

DAT ASSOCIATION REMOTE & RURAL COMMUNITIES SUB-GROUP

Wednesday 23rd February 2005 @ 1000

held at Abbey Business Centre, 83 Princes Street, Edinburgh

Present:

Anni Stonebridge, Aberdeenshire ADAT [Chair]
Linda Bates, DAT Association Administrator [minutes]
Sharon Flynn, Ayrshire & Arran ADAT
Gaynor Jones, Orkney DASAT
Martin Kerrigan, Orkney DASAT
Angus MacKay, Western Isles ADSAT
Davie McCue, Effective Interventions Unit, Scottish Executive
Catriona Oxley, Shetland DAAT
Fraser Ross, Moray DAAT
Ian Smillie, Perth & Kinross DAAT
Valerie Tallon, Lanarkshire ADAT

Apologies:

Grace Ball; Margaret Birrell; Suzy Calder; Liz Coates; Eric Corstorphine; Grahame Cronkshaw; Jackie Davies; Pat Greenhough; Maggie Jamieson; Rita Keyte; Maurice Kilday; Marion Logan; Stevie Lydon; Joni McArthur; Hannah Muldoon; Julie Murray; Jim Parker; Donna Reid; Patricia Russell; Ruth Shepherd; Hilary Smith; Karyn Tait; Iain Turnbull; Liam Wells

1. Welcome

Anni Stonebridge welcomed all to the meeting, and explained that she was deputising for Liam Wells, who (along with several other members) had been unable to attend today's meeting due to transportation problems after recent heavy snowfalls.

2. Apologies

Apologies had been received from those listed above.

3. Minutes of Previous Meeting [29th September 2004]

The minutes of the previous meeting were accepted as an accurate record.

4. Matters Arising

With reference to the proposed web forum (item 7, page 3), Anni reported that she has recently been in touch with Graham Lockhart of ISD, who has suggested that any forum be broadened to include all DATs and not just those from Rural and/or Remote areas. A moderator would be required to oversee content; it was suggested that the best person for this might be an Information Officer from one of the local DATs. Linda shall send an email to all DAT officers, asking for expressions of interest in this post.

action: LB

It was also suggested that in addition to an ongoing web forum, a weekly email digest of current topics being discussed may be of interest and/or benefit to officers; this could be compiled by the moderator and distributed to interested parties.

5. Internet Approaches to Treatment - update

Anni Stonebridge gave an update on her ongoing research work surrounding the possibility of running a pilot study offering support to drug users over the internet. This would be in collaboration with WIRED (an online treatment and research organisation), developed from a model currently used in gambling therapy. It is intended that the service offered would enable services to offer their clients an additional option in terms of communication, offering some treatment and informational resources to support a link between the service and client, using webcams and voice/text links.

Anni has held discussions surrounding these issues (including a seminar held last September in Stirling); a proposal has been sent to Colin Cook at the Scottish Executive for funding a national pilot, and a decision is due to be made imminently .

To date, eight DATs have expressed an interest in participating in any pilot scheme; should national funding not be approved, it may be possible for local DATs to secure funding for their own area from other sources (e.g. in Aberdeenshire, Barnados have stated that they would be keen to develop web-based support for their clients and have secured some funding from the Changing Children's Services Fund). Shetland DAAT have already put in a bid for collaborative work with WIRED, as part of their future drug treatment funding allocation.

It was agreed that internet support for a wide range of clients may also have positive implications for employability issues.

6. Integrated Care in Rural and Remote Areas: EIU Progress Update

Background

Davie McCue, Development Officer (Integrated Care) of the Effective Interventions Unit [EIU] at the Scottish Executive, presented a progress report on the number of evidence gathering exercises which aim to examine the key issues that influence the effective commissioning, planning and delivery of integrated care in rural and remote areas. The papers presented were: 1) Integrated Care in Rural and Remote Areas: Summary Report of Consultation Seminars; and 2) Service Provision for Drug Users in Rural and Remote Areas of Scotland: Qualitative Study: Summary Report [attached at **Appendices 1 and 2** – N.B. main reports are available from the EIU on request]. These methods, in conjunction with a literature review, web-based survey, service mapping and contribution from a reference group, will contribute to a guide document.

Outline of Guide

The guide is presently being drafted and is expected to be published in April 2005. The present draft is split into six chapters: 1) What do we mean by rural Scotland; 2) The scale and nature of drug misuse; 3) Issues and factors that influence services in rural areas; 4) Current practice in service provision; 5) Emerging and potential approaches to delivering effective integrated care; and 6) Key principles and elements of effective practice. Whilst seeking to underline issues and solutions which are specific to rural areas, the guide will acknowledge that not all the factors highlighted are unique to rural and remote areas, or, indeed, to the drug and alcohol user care

group. It is intended that the guide will prove useful to a range of stakeholders to develop and help improve practice at local level, as well as flagging up potential policy development topics.

Literature review

Davie undertook a literature review, which included a broad search and analysis of about sixty publications in total. These varied in terms of their direct relationship to drug misuse and associated service provision in rural areas; there are more sources of literature on this theme in England and internationally than in Scotland. In addition to published research and locally available studies, the grey literature was examined. There appears to be no specific mention of drug misuse or services for drug users in Scottish rural policy and guidelines; only general references to services are made. Equally, there is little recognition of issues that are specific to rural areas in drug and alcohol policy, although the EIU have highlighted rural issues in several of its publications (Integrated Care, Needs Assessment and Advocacy). When reviewing the published literature, the themes were very similar to those highlighted in both the qualitative research and the consultation seminars. It is important to note that there are many positive factors about living in rural areas as well as negative issues. One of the main barriers to come out of the literature review is the definition of rural and remote areas, which varies from agency to agency. For the purposes of the EIU review, the Scottish Executive's 'Urban Rural Classification' will be used as a definition.

Service Mapping

The EIU has conducted a number of exercises to obtain further information about local solutions/innovations to plan and deliver services in rural areas. Service examples and views of service users will be a common and fundamental feature of the guide. Many service examples have derived from the qualitative study, the consultation seminars and the reference group. However, other methods include: analysis of Corporate Action Plans and Extended Local Partnership Agreements, information provided by Lloyds TSB, Scotland Against Drugs, and Rural Partnership Funded projects.

Survey

The EIU have posted a questionnaire on drug and alcohol use in rural areas on the Rural Gateway website which is managed by SCVO. To date, only a few responses have been received but the feedback has consistently recognised the problems associated with substance use in rural areas, and the need to provide more effective local solutions (including better service provision).

Reference group

Anni Stonebridge and Liam Wells from the ADAT Rural Sub Group are on the EIU reference group which is providing information and advice on the development of the guide. This contribution has been extremely useful in providing an accurate assessment of the issues that affect DAATs locally, and highlighting local solutions that have been deployed to overcome barriers.

Consultation seminars

Davie summarised the main points raised from discussions at two regional seminars which were attended by 64 people. Main points covered included: 1) positive and negative issues and factors that effect treatment, care and support for drug users in rural areas; 2) the belief that an

integrated care approach is viable in light of identified factors but only subject to a number of criteria being addressed and/or put in place; 3) the impact identified factors have on the ability of agencies/service providers to deliver integrated care; 4) the requirements to deliver integrated care in rural areas; and 5) examples of current and emerging practice.

Qualitative study

A qualitative study was conducted by Clear Plan (UK) Services Ltd. The study focused on 4 case study areas which were selected due to their significant rural populations, namely Orkney, Highland, Dumfries & Galloway, and Stirling (part of Forth Valley). Data was collected through semi-structured interviews with service commissioners, service providers, service users and drug users not presently in contact with services. Findings included a number of issues related to financial resources, unit costs, services (specialist and generic, location, accessibility, range, capacity), society and culture, travel and transport, staffing and partnerships and current and emerging practice.

Discussion

The two papers presented provoked discussion and the group underpinned the importance of highlighting the following key points:

- Weighting themes based on how frequently a given issue arose and/or importance of issue.
- Staff pay issues, including comparison between urban and rural and remote areas in terms of unit costs, recruitment and retention issues, enhanced or incentive payments.
- Valerie Tallon advised that in Lanarkshire a survey had been carried out by Maureen Woods (a member of the Harm Reduction Team), which looked at the experiences of 106 service users over an 18-month period. This exercise has provided some very useful information for Lanarkshire ADAT. Linda shall obtain this report and disseminate it amongst the group.
action: LB
- Training and development (which Davie confirmed has regularly come up during evidence-gathering) are areas of concern for DAATs; there does not appear to be any standardised level of qualification needed for new DAAT team members, nor any nationally-approved scheme to provide consistent training. It was suggested that the issue of training be progressed at national level via full DAT Association meetings.

Davie concluded by stating that he shall be leaving the Scottish Executive on 4 March 2005 to take up a new post. Any queries relating to EIU work on rural areas should be sent to Davie's EIU colleague, Linsey Duff who can be contacted on 0131 244 3024 or at linsey.duff@scotland.gsi.gov.uk until 24 March 2005. Davie thanked the group for their contribution towards and support of EIU work on rural issues over the past year, and wished them success in the future.

Davie invited any local examples of good and/or innovative practice related to service planning and delivery to be sent to him no later than 12.00 hours on 3 March 2005.

action: all

Davie advised that he shall inform Linda whether EIU can continue to send a representative to the ADAT Remote & Rural sub-group meetings in future.
action: DMcC

7. Needle Syringe Exchange & Harm Reduction – Rural Solutions

Anni Stonebridge led a discussion on issues surrounding needle syringe exchanges; in Aberdeenshire NSE is scarce, and local community forums feel a clear need to modernise Harm Reduction services. Ian Smillie stated that in Perth & Kinross, services are de-centralising away from Dundee; one recent initiative has been to set up a roving van (funded equally between Community Safety Partnership and DAAT) which can go to the area of greatest need throughout the region. Martin Kerrigan suggested that 'Choose Life' could be one potential source for funding of similar initiatives; Valerie Tallon reported that a general nurse in Lanarkshire, through vaccinating people against Hepatitis B, had been very successful in raising other issues with clients (and that the nurse in question would probably be happy to discuss this further with Anni).

action: AS

It was suggested by several members that community pharmacists might be more actively involved in needle exchange and harm reduction programmes (although it was recognised that the new national Pharmacy Contract might lead to an opting-out of such services by pharmacists), and that one way to advance issues would be to have a Pharmacy sub-group of the DAT Association. Anni shall look at progressing this at national level.

action: AS

Catriona Oxley reported that in Shetland, an outreach worker has been employed to meet clients for needle exchange; this had seen a dramatic increase in the number of needles handed out (up from 503 distributed / 310 returned in 2002-03, to 4215 distributed / 4236 returned 2004-date). The increase in number of needles distributed/exchanged does not necessarily indicate an increase in injecting drug users in Shetland; rather, it indicates that clients are sourcing their needles direct from the outreach worker rather than from pharmacies. This personal contact with the outreach worker can open up lines of communication for information (e.g. regarding Hepatitis and other BBVs), and is an effective 'in' to assisting them with associated issues.

8. Any Other Business

No other business was tabled.

9. Date of next meeting

The date of the next meeting shall be timed to coincide with the next full Association meeting [after today]; Linda shall advise members once a date has been agreed.

action: LB

Effective Interventions Unit Integrated Care in Rural and Remote Areas Summary Report of Consultation Seminars

Introduction

In October 2004, the Effective Interventions Unit (EIU) held two consultation seminars 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*¹ 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*² and *Advocacy*³, 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 study involving service users, commissioners and providers, consultation seminars and advice and information from a working group drawn from 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.

¹ *Integrated Care for Drug Users: Principles and Practice*, Effective Interventions Unit, 2002

² *Needs Assessment: A Practical Guide to Assessing Local Needs for Services for Drug Users*, Effective Interventions Unit, 2004

³ *Advocacy for Drug Users: A Guide*, Effective Interventions Unit, 2004

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.

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, employability.
- **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. interpreters, 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**.

DAT Association Remote & Rural minutes, 23 February 2005

- 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 seminars 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 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.

Effective Interventions Unit Service Provision for Drug Users in Rural and Remote Areas of Scotland: a Qualitative 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 areas⁴. *Integrated Care: Principles and Practice*⁵ (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.

⁴Annual Rural Report 2004, Scottish Executive, 2004

⁵ *Integrated Care: Principles and Practice*, Effective Interventions Unit, 2002
DAT Association Remote & Rural minutes, 23 February 2005

Note: Since this qualitative study was conducted, the second national prevalence study of problem drug misuse in Scotland⁶ 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.

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.

⁶ Estimating the National Prevalence of Problem Drug Misuse in Scotland, University of Glasgow (Centre for Drug Misuse Research) and Health Protection Scotland, 2005

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.