs, specialists and other health professionals involved in prescribing through the extension of the provision of RCGP Certificates in the Management of Drug Misuse being extended to Scotland. Similarly, **improving access to methadone dispensing**, from pharmacies and GPs, requires education and training to encourage more people to provide the service. Training and awareness raising also needs to address issues such as premises development (the provision of confidential dispensing /consumption areas).

We have included three short case study examples and one larger service example (the West Lothian Locality Clinics) which have sought to address these various issues.

Service Examples

In the **Borders**, the **lack of supervised methadone dispensing in some areas,** led to the Integrated Care Subgroup of the DAAT visiting all community pharmacies to support and encourage further supervision. In 2003/2004 this resulted in increased provision of supervised methadone in community pharmacies, including provision in Hawick for the first time. Planned action for 2004/2005 includes **support to community pharmacies through education and training and premises development** to enable supervised Methadone dispensing to take place throughout the Scottish Borders.

Turning Point in Stranraer provides a service whereby drug workers collect clients' methadone from the pharmacies, and take it back to their service, from where they dispense the methadone to the client under the supervision of a competent witness.
Contact: **Tom McIntosh, 01776 700666, email: tom@turningpointstranraer.fsnet.co.uk**

In **Argyll and Clyde,** in recognition of the importance of **education and training for staff in pharmacies,** the Specialist Pharmacist in Substance Misuse visits the pharmacies to provide one-to-one training on methadone/buprenorphine and harm reduction with the staff. She also provides more formal training sessions on specific issues such as blood borne viruses for all staff. Contractors are expected to complete the NES Pharmacy distance learning packs on substance misuse prior to providing the methadone supervision service and needle exchange service. Contact: **Sarah Harris, 01389 812006**

Service Example

West Lothian's Locality Drug Clinic has been fully operational since December 2002. It was developed in response to an increase in the number of people presenting to services with drug misuse problems. At that time, eight out of 24 GP practices in West Lothian refused to treat drug users. This reluctance was due in part to **a perceived lack of training and support for GPs.**

The Locality Clinic operates **in different locations on different days**, with the aim of improving access for clients across the area. There are clinics based at the health centres in Bathgate, Broxburn, Whitburn and Livingston. All **venues are accessible by public transport.**

The clinics are staffed by an addiction specialist who is also a consultant with the Community Drug Problem Service, CDPS, (four sessions), a West Lothian Drug and Alcohol Service, WLDAS, counsellor (four sessions), a CDPS Community Psychiatric Nurse (three sessions). A part-time administrative assistant supports the service.

A **Locality Clinic steering group** has been set up, chaired by a GP, with representation from the three drug treatment and care service in the area: WLDAS; CDPS and West Lothian Social Work Drug Team, plus officers from the DAAT support team.

The four core agencies meet weekly to consider referrals and allocate clients, on the evidence available, to the most appropriate service. This integrated arrangement has clients needs as the focus, and allows more effective collaboration with external agencies involved. It creates a service that is more effective and accessible to the client, referrers and other involved parties. A rapid re-referral service is available to GPs in the event of de-stabilisation of those clients who have initially been stabilised through the Locality Clinic. **Common priorities for patient referral were put in place on 1st April 2004**

The Locality Clinic is available to clients with an opiate dependence and **offers the following services:**

- Joint assessment by substance misuse professionals
- Access to specialist medical and substitute prescribing
- Advice and information
- Support and counselling
- Support in accessing other services
- Maintenance for those patients who do not have a prescribing GP

Contact: **Joni McArthur, 01506 774082, email: joni.mcarthur@westlothian.gov.uk**

There are a number of example of **needle exchange outreach** services operating in rural (and also urban) areas. The three common models are:

- **detached** – working in locations where drug workers meet
- **peripatetic** – working in and or with different agencies In rural areas there may an arrangement to work in their premises, e.g. room in GP surgery on certain days
- **domiciliary** – visiting clients where they live –at home, hostel, in prison.

These services also provide the opportunity to give advice and information, and referral on to other services.

Service Example

In **Highland**, in some remote and rural areas, sterile needles are delivered to clients' homes by community psychiatric nurses who are specialists in substance misuse problems. While this arrangement does not permit client anonymity, it is frequently preferred by clients who feel confidentiality would be compromised attending pharmacy exchanges where methadone is also dispensed. This service also allows for detailed discussion of harm reduction issues on a one-to-one basis. It is interesting to note that 62% of this outreach activity has been with female clients. **This compares with one of the busiest pharmacy exchanges in Inverness where only 31% of exchanges are with female clients.**

One of the key influences on the range and capacity of services available to drug users in rural and remote areas is the extent to which generic services address drug misuse problems among their clients. When conducting a needs assessment, DAATs and partner agencies should pay particular attention to **the role of services, such as social work and housing, whose clients may have drug misuse problems**. In some cases, this may mean that more training is required (see below). It may also point to the need to agree some shared objectives and new ways of working with this client group in order to make more effective use of existing skills and resources.

6. Staffing

The recruitment and retention of staff was identified in Chapter 3 as a key issue. **Financial incentives** (for example, higher salaries, or a lump sum on starting a new job) are one mechanism for bringing in new staff. There are examples of this already, but not specific to substance misuse. For example, in social work, difficulties in recruiting and retaining staff have led to this approach, both in urban and rural areas. Another example is in teaching, where, similarly, financial incentives are being used to attract staff. Several interviewees in the qualitative research study advocated providing additional payments to attract staff. However, this should be conditional on the person staying in post for a specified period. Financial incentives can also be used to help retain existing staff. DAATs and partner agencies should also consider whether there are ways to improve career progression. Another possibility is to **employ sessional workers**.

As noted above staff in generic services may provide more services to drug users than their urban counterparts. Training is even more important in these circumstances and there is further benefit from multi-agency training and more informal sharing of knowledge through initiatives such as work shadowing. STRADA (Scottish Training on Drugs and Alcohol) provide training for practitioners working with people with substance

misuse problems in both specialist substance misuse and other services throughout Scotland. The qualitative research study found that, to address problems with a lack of suitably skilled staff, some areas had provided training for existing staff, most commonly through STRADA.

The Scottish Executive has bid for funding from the European Structural Fund to assist the social care workforce in the Highlands and Islands area of Scotland (Objective 1 area) gain qualifications. This funding will extend the current Achieving the Challenge project funded by the Scottish Executive and the Scottish ESF Objective 3 Partnership to cover the whole of Scotland. The new funding will enable workers living in Highlands & Islands and parts of Argyll & Bute who were not previously eligible will be able to apply to join the project.

The aim is to assist the upskilling of the social care workers and develop **a confident, competent social service workforce**. The project will run from July, 2005 until June, 2006 and will allow up to 200 people in the social services workforce from the independent and voluntary sectors to gain a qualification. To obtain more information please visit the website at www.achievingthechallenge.com where you can register your interest or call the free phone number on 0800 652 2980.

In the previous chapter we also identified the potential risks of worker isolation and low morale. One approach to this problem is to set up **a forum or learning support network** for workers to help them meet and talk regularly. In rural and remote areas this could also be facilitated by the use of the internet.

7. Funding

At national level there is recognition that the circumstances of rural and remote areas need to be addressed when considering funding allocation arrangements. 'Services in Rural Scotland' (SE 2000), included the following recommendation :

National bodies, including the Executive, should consider better and at an early stage how their standards will impact on providers in rural areas. All funders should consider the necessity for particular specifications for projects in rural areas.

'*'Monitoring the Implementation of the Services in Rural Scotland* Report was published in November 2002. Amongst the key issues identified for further exploration were:

- There continues to be a need for a **more robust approach to assessing and measuring rural service needs and how delivery is meeting these needs.** An enhanced evidential base & research, as well as mechanisms for assessing satisfaction among rural dwellers with the level and quality of provision of services, is essential.

- **Community Planning** has huge potential to transform how services are planned and provided, but service providers will need to consult with local communities through existing mechanisms in the meantime (SIPs, LRPs, CVSs). Community budgeting, bringing all partners' budgets to the table, is another potentially crucial development.

The Closing the Opportunity gap target to improve accessibility and quality of services in rural areas has given a focus for activity at national level as, for example, in the work on derivation indices. At local level, the progress of Joint Future which allows the pooling and aligning of heath, social work and housing budgets for all community care groups and the development of Community Planning Partnerships and Community Health Partnerships provide a basis for more partnership working to maximise the use of

resources. *'Guidance for Commissioners of Rural Services'* (Henderson S, 2004) suggests a number of ways that **DAATs could address the "rural premium"** including:

- ✓ **allowing for higher unit delivery costs** in funding formulae e.g. a sparsity factor
- ✓ **joint provision** where two or more services are delivered from a single (static or mobile) location although this may only be feasible on a small scale
- ✓ **sharing services** with a neighbouring authority
- ✓ **encouraging service provider links** with other rural service providers e.g. transport providers, or policy/commissioning structures e.g. joint contracting with statutory or voluntary transport providers (DEFRA 2002)
- ✓ **setting realistic performance targets** that take account of the degree of rural remoteness
- ✓ where services are largely provided by the voluntary sector, **giving support in the tendering process** to ensure the best outcomes

8. Using information technology to improve accessibility

The use of the internet and other information technology may offer considerable scope to improve accessibility for service users and communication between service providers. There are some examples of how that is being developed.

'*The Implementation of Connexions in Rural Areas: a good practice guide'* (The Country side Agency 2003) identifies rural outreach as a useful way of reaching isolated people, particularly in making initial contact and in giving anonymous advice in relation to sensitive personal issues. However, it goes on to point out that some rural areas suffer from signal limitations and consequently have a poor mobile phone service. Therefore, electronic communications need to be combined with the opportunity for face to face contact and are not a substitute for it.

Service Examples – It Related (Various)

Drugs/alcohol education and use of IT/new technology – young people

90% of 12 -18 year olds are now members of Angus Young Scot, operated under the **Angus Dialogue Youth Initiative.** Young people can access both the national Young Scot and local Angus Young Scot websites which have specific links to information on alcohol and drugs. In 2003/2004, using MGF funds, the Dialogue Youth network was expanded to include a number of voluntary youth work providers across Angus. This involved the installation of the Broadband communications hardware enabling young people to access the key information sites. In 2004/2005, there are plans, under the Dialogue Youth Initiative, to introduce **a mobile youth work resource vehicle with satellite broadband equipment providing youth information support to young people locate in more remote rural locations where no current IT link is available.**

Also in **Angus**, the "Cool2Talk" **young people's interactive health** website was launched in January 2004. This is a Partnership initiative involving Angus Dialogue Youth and NHS Tayside with a Community Nurse based at No1 for Youth, Forfar responding to on line health related enquiries. Site has specific section on alcohol and drugs.

The qualitative research study described a good deal of positive feeling and hope for the provision of services, particularly lower level counselling and monitoring, via the internet, but identified very few examples in current practice. The one example cited was from Counselling and Support Service for Alcohol and Drugs (CSSAD) in Stirling who had given one drug user a PC and were maintaining contact with them via the internet, supplemented by less regular face-to-face contact. They were confident that this was working well and that it had the added benefits of allowing the user access to other benefits available from the internet and that the existence of a physical resource belonging to the agency in the home of the service user provided an incentive for them to remain in touch with the agency. The service example below describes a proposal to develop internet-based treatment and support for substance misusers in Scotland.

Service Example

WIRED is currently planning a **12 month pilot project to support the uptake and development of virtual treatment, care and support** in Scotland. Following discussions with members of the Remote and Rural Sub-Group of the Scottish DAAT Association, they have identified 10 rural/semi-rural (member) DAATs with an interest in offering a service supplied via Virtual Outreach.

WIRED was developed five years ago as a way of empowering people to tackle substance misuse, It combines real world activities with a high profile **web-based communication system,** for the purpose of disseminating information, providing support, conducting research, and increasing the capacity of already successful programmes to reach their audience. They recognise the need for a holistic substance misuse service, delivered on the internet, **closely linked to real-world treatment and support agencies.** It must offer interventions for people in the early stages of drug use, people in transition between recreational and problematic use and long-term problem drug users. They recognise also that such a service will be of particular benefit to remote and rural areas in Scotland, where barriers receiving support such as physical proximity and lack of public transport, limits to the range of services available and stigma and confidentiality are particularly evident.

WIRED will aim to provide a range of interventions , including prevention, education, brief interventions, counselling, aftercare (including relapse prevention) and rehabilitation. The service will engage treatment agency practitioners, service users and commissioners in its development and maintenance.

WIRED has recently established a strong working relationship with Distance Therapy , who have developed a unique and secure communication tool which will act as the delivery system of the WIRED treatment and support service. The system, to be called "Virtual Outreach", will be marketed with the Federation of Drug and Alcohol Professionals (FDAP).
Contact: **Sarah Davies, 07773 666907**

The Scottish Executive is committed to improving internet and wider IT communications access in rural and remote areas. The Scottish Executive's Annual Rural Report 2004, which sets out the key achievements in rural Scotland since May 2003, describes how the achievement of the **broadband target,** set in December 2002, of **70% population coverage** was reached in January 2004, two months ahead of target. A new broadband coverage target has been announced of **access in every community in Scotland by the end of 2005.** This will benefit up to 100,000 households and businesses in rural and remote areas across Scotland which would otherwise not have access. The report also notes that there has been funding for the creation of **750 new**

public internet access points (PIAPs) in villages and towns throughout Scotland in places like post offices, pubs, community centres and shops. A full independent evaluation is underway, but early indications are that the scheme has been very successful with 98% of respondents feeling that access to a PIAP had improved their IT skills to at least some degree. The Scottish Executive is also working with libraries to develop enhanced public internet access points, trialling WIFI to provide broadband access for libraries in largely rural areas where there are no cost-effective alternatives.

Service Example

The Community Broadband Project in Ayrshire was an innovative pilot helping a number of community organisations in Girvan and Ardrossan to enjoy the benefits of faster access to the Internet and improve their services locally. The programme, **delivered by Scottish Enterprise Ayrshire** was part of Scottish Enterprise's successful **Broadband for Business Programme**. The initiative linked **11 voluntary groups, connecting more than 70 users to the Internet daily.** The groups taking part included Three Town's Healthy Living Community, Cunninghame Housing Association, Girvan Youth Trust, Family Connections, Girvan Online, Travel Connections, Glendoune Community Centre, Boyle Court and MAYTAG. Using Broadband access Girvan Youth Trust organised an exchange trip between its members and a youth group in Greece. They were able to use their new Broadband facilities to help organise the trip. Girvan Youth Trust is also part of a Europe-wide Intranet initiative aimed at young people and youth workers alerting them to the opportunities for volunteering and gaining work experience overseas. Access to broadband allowed them to exploit this resource more effectively. This pilot ran from July 2002 - March 2004. It has now concluded but investigations are being made into the sustainability of activities and services beyond the life of the funded pilot. Further information can be found at:
http://www.scottish-enterprise.com/sedotcom_home/news-se/key_summaries/sedotcom_home/services-to-business/broadband/broadband-news/broadband-community_broadband.htm

Contact: **Gavin Moir at Scottish Enterprise Ayrshire, 2 Cockburn Place, Irvine, KA11 5DA, 01294 316529, gavin.moir@scotent.co.uk**

Chapter 5: Key principles and elements of effective practice

We undertook this review on the implementation of integrated care in rural and remote areas to explore whether there were factors that were either unique, or particularly important to address, in those areas. The evidence that we gathered showed that many of the issues and factors that would influence the development of integrated care were the same as in other parts of Scotland. There were, however, some factors that presented specific problems for rural and remote areas. These were:

- **Geography**: the distances between, and from, centres where services are likely to be based
- **Travel and transport:** irregular and infrequent public transport
- **Smaller pool of staff** and difficulties of recruitment and retention
- **Limited range of services** both specialist and generic
- **High unit costs** of providing services: and perceived disadvantage in funding formulae
- **Lack of suitable premises**
- **Community attitudes**

The evidence suggests that these factors do not exist to the same degree in all areas and that there are many examples of local innovation and good practice. However, it seems clear that, for **commissioners , managers and providers, who are aiming to promote and develop integrated care for drug users in their area, these are the key issues to address.**

Key Principles

The principles and key elements of practice set out in 'Integrated Care for Drug Users' will apply and are, therefore not repeated here. We have identified the following principles that we believe are particularly relevant in rural and remote areas:

Recognising that there are differences between, and within, rural and remote areas

Focusing on developing strategies to recruit and retain skilled and knowledgeable staff in both specialist and generic services

Devoting time and resources to raising awareness among communities about the nature and extent of drug misuse problems and to supporting community engagement

Working towards better co-ordination of travel, transport and location

Building on local innovation and existing networks

Key elements for effective practice

For DAATs, commissioners and partner agencies

- ✓ Conduct a **needs assessment** to establish the numbers of drug users, types of drugs, current patterns and usage of service. Take account of the differences between rural and remote areas within a DAAT area; the impact of geography on location, travel and transport; and the difficulties of accessing other relevant services such as employment and housing.

- ✓ **Consider how to fill the gaps identified in the needs assessment** e.g. lack of prescribing GPs and dispensing pharmacists, and how to ensure, as far as possible, an equitable level of services across rural and remote areas.

- ✓ **Engage with communities** to raise awareness of drugs issues with a view to reducing negative attitudes and encouraging acceptance of services. Consult and link with all local agencies and community organisations that may have drug users in their client group.

- ✓ **Explore the views of drug users** and use them to inform the planning and commissioning of services. A key issue is the development of protocols agreed between services to govern information sharing. Protocols should protect confidentiality and anonymity but **not create unnecessary barriers to information sharing.**

- ✓ **Pool or align budgets** where possible. Collaborate on bids for funding to maximise the benefits from short term funding streams. Offer support to voluntary sector agencies in preparing bids.

- ✓ Work in **partnership with other agencies. Use all the mechanisms available** through Joint Future, Community Planning Partnerships and Community Health Partnerships. Specific issues include locations of services, travel and transport and the role of generic services. Consider whether, and how, to use contracting, including joint contracting, to achieve strategic objectives.

- ✓ Invest in **training and development of staff** across specialist and generic services to maximise the skills and resources available in the area to work with drug users. Support multi-agency training and other strategies e.g. work shadowing, to promote greater knowledge of drug misuse issues. Consider ways to improve staff recruitment and retention e.g. by financial incentives.

- ✓ Develop and implement **effective monitoring and evaluation** systems.

For service providers

- ✓ **Make services accessible.** Consider, in particular, the difficulties caused by travel and transport when planning location of services, opening hours and appointment times. Build **flexibility** into systems where possible. Consider whether there is scope for more **outreach or mobile services**. For services which are based in a centre, examine the possibility of **co-location** with other services likely to be needed by clients.

- ✓ **Build relationships** with the communities where services are located, or may be located in the future. Look for ways to raise awareness of the impact of drug misuse on individuals and their families, working in collaboration with other agencies.

- ✓ **Build on existing relationships** with other services and challenge negative organisational and cultural attitudes.

- ✓ Consider how to **combine both financial and people resources** to secure the best outcomes for drug users in the area. Be prepared to combine with other agencies in funding bids.

- ✓ Develop and/or implement **information sharing protocols and referral arrangements** to ensure that clients receive the most appropriate service from all relevant agencies and ensure that confidentiality and anonymity do not become unnecessary barriers to effective integrated care.

- ✓ Ensure that there is **good, easily accessible information** about services available to clients and to other service providers. If possible, produce a directory of services.

- ✓ **Involve users, and potential users**, in the planning and design of services. Develop ways for them to feed back on the effectiveness of delivery.

- ✓ Consider how to use the **internet and other information technology** to reach clients and to provide continuing communication and support.

Appendix 1: Qualitative research study: summary report

Introduction

There are almost 1 million people currently living in rural Scotland. This accounts for almost 20% of the population of Scotland. Of these, around 6% live in remote rural areas with the remainder living in accessible rural areas[2]. *Integrated Care: Principles and Practice*[3] (2002) identified a number of factors that may affect the ability of drug users in rural and remote areas to access services.

In August 2004, the Effective Interventions Unit commissioned qualitative research into the issues that influence the effective planning, design and delivery of integrated care for drug users in rural and remote areas from the perspectives of service commissioners, service providers and service users. This study was conducted by Clear Plan (UK) Services Ltd.

A fictitious character, 'Harry', is used in this summary to illustrate the experiences of drug users in rural and remote areas.

Methods

The study used four Drug and Alcohol Action Team (DAAT) areas with significant populations in rural and remote areas as case studies. Data for rurality and remoteness is not collected for DAAT areas. For this reason data from the Scottish Executive 6-Fold Urban Rural Classification relating to coterminous local authority areas was used to inform the selection of case study areas. The four DAAT areas were: two mainland areas with the highest levels of population in rural and remote areas (Dumfries and Galloway and Highland); one mainland area with a strong mix of rural and urban settlement (Stirling, part of Forth Valley); and Orkney in recognition of potential special circumstances that may apply in the islands.

Data was collected through semi-structured interviews with 11 service commissioners, 45 service providers and 20 local drug users.

Findings

Scale of problem

The lower level and number of services in rural and remote areas and the possibility of drug users being supported by extended families and close knit communities without recourse to services suggest an unmeasured level of under reporting in these areas. There is evidence that some rurally based drug users maintain urban addresses and this can make accurate assessment of prevalence difficult. However, comparisons of key data associated with levels of drug misuse between the case study areas used in this research and other more urban DAAT areas suggest that problematic drug use is not as prevalent in rural and remote areas as it is in more urban areas.

Note: Since this qualitative research study was conducted, the second national prevalence study of problem drug misuse in Scotland[4] has been published with data from 2003. This data, which can be broken down to DAAT and LHCC areas, also suggests lower levels of problematic drug use in rural and remote areas.

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[2] Annual Rural Report 2004, Scottish Executive, 2004

[3] Integrated Care: Principles and Practice, Effective Interventions Unit, 2002

[4] Estimating the National Prevalence of Problem Drug Misuse in Scotland, University of Glasgow (Centre for Drug Misuse Research) and Health Protection Scotland, 2005

In rural and remote areas, the **scale of alcohol use** and the problems associated with it dwarfed the problems relating to illegal drug use. There were, however, no distinguishable differences in the experiences and issues of staff working with problem alcohol users and illegal drug users in rural and remote areas.

Unit costs, location, range and capacity of services

The **unit costs of service provision in rural and remote areas were higher** than those in urban areas because of increased staff travel costs and loss of productive staff time on travel. Some service providers accepted this as a fact of life; others offered a higher level of service in the larger centres of population because of the additional costs of service provision in rural and remote areas.

The **availability of premises for services in rural areas was problematic**. It was not normally financially viable for services to obtain dedicated satellite premises. This meant that premises belonging to other agencies were commonly used. While there were very strong local arrangements for access to premises held by a wide range of agencies, including non drug related agencies, these were often not fully suitable for maintaining confidentiality or the provision of counselling or clinical services.

Service providers tended to be based in the larger centres of population regardless of the overall rurality of their full catchment area. Drug users in rural and remote areas were likely to receive a **different level and range of services** than their urban counterparts. The overall picture in terms of service provision for drug users in rural and remote area suggests a form of radial diffusion, i.e. the further away from the physical centre of settlement a drug user lives, the lower the level and range of services they can expect to receive. Drug users in rural areas could generally expect to see key workers less often, have less access to *ad hoc* services and are less likely to access generic or non drug specific support services unless they were based in their home town or village.

There was anecdotal evidence of drug users **migrating in and out of rural areas** in order to avoid other drug users, to access centrally based services or to be closer to drug markets.

The most commonly reported, and in the views of the interviewees, most serious gaps in provision in rural and remote areas involved the **inconsistent availability of General Practitioners** (accepting new patients with drug problems), **methadone dispensing** (lack of pharmacists willing to dispense) and lack of **needle exchange** services. These were felt to be unevenly distributed even within more urban areas but the issues of access in rural areas were exacerbated by a lower tolerance of drug users, by the lower demand for services and the lower numbers of potential service providers. This led to increased travel demands on drug users in order to access services which accept them.

Service User Example

When Harry moved to a remote village outside his home town he was not able to stay with his old GP as he had left their catchment area. He had to try three other GPs before one would accept him. He now has to travel two miles to a nearby village to see the GP for any sort of medical problem. He thinks that it is wrong that he can't register with the practice of his choice when he feels he has not done anything to legitimately disbar him. It has not put him off attending the GP as his new one is very understanding, it is just a pain having to get a bus to the next village to do so.

Society and culture

Some service providers felt that **rural and remote areas were inclined to deny the existence of drugs problems** in their communities. This was more likely to be the case in more affluent areas and created difficulties in getting evidence of need and gaining community support for rurally based services.

There were high levels of concern among service providers and commissioners about the **difficulties of maintaining anonymity and confidentiality** for service users in tight knit rural communities. Despite this concern there was no evidence that fears about anonymity and confidentiality acted as a disincentive to drug users in coming forward to use services. Drug users were less concerned about this than service providers. Levels of concern among drug users appeared to diminish according to the length of their drug using career.

Travel and transport

Travelling to sites of services was difficult because **public transport was infrequent, costly and presented logistical problems.** Drug users had problems in keeping appointments and attending punctually. This could lead to problems in their relationship with service providers and, in the extreme, lead to their exclusion from services. There was a call by service users for better coordination of appointment times and greater flexibility from service providers.

The **support of family members** with access to their own vehicles was crucial in assisting drug users to reduce the problems associated with travel. This was only an option for drug users who were open about their drug problem with their family, were housed in areas near their family and who maintained good relationships with their family. This form of support was of importance in providing the drug user with encouragement and motivation, and in some cases, a stable living environment. There were calls for greater formal involvement of families in the package of care provided to drug users.

Drug users with care responsibilities faced magnified challenges in dealing effectively with the above barriers in accessing services located in centres of population. In the more remote areas this could include responsibilities to livestock as well as human dependents or other relations.

Staffing and partnerships

While delivery level staff were confident of developing and maintaining good **local networks**, they still felt restricted by the time and distances involved in achieving face to face contact with people from other service providers, for example, attendance at a multi-agency case conference. More senior level staff were concerned that the limited number of people in senior positions could lead to an 'in group think' where new ideas and approaches were less likely to develop.

The value of **national networking** was recognised by staff at all levels in all of the case study areas. Despite a commitment to staff development through national networking, the additional barriers of travel, time and cost meant that staff in rural and remote areas felt less able to attend networking events held in the central belt of Scotland.

Difficulties in the **recruitment and retention of staff** were common. Salary levels were not considered sufficient to attract staff away from the central belt to rural and remote areas. To compensate, there was a preference for employing local people and developing them in post. However, once trained, they could apply for posts elsewhere in Scotland and ambitious individuals were often drawn away by better career development prospects in the central belt.

Competitive funding processes served to diminish trust in partnerships and damage agency relationships. National funding allocation formulae for the public sector were believed to disadvantage rural and remote areas through per capita allocations. There was support for some form of rural proofing of policy development.

Current Practice in Service Provision in Rural and Remote Areas

There were a **variety of strategies employed in order to minimise the negative effects of rurality and remoteness**. These involved the use of shared premises, home visits and meetings in public places. Mobile services and internet based services existed but were uncommon. There was some hope that internet based services would provide an effective balance to existing services. Telephone contact with clients was used as an interim measure in counselling services where face-to-face contact was not possible. It was identified that some agencies provided transport to bring clients into a central base.

Emerging and Potential Practice in Service Provision in Rural and Remote Areas

The use of highly trained professional drugs workers was considered an expensive form of delivery of services to rural and remote drug users. Many drug users in rural and remote areas may not require supervision or support from such highly trained and paid staff. There was interest in the **idea of training up staff from other disciplines** who were sited in rural and remote areas to take on low level support duties.

There was support for the idea of **rural weighting payments** or enhanced salaries to staff willing to live and work in rural and remote areas.

Services could provide a more rounded package of care through **better joined up working.** Specifically this related to the inclusion of a broader range of agencies in single shared assessment protocols and co-location. The perceived need for some services to maintain confidentiality was seen as an unnecessary barrier to effective joint working.

Conclusions

Many of the issues raised throughout the research were not peculiar to service provision for drug users in rural and remote communities. They were either issues which were common to drug services regardless of the nature of the area they covered, or issues which were common to providers of services in rural and remote areas regardless of the nature of the service they provided. Although a range of different types of rural and remote areas were selected, the findings from the case study areas were very similar.

The major intractable issues associated with the provision of services in rural and remote areas are summarised above. These revolved around the following: community **denial** of drug problems; limited **financial resources**; **higher unit costs**; lack of **availability of premises**; limited **level and range of services**, e.g. needle exchange; inconsistent availability of **GPs** and **pharmacists** willing to support drug users; difficulties maintaining **anonymity** and **confidentiality**; problems related to **travel** and **transport**; and difficulties in staff **recruitment** and retention.

Strategies to minimise the negative effects of these circumstances were well formed and embedded in everyday practice in some areas. Positive examples of planning and delivering client centred, needs led services include the following: range of **staff skills**; **flexibility** within agency procedures, **partnership working**; willingness to **innovate**, appropriately **devolved decision** making and **acceptance** of the factors that cannot be changed in the short term.

Appendix 2: Qualitative research study – interview schedules

Questions for Service Commissioners

1. What are the issues associated with commissioning services for drug users in rural and remote areas?
2. What impact do the following have on the commissioning of services?
   - additional travel costs
   - the high level of unproductive time spent travelling
   - the duplication of facilities
   - need for additional time for management
   - need for additional time for networking
   - the effect of national funding allocation formulae
3. What other factors related to rurality and remoteness positively or negatively affect the commissioning of services to drug users in your area?
4. What methods have you employed to minimise the negative impact of rurality and remoteness on the commissioning of services?
5. How can these issues be resolved and/or further minimised with the support of other agencies?
6. What effect has the implementation of Community Planning had on the commissioning of services to drug users in your area?
7. Can you tell us about any examples of effective and/or innovative approaches employed locally?

Questions for Service Providers

1. What are the issues in providing services for drug users in rural and remote areas?
2. What impact do the following have on the provision of services?
   - additional travel costs
   - the high level of unproductive time spent travelling
   - the duplication of facilities
   - need for additional time for management
   - need for additional time for networking
   - the effect of national funding allocation formulae
   - attracting suitably qualified and experienced staff
   - maintaining the anonymity of service users
   - maintaining community confidence in mainstream provision
   - networking beyond the local area
3. What other factors related to rurality and remoteness positively or negatively affect the provision of services to drug users in your area?
4. What methods have you employed to minimise the negative impacts of rurality and remoteness on service delivery?
5. What effect has the implementation of Community Planning had on the delivery of services to drug users in your area?
6. What factors affect the availability and quality of your services from the perspective of the service users?
7. How can these issues be resolved and/or further minimised with the support of other agencies?
8. Can you tell us about any effective and/or innovative approaches employed by local agencies?

Questions for Service Users

1. How does rurality/remoteness affect your ability to get access to drug related services?
2. What sort of impact, if any, do the following things have on your ability to get access to services?
   - The distance between your home and the where the services are
   - The cost of transport to services
   - The quality of public transport.
   - The kind of places where services are based
   - The views of others in the community
   - Maintaining anonymity within your community
   - Knowing about the sorts of services which exist
3. Are there other things which we should bear in mind in relation to the effects of rurality/remoteness on your ability to get access to services
4. What do the services do to get around these sorts of things?
5. What do you do to get around the effects of these things
6. What else could services do to get around the effects of these things?
7. What else could you do to get around the effects of these things?

Appendix 3: Qualitative research study – list of interviewees

The EIU and the researchers would like to gratefully acknowledge the time and insight of the service commissioners and providers named below and the anonymous drug users who contributed to this research.

Jim Parker, Joint Coordinator, Dumfries & Galloway Alcohol a& Drug Action Team

John Waterhouse, Consultant Psychiatrist, Cameron House

David Strang, Chief Constable, Dumfries & Galloway Police

Kath Lord-Green, Service Manager, Turning Point Scotland

Angela Roberts, Manager, Alcohol & Drugs Support South West Scotland

Innes McMinn, Arrest Referral Scheme Coordinator, Apex Scotland

Barbara McArthur, Community Development Worker, Dumfries & Galloway ADAT

John Miller, Needle Exchange Outreach Worker, Cameron House

Hugh Robertson, Manager & **Julie Shaw**, Development Worker, Sunrise Project

Mark Frankland & **Yvonne Kilpatrick** First Base Agency

Mark Blount, Pharmacist, Blount Pharmacy

Kevin Wield, Team Leader, Cranstoun Dumfries & Galloway

John Edwards, Coordinator, Lochbank Trust

Suzy Calder, Substance Misuse Strategy & Implementation Officer, Highland DAAT

Armrget Kaur, Drug and Alcohol Coordinator, Highland Social Work

Dougie Montgomery, Substance Misuse Coordinator, NHS Highland

Lynn Millar, Senior Social Worker (Drugs Misuse), Highland Social Work

Sheena Stubbs, Charge Nurse, Osprey House, NHS Highland

Dorothy MacLennan, Chair, Alness Mothers Against Drugs

Bob MacKinnon, Highland Well-Being Alliance

Ivor Bisset, Development Worker, Alness Mothers Against Drugs

Jeanette Laird Measures, CPN (Addictions), Skye and Lochalsh, NHS Highland

John Sword, CPN (Addictions), Lochaber, NHS Highland

Alastair McDonald, Unit Manager Progress2Work, Apex Scotland

Peter Mulvey, NOF Employability Fundraiser

Lorraine McLeod, Cranstoun (SPS aftercare), Team Leader

Annie Novak, CPN (Addictions), Badenoch & Strathspey, NHS Highland

Aileen Featherstone, Substance Misuse Officer, Lochaber, Highland DAAT

Liam Wells, Stirling Drugs Forum Officer, Stirling Council

Ann Pinkman, Social Work Criminal Justice Manager, Stirling Council

Colin Bennie, Service Manager, Community Alcohol and Drugs Service

Jackie Johnstone, Manager & Liz Harrison, Support Worker, Signpost Forth Valley

Janine Rennie, Manager, Counselling and Support Service for Drugs and Alcohol

Dr Deborah Zador, Consultant Psychiatrist, Community Alcohol and Drugs Service

Rebecca Litts, Community Worker (Mental Health), Stirling Council

Ken Scott, Manager, Forth Dimensions

Gail Bowen, Unit Manager, Apex Scotland Forth Valley

Michael Grassam, Social Worker, Fast Track Service, Stirling Council

Sally Bartkowiack, Community Psychiatric Nurse, Orkney Community Mental Health Team

Janet Burgon, Community Psychiatric Nurse, Orkney Community Mental Health Team

Mike Craigie, Alcoholics Anonymous Orkney, Member and spokesperson.

David Dawson, Police Constable, Northern Constabulary

Eric Gilbertson, Administrative Assistant, Orkney Alcohol Counselling and Advisory Service.

Jon Humphreys, Service Manager, Orkney Island Council Criminal Justice

Martin Kerrigan, Manager, Orkney Island Council Mental Health and Substance Services

Tony Miller, Social Care worker (Substance Misuse), Community Mental Health Team

Jackie Platt, Community Accommodation Officer, Orkney Island Council Housing Division

Juliet Annesley-Gamester, Principal Housing Officer, Orkney Island Council Housing Division

Karyn Tait, Substance Misuse Development Officer, Orkney Drug Alcohol and Smoking Action Team

Yvonne Allan, Development Worker, Stirling Family Support Service

Appendix 4: Remit and membership of reference group

The remit of the group was 'to examine and identify the factors that influence effective commissioning, planning and delivery of integrated care for drug users in rural and remote areas; and to offer information and advice to support the EIU review'.

The group had representation from the Scottish Executive (Substance Misuse Division, Effective interventions Unit and Environment and Rural Affairs Department), and the statutory and voluntary sector health, substance use, criminal justice and social work services fields:

Stuart Anderson, User Involvement Manager, Scottish Drugs Forum

Kirsteen Bristow, Project Leader, Big River Project, Borders

Suzie Calder, Drug and Alcohol Action Team Co-ordinator, Highland Drug and Alcohol Action team

Sam Coope, Senior Researcher, Effective Interventions Unit

Moira Cossar, Team Leader, Cameron House, Dumfries

Karin Dowell, Administrative Officer, Effective Interventions Unit

Donna Easterlow, Senior Researcher, Environment and Rural Affairs Department

Emma Harvey, Unit Manager, Effective Interventions Unit

Dr Charles Lind, Associate Medical Director, Ayrshire and Arran Primary Care Trust

Shona MacLeod, Substance Misuse Co-ordinator, Western Isles Alcohol, Drugs and Smoking Action team

David McCue, Development Officer (Integrated care), Effective Interventions Unit

Steve Pavis, Programme Development Manager (Drug Misuse), ISD Scotland

Patricia Russell, Head of Unit, Effective Interventions Unit

Jim Stephen, Head of cross-cutting team, Substance Misuse Division

Anne Stonebridge, Drug and Alcohol Development Officer, Aberdeenshire Alcohol and Drug Action team

Liam Wells, Substance Development Officer, Forth Valley Substance Action team

George Wilson, Area Manager, Cranstoun Drug Services (Scotland)

Maggie Wright, Rural Policy Manager, Scottish Executive

Appendix 5: Consultation workshops: summary report

Introduction

In October 2004, the Effective Interventions Unit (EIU) held two consultation workshops in Stirling (7 October) and Inverness (19 October) on *Integrated Care in Rural and Remote Areas*. Seminars included presentations on integrated care and topics specifically related to rurality, but the main activities were workshop discussions on key questions led by facilitators. Those with experience of working with drug users in rural and remote areas were targeted to share their experience with us. 64 people in total from a range of service providers and agencies attended the events; 22 in Stirling and 42 in Inverness.

Background

In 2002, the EIU published *Integrated Care*[5] which sets out the rationale for integrated care; effective practices on planning, designing and delivering integrated care; and offers practical guidance and tools. In the course of developing *Integrated Care* and subsequent guides on *Needs Assessment*[6] and *Advocacy*[7], we identified some specific issues for rural areas.

We are now examining in more detail the key factors that influence the effective commissioning, planning and delivery of integrated care for drug users in rural and remote areas. In line with our usual practice, we undertook a number of evidence gathering exercises. These include a literature review, a qualitative research study involving service users, commissioners and providers, consultation workshops and advice and information from a working group drawn form health, social care and the voluntary sector.

Structure of the Seminar Summary Report

This summary report sets out the main points raised in the discussions. Focal points are highlighted in bold to reflect their significance and we have attempted to categorise common themes. Feedback from discussions at both seminars, including the various workshops, has been amalgamated.

The main seminar report provides a more comprehensive record of workshop discussions based on key questions posed and suggests ways to develop an integrated care approach for drug users in rural and remote areas.

Copies of the main seminar report and PowerPoint presentations used in both seminars can be viewed and downloaded from the EIU website: www.drugmisuse.isdscotland.org/eiu. Alternatively, paper copies can be requested by contacting EIU@scotland.gsi.gov.uk by email or telephoning 0131 244 5117.

Aim of seminars

The aim of the seminars was to explore the key issues and factors associated with the commissioning, planning and delivery of integrated care for drug users in rural and remote areas; and to identify, where possible, practical examples of good/innovative approaches.

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[5] *Integrated Care for Drug Users: Principles and Practice*, Effective Interventions Unit, 2002
[6] *Needs Assessment: A Practical Guide to Assessing Local Needs for Services for Drug Users*, Effective Interventions Unit, 2004
[7] *Advocacy for Drug Users: A Guide*, Effective Interventions Unit, 2004

Specific issues and other factors that affect treatment, care and support for drug users

Positive Issues/Factors

- The country and small towns and villages are a **nice place to stay**.
- Close knit and **supportive** of traditions and values and all its citizens.
- **Good socio-economic factors** imply less crime and lower unemployment.
- Unique opportunities, e.g. **private sector** employers willing to employ difficult folks.
- Conflicting perceptions, e.g. less drugs available or area will help people stay clean.
- Travel complexities can help service users **focus** better on recovery.
- Range of specialist services, e.g. needle exchange are being expanded.
- There is a resource of **knowledge** and **experience** within current resources.
- Partnerships **working** easier to develop and sustain due to low numbers of services.
- **Trust** and professional integrity in an setting where people know others' business.
- More **personalised 1-1 care** due to lower staff case loads.
- Increased **flexibility** in delivering services: taking services to customers.
- Increased staff time can lead to **multi-tasking**.

Negative Issues/Factors

- Cultures and morals - **denial** and unwillingness to accept drug-related problems.
- **'Zero tolerance'** attitudes discourage harm reduction approaches.
- Alcohol is tolerated but drug users are **stigmatised** and associated with **incomers**.
- High levels of **disposable incomes are** often spent rapidly on drink and drugs.
- **Poor transport** links.
- **Service accessibility**, compounded by weather, distance, time, transport and costs.
- Difficult for drug users to '**move on'** due to **discernment** with past reputation.
- General rises in crime creates **negative attitudes** towards drug services and users.
- Current **funding formula** are based on population sizes **no rural proofing.**
- **Adverse cost implications** in delivering services to few people.
- Unrealistic to provide **equitable** services similar to those in urban areas.
- Limited service **range**, especially specialist services, culminating in mainland access.
- A lack of affordable and/or suitable **accommodation**.
- **Supervised dispensing** regulations have an adverse effect on many service users.
- Maintenance of **confidentiality** and **anonymity**.
- Staff working **out with limitations** and/or professional boundaries.

The viability of an integrated care approach in light of identified factors

Participants generally felt that, in principle, **yes**, integrated care is viable. However, a number of particular factors affecting the practical development and implementation of integrated care in rural and remote areas were identified. These include:

- All key stakeholders and services must be fully **connected**, including outlying areas.
- **Territorialism** must be overcome and real partnership working must prevail.
- Services must demonstrate more **flexibility** and adopt a holistic user led approach.
- **Co-location** may help, although some clients oppose this model.
- Use **levers**, e.g. Joint Future agenda and Community Health Partnerships.

Impact identified factors have on the ability of agencies/service providers to commission, plan and deliver integrated care

- Small populations **limit** the possible range of services.
- Staffing **skill shortage** in many rural areas.
- An integrated care approach is more **expensive**!
- **Equitable** services across whole DAAT areas cannot be achieved.
- Lack of **housing** opportunities adversely affect the 'moving on' stage.

Requirements to plan and deliver integrated care

Below is a summary of the key requirements identified from the perspectives of hypothetical 'commissioners' and 'service providers'. Participants highlighted that the same requirements are applicable to both commissioners and service providers; and to both urban areas and rural and remote areas.

Commissioners

- Think 'outside the box' and focus on positive local **innovations**.
- Promote and manage **change** and continuous **improvement** – involve stakeholders.
- Pool or align and manage **budgets**.
- Submit **funding** bids for joint services to national and local funding agencies - avoid duplication of bids, where possible.
- Encourage, design and commission **joint services**.
- Ensure **exit strategy** for non recurring short term funding allocation.
- Conduct ongoing **needs assessment** to determine aggregated client needs.
- **Review** services - establish provision, gaps, duplication, results including successes.
- Develop links with **private sector** regarding joint funding, empolyability.
- **Consult** the local community, especially hard to reach people including service users.
- Agree shared **outcome measures, mission statement, principles and actions.**
- Ensure robust **monitoring** and **evaluation** systems to measure results.
- **Observe** differential between theoretical and operational integrated care system.
- Consider sharing facilities and/or **co-location**.
- Develop and implement a **single shared assessment** tool and process.
- Invest in **training and development** to attract/retain staff and improve service quality.

Service Providers

- **Appropriate funding** commitments, both nationally and locally.
- Commitment from partners to provide **joint** financial and people **resources**.
- **Good networking** – know what others are providing, and can and cannot provide.
- Negative cultural and organisational **attitudes** need to be challenged and shifted.
- Be realistic and take **time** to plan and implement new approaches to service delivery.
- Provide drug-related **awareness** to the local community using joint approaches.
- Ensure better provision for **diverse groups**, e.g interpretors, staff training.
- Increase **support** to voluntary service providers, e.g. on funding, tender proposals.
- Improved **monitoring** and **evaluation** systems and increased **accountability.**
- Maintain **user focus** – plan and deliver services to meet client, not provider, needs.
- Availability and accessibility of **'fit for purpose' premises** with shared access.

- Adopt a **family centred** approach – take account of influencing factors.
- Agree a joint multi-agency **mission statement** using common language.
- Improve **links** between specialist services and between specialist and generic services.
- **Pilot** new service(s), e.g. Locality Clinic, ensuring monitoring and evaluation.
- **Co-ordination** of planning and delivery of care (care management) is crucial.
- Maximise **IT** use, e.g. complementary web-based interventions and shared **databases**.
- Agree joint **information sharing** protocols.
- Joint **training and development** – develop competent/multi-skilled staff workforce.
- Ensure **flexibility**, e.g. outreach, mobile services, home visits, use of internet.
- Learn from **experience** and innovations from other areas – tailor locally.

Current practices to develop an integrated approach to treatment, care and support services

Below are anonymised examples of current good and/or innovative practices in rural and remote areas.

- Formal integrated care systems have been developed and **implemented**.
- **Amalgamation of alcohol and drug services** and related planning frameworks.
- Services planned and delivered to reflect **local cultures** and traditions.
- **Co-location** - health, SW/CJS including prisons, generic services, voluntary sector.
- Development of locally tailored **information literature** for service users and others.
- Creation of a **shared care** substitute prescribing clinic with GP input.
- Joint community **mental health and addiction** (dual diagnosis) services.
- Creation of **local telephone help lines**.
- **Local events**, conferences, seminars, workshops, skills exchange.
- Joint **training and development** opportunities, e.g. prison based secondments.
- Proposal to Scottish Executive to pilot **internet based treatment and support**.
- Establishment of **user involvement** groups.
- Commissioning of **local research**.

Conclusion

Some of the key points highlighted in this report are applicable to non rural areas. Equally, some of the features outlined are not exclusive to drug users; they affect other community care groups and in some cases, the entire local population, albeit to varying degrees.

The consultation workshops have proved invaluable to elicit the views of a large number of key stakeholders involved with planning, commissioning, delivering and evaluating services for drug users in rural and remote areas. The findings in this report reinforce the key messages identified during the EIU commissioned qualitative research study on 'Service Provision for Drug Users in Rural and Remote Areas' which was completed in December 2004. An executive summary of this research is also available on the EIU website. Furthermore, this report embraces many of the findings from published literature relating to service provision for this client group in rural and remote areas.

Appendix 6: Participants at consultation workshops

Stirling seminar – 7 October 2004

Kate Balfour	Crannog Service, Aberlour Childcare Trust
David Bell	Argyll & Clyde Health Board
Sally Brown	Bridge Addiction Service
John Cameron MBE	Ayrshire and Arran Trust
Frances Donachie	NHS Ayrshire & Arran
Lorraine Gillies	Cyrenians
Sarah Harris	Dumbarton Joint Hospital
James Hunter	SACRO Services N. & S. Lanarkshire
Bill Kerr	Cyrenians
Maurice Kilday	Borders DAAT
Angus Mackay	Western Isles NHS Board
Lorna McIntyre	NHS Ayrshire & Arran Addiction Services
Garry Morgan	Cowal Council on Alcohol & Drugs
Jo Murray	Bridge Addiction Service
Julie Murray	Borders DAAT
Anne Pinkman	Stirling Council Criminal Justice Service
Janine Rennie	Drugs/Alcohol Counselling Support Service
Ian Smillie	Perth and Kinross DAAT
Iain Turnbull	Angus DAAT
Liam Wells	Forth Valley SAT
Giles Wheatley	Cowal Council on Alcohol and Drugs
Elaine Wilson	Lloyds TSB Foundation for Scotland

Inverness seminar – 19 October 2004

Agnes Aburrow	Highland Council - Addiction Team
Lisa Barnetson	Highland Drug and Alcohol Action Team
Fiona Bonnar	NHS West Lothian
Janet Burgon	NHS Orkney
Elaine Chalmers	Children 1st
Grahame Cooper	NCH (Scotland) Gallog Project
Karin Dowell	Effective Interventions Unit
Audrey Drysder	Advocacy North East
Elaine Fetherston	Highland Drug and Alcohol Action Team
Iver Forsyth	Highland Council
Nikki Fraser	BLAST Drug Project
Lynne Geddes	Moray Council on Addictions
John Glenday	NHS Highland
Elspeth Grainger	NHS Highland
David Greenwell	Lomond & Argyll Primary Care NHS Trust
Dawn Griesbach	Effective Interventions Unit
Brian Grieve	Tayside Drug Problem Service
Eileen Hamilton	Scottish Prison Service
Sandy Hamilton	Scottish Prison Service
Emma Harvey	Advocacy Safeguards Agency
Gill Hession	Shetland Community Drugs Team
Jeanette Laird-Measures	NHS Highland
Anne MacDonald	Highlands and Islands Enterprise
Lorraine MacLeod	Cranstoun Drug Services
David McCue	Effective Interventions Unit
Alistair McDonald	APEX Scotland

Shona McLeod	Western Isles DAAT
Dougie Montgomery	NHS Highland
Donna Munro	Blast Drug Project
Jim Neville	Community Mental Health Team
Debbie O'Hara	Highland Council
Donna Petrie	Highland Progress2Work Team
Bob Pollock	Northern Constabulary
Tam Reardon	NCH Scotland Gael Og Mentoring Project
Mary Rhind	Highland Adult Literacies
Patricia Russell	Effective Interventions Unit
Nina Semple	Apex Scotland
Rab Sneddon	West Lothian Drug and Alcohol Service
Anni Stonebridge	Aberdeenshire ADAT
John Sword	Community Mental Health Service
Helen Tripp	Highland Progress2Work Team
Eric Watson	Barnardos Youth Drug Initiative

Appendix 7: Useful Resources

Some useful web-based resources focussing on rural areas and rural issues, include:

The **Scottish Executive Environment and Rural Affairs Department (SEERAD)** is responsible for advising Ministers on policy relating to agriculture, rural development, food, the environment and fisheries, and for ensuring the implementation of those policies in Scotland. The Department also supports and promotes the agricultural and biological science base in Scotland. Further information is available on the SEERAD web pages at: http://www.scotland.gov.uk/About/Departments/ERAD

The **Rural Community Gateway** is a Scottish Executive initiative, designed and developed by online community specialists Sift, with content and editorial services provided by the Rural Communities Team of the Scottish Council for Voluntary Organisations. The Rural Community Gateway's forum encourages networking with contacts in the rural community and discussion of common issues faced by those living and working in rural Scotland. The site also provides news on rural issues and information materials. There is a documents library containing: consultation papers, conference presentations and research reports on various rural issues and programmes. A search facility is available to find the documents you want. The Gateway also offers links to other websites. See: http://www.ruralgateway.org.uk/index.html

Scottish Enterprise undertakes a wide range of activities across rural areas of Scotland to encourage enterprise, improve skills and infrastructure and develop business. The **Scottish Enterprise Rural Group was established in 1999,** to ensure that Scottish Enterprise plans and develops vital responses to rural issues, in line with its overall strategy of building a Smart Successful Scotland. There are representatives from the Scottish Executive on the group (both the Enterprise and Lifelong Learning and Environment and Rural Affairs Departments. Further information, including more details on the remit of the group and case study examples form rural areas are available at: http://www.scottish-enterprise.com/sedotcom_home/services-to-the-community/rural.htm

The **Countryside Agency**, in England, acts as a rural advocate, expert adviser and independent watchdog, with a particular focus on disadvantage. Further information on the work of the agency, including agency publications, is available at:http://www.countryside.gov.uk/WhoWeAreAndWhatWeDo/Index.asp

The **Arkleton Institute** (formerly Centre) **for Rural Development Research** was established in 1995 to research issues of rural change and development in Europe, including rural policy and practice. It brings together researchers from a number of Departments at **the University of Aberdeen and from the Arkleton Trust**. The Institute has developed an extensive programme of interdisciplinary social science research, has built strong links with researchers in Europe and North America and has worked closely with rural communities, policymakers and practitioners. See: http://www.abdn.ac.uk/arkleton/

The **Institute of Rural Health's "Database of Good Practice in Rural Health and Wellbeing**" is funded and supported by Defra (Department for the Environment, Food and Rural Affairs). Its aim is to provide an easily searchable website for organisations looking to improve service delivery and access to care for people living in rural communities. The database disseminates examples of good practice on a national basis and can be used to encourage networking and development of links between different organisations involved in healthcare both from the statutory and the voluntary sector. Further information on the Institute of Rural Health, and the database of good practice, is available at: http://www.ruralhealthgoodpractice.org.uk/welcome.htm

Another Institute of Rural Health initiative is the **Rural Proofing for Health project.** This is being funded by the Department of Health and Defra. Collaborators on the project have included rural Primary Care Trusts across England.

The final aim of the project is to develop a rural proofing toolkit for use by Primary Care Trusts and other agencies involved in the delivery of health care. **The toolkit will act as a guide for organisations to enable them, when planning policy, to take account of the needs of people living in rural communities.** See: http://www.ruralhealthforum.org.uk/proofing.htm

Appendix 8: References

Scottish Executive Publications

Rural Scotland: A New Approach (2000)

Annual Rural Report 2004 (2004)

The Scottish Executive Urban Rural Classification 2003-2004 (2004)

A Partnership for a Better Scotland: partnership agreement (200…..

Services in Rural Scotland

Implementing Services in Rural Scotland : a progress report (2002)

These publications should all be available on the Scottish Executive website: http://www.scotland.gov.uk/

Effective Interventions Unit Publications

I*ntegrated Care for Drug Users: principles and practice* (EIU October 2002)

Needs assessment: A practical guide to assessing local needs for services for drug users (EIU….. 2004)

Advocacy for Drug Users: a Guide (EIU July 2004)

Working with Young People: a profile of projects funded by the Partnership Drug Initiative (EIU April 2004)

An Evaluation of the first three Information Sharing Workshops for Drug and Alcohol Action Teams (DAATs) (EIU June 2004)

Other publications

Alcohol Focus Scotland. (2004) *A report on funding.* Glasgow: Alcohol Focus Scotland.

Connexions and Countryside Agency (2003) *The implementation of Connexions in rural areas A good practice guide.* The Countryside Agency.

Countryside Agency (2003) *Delivering services to children and families in rural areas: The early lessons from Sure Start.* The Countryside Agency.

Cragg, A (2003) *Drugs in Rural Areas: Qualitative research to assess the adequacy of communications and services.* Home Office.

Currie C, et al (2005) '*Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) National Report - Smoking, Drinking and Drug Use Among 13 and 15 year olds in Scotland in 2004*' TSO (The Stationery Office) Edinburgh

End Child Poverty, NCH and the Forum for Rural Children and Young People (2003) *Rural Child Poverty Briefing Paper.* London, NCH and Forum for Rural Children and Young People,

Forsyth AJ, Barnard M. (1999) *Contrasting levels of adolescent drug use between adjacent urban and rural communities in Scotland*. Centre for Drug Misuse Research, University of Glasgow, Scotland, UK. in Addiction. Nov; 94(11):1707-18.

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Martin C et al (2005) *'Scotland's People: Results from the 2003 Scottish Household Survey Annual Report'.* Scottish Executive, Edinburgh

Sale, S. (2004) *Rural Drug Treatment and Rehabilitation Programmes: A scoping Project Highlighting the Unique Problems in Access and Treatment in Rural Areas with Special Reference to the South of Scotland,* unpublished.

Solutions Strategy Research facilitation (2003) *Drugs Stigma Research* – Report prepared for COI Communications on behalf of the Home office and the Department of Health.

Shucksmith M, (2000) Exclusive Countryside? Social Inclusion and Regeneration in Rural Areas. Joseph Rowntree Foundation.

Appendix 9: Scottish Executive Urban Rural Classification: Statistics by Local Authority and Health Board

The following tables show the percentage of the population classed as urban, rural and remote, by local authority and health board area.

Table 1: Scottish Executive 6-Fold Urban Rural Classification 2003-2004, by Local Authority

Local Authority	6-Fold Urban Rural Classification					
	Large Urban Areas	Other Urban Areas	Accessible Small Towns	Remote Small Towns	Accessible Rural	Remote Rural
Aberdeen City	93.0	0.0	5.0	0.0	2.0	0.0
Aberdeenshire	0.0	18.2	16.8	10.0	39.0	16.0
Angus	7.5	53.8	12.1	0.0	25.9	0.6
Argyll & Bute	0.0	18.0	0.0	29.9	12.1	39.9
Clackmannanshire	0.0	53.7	31.0	0.0	15.3	0.0
Dumfries & Galloway	0.0	28.4	17.9	4.8	28.2	20.8
Dundee City	99.5	0.0	0.0	0.0	0.5	0.0
East Ayrshire	0.0	36.3	35.7	2.6	23.1	2.3
East Dunbartonshire	59.1	26.9	7.1	0.0	6.8	0.0
East Lothian	24.5	0.0	33.7	14.0	16.7	11.1
East Renfrewshire	86.0	0.0	9.3	0.0	4.7	0.0
Edinburgh, City of	95.9	0.0	2.8	0.0	1.4	0.0
Eilean Siar	0.0	0.0	0.0	30.4	0.0	69.6
Falkirk	0.0	85.7	4.6	0.0	9.6	0.0
Fife	0.0	62.1	17.3	0.0	20.6	0.0
Glasgow City	99.6	0.0	0.0	0.0	0.4	0.0
Highland	0.0	21.1	10.1	18.0	14.1	36.7
Inverclyde	0.0	87.4	4.8	0.0	7.8	0.0
Midlothian	0.0	66.2	15.0	0.0	18.8	0.0
Moray	0.0	24.0	32.6	0.0	34.0	9.4
North Ayrshire	0.0	70.5	17.2	0.0	8.5	3.7
North Lanarkshire	65.0	15.7	10.9	0.0	8.4	0.0
Orkney Islands	0.0	0.0	0.0	32.2	0.0	67.8
Perth & Kinross	1.2	32.2	20.5	0.0	34.9	11.3
Renfrewshire	75.3	9.8	9.5	0.0	5.4	0.0
Scottish Borders	0.0	27.1	19.9	4.8	39.4	8.7
Shetland Islands	0.0	0.0	0.0	31.1	0.0	68.9
South Ayrshire	0.0	67.9	4.1	6.2	19.0	2.8
South Lanarkshire	22.1	56.2	9.4	0.0	12.0	0.3
Stirling	0.0	52.3	9.2	0.0	33.4	5.1

West Dunbartonshire	49.6	48.9	0.0	0.0	1.5	0.0
West Lothian	0.0	70.1	14.2	0.0	15.7	0.0
Scotland	**39.0**	**29.1**	**10.4**	**2.8**	**13.1**	**5.7**

Table 2: Scottish Executive Urban 6-Fold Rural Classification 2003-2004, by Health Board Area

Health Board	6-Fold Urban Rural Classification					
	Large Urban Areas	**Other Urban Areas**	**Accessible Small Towns**	**Remote Small Towns**	**Accessible Rural**	**Remote Rural**
Argyll & Clyde	35.3	36.3	6.1	6.5	7.1	8.7
Ayrshire & Arran	0.0	58.5	19.3	2.8	16.5	3.0
Borders	0.0	27.1	19.9	4.8	39.4	8.7
Dumfries & Galloway	0.0	28.4	17.9	4.8	28.2	20.8
Fife	0.0	62.1	17.3	0.0	20.6	0.0
Forth Valley	0.0	69.9	10.6	0.0	17.9	1.6
Grampian	37.5	11.8	14.7	4.3	23.2	8.5
Greater Glasgow	92.4	3.4	2.5	0.0	1.6	0.0
Highland	0.0	21.1	10.1	18.0	14.1	36.7
Lanarkshire	39.5	39.7	9.5	0.0	11.1	0.2
Lothian	58.1	21.2	10.0	1.6	7.9	1.3
Orkney	0.0	0.0	0.0	32.2	0.0	67.8
Shetland	0.0	0.0	0.0	31.1	0.0	68.9
Tayside	39.8	26.2	10.5	0.0	19.5	4.1
Western Isles	0.0	0.0	0.0	30.4	0.0	69.6
Scotland	**39.0**	**29.1**	**10.4**	**2.8**	**13.1**	**5.7**

Scottish Executive Effective Interventions Unit Dissemination Policy

1. We will aim to disseminate the right material, to the right audience, in the right format, at the right time.

2. The unit will have an active dissemination style. It will be outward looking and interactive. Documents published or sent out by the unit will be easily accessible and written in plain language.

3. All materials produced by the unit will be free of charge.

4. Material to be disseminated includes:

- Research and its findings
- Reports
- Project descriptions and evaluations
- Models of services
- Evaluation tools and frameworks for practitioners, managers and commissioners.

5. Dissemination methods will be varied, and will be selected to reflect the required message, and the needs of the target audience.

These methods are:

- Web-based – using the ISD website 'Drug misuse in Scotland' which can be found at: http://www.drugmisuse.isdscotland.org/eiu/eiu.htm

- Published documents – which will be written in plain language, and designed to turn policy into practice.

- Drug Action Team channels – recognising the central role of Drug Action Teams in developing effective practice.

- Events – recognising that face-to-face communication can help develop effective practice.

- Indirect dissemination – recognising that the Unit may not always be best placed to communicate directly with some sections of its audience.

6. This initial policy statement will be evaluated at six-monthly intervals to ensure that the Unit is reaching its key audiences and that its output continues to be relevant and to add value to the work of those in the field.

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