

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 areas¹. *Integrated Care: Principles and Practice*² (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 study was conducted, the second national prevalence study of problem drug misuse in Scotland³ 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.

¹Annual Rural Report 2004, Scottish Executive, 2004

²Integrated Care: Principles and Practice, Effective Interventions Unit, 2002

³Estimating 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.