Rural Matters

Understanding alcohol use in rural Scotland:

Findings from a qualitative research study

Scottish Health Action on Alcohol Problems (SHAAP) provides the authoritative medical and clinical voice on the need to reduce the impact of alcohol-related harm on the health and wellbeing of people in Scotland and the evidence-based approaches to achieve this. SHAAP was set up in 2006 by the Scottish Medical Royal Colleges and is based at the Royal College of Physicians of Edinburgh (RCPE). SHAAP is advised by a Steering Group made up of members of the Scottish Royal Colleges, the Faculty of Public Health in Scotland and invited experts.

SHAAP works in partnership with a range of organisations in Scotland and beyond. Key partners include Alcohol Focus Scotland, the British Medical Association (BMA), the Scottish Alcohol Research Network (SARN), the Scottish Recovery Consortium, the Alcohol Health Alliance, the Institute of Alcohol Studies, Eurocare, the European Public Health Alliance (EPHA) and the World Health Organization (Europe).

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EXECUTIVE SUMMARY

BACKGROUND

This project aimed to learn about the cultural and social context of drinking in rural areas and barriers to accessing services in rural Scotland. A literature review was undertaken, and five community consultations and 25 semi-structured interviews were conducted with healthcare and service providers, individuals with lived experience of alcohol harm, young people and family members of people with alcohol problems. Based on evidence from this research, recommendations have been developed for research, policy and practice, in order to prevent alcohol harms and improve support.

ALCOHOL AND SOCIAL NORMS

Alcohol use is a part of daily life and social activities in rural areas, as in the rest of Scotland and the UK. However, participants suggested that the importance of alcohol is disproportionate in rural communities, given the lack of alternative recreational activities, particularly in winter. The significance of alcohol is entrenched in cultural and social norms due to traditions, hospitality and economic dependence on tourism and alcohol production. Research participants argued that non-drinkers often feel ostracised from social gatherings and few alcohol-free spaces, if any, exist in their communities.

CHALLENGES FACING RURAL COMMUNITIES

People who need alcohol-related support services, their family members and service providers face unique challenges in rural areas. Expensive, lengthy and infrequent public transport links and limited internet service provide further challenges. Healthcare and service providers reported challenges in accessing networking and professional development opportunities and difficulty in recruiting and retaining staff. Service providers also described the challenge of funding models often being related to population size, which does not take into account the added costs of providing services in a rural population of fewer, harder to reach people.

STIGMA

Stigma in the community, healthcare settings, media and online was also found to be a significant barrier to accessing services and support for alcohol problems. Research participants argued that stigma was made worse if living in a small community where privacy is difficult if not impossible to maintain. Participants expressed fears of social, professional or family consequences (such as having children removed) if they were found to be seeking assistance. Stigma in healthcare settings was also described by research participants, who spoke about what they felt were judgmental or unhelpful attitudes of General Practitioners (GPs) and Accident and Emergency (A&E) staff when seeking support for alcohol-related problems. This was described by people with lived experience of alcohol problems and their family members. Participants also described situations where their care was delayed or compromised given that they had a reputation as someone with an alcohol problem

in their community and they felt they were ignored or dismissed by healthcare providers as a result of this. Local newspapers and social media were also portrayed by participants as sources of stigmatising attitudes and language regarding substance use which further compromised the privacy and reputations of people experiencing an alcohol problem.

RECOVERY

Several research participants with lived experience of alcohol-related problems emphasised the importance of peer support, mutual aid groups, recovery communities and twelve-step programmes such as Alcoholics Anonymous (AA) and Al-Anon in their recovery or while supporting a loved one. Recovery communities offer opportunities for social interaction, support and provision of safe, alcohol-free spaces and activities for people in recovery. One of our recommendations is that linking these groups with healthcare professionals and investing in visible recovery groups so as to provide alcohol-free spaces and programmes is a key way to provide psychosocial supports for people in recovery.

COVID-19

The COVID-19 pandemic presents challenges but also opportunities for new ways to support people with alcohol-related problems. Greater flexibility in assertive outreach and the provision of online services may have been beneficial to service users. Another silver lining has been the integration of remote technology into meetings, training and education tools given the inability to meet face-to-face. For remote and rural communities, this represents improved access and ability to participate in meetings, events and training. However, it should be recognised that the provision of online services is not accessible for people who lack access to a reliable internet connection and that for many, face-to-face service provision may remain preferable.

LOOKING FORWARD

Remote and rural communities across Scotland each face unique challenges when it comes to prevention and support of people with alcohol problems. Approaches to reducing these harms tailored to fit their needs are required by service and healthcare providers and policy makers and should be investigated and evaluated with future research.

RECOMMENDATIONS

A FOCUS ON ALCOHOL AND RURAL COMMUNITIES

- The Scottish Government should designate the responsibility of ensuring that there is a rural component to alcohol strategies with a named Lead Officer. Many of our recommendations are cross departmental and take a holistic view. Actions to be prioritised in order to address the unique needs of remote and rural communities by the Scottish Government should include the recommendations which follow below.

ACCESSIBILITY AND INFRASTRUCTURE

The following recommendations are aimed at the Scottish Government, Local Authorities and Alcohol and Drug Partnerships (ADPs):

- Ensuring that the stated intention of the 2020 National Transport Strategy, "Minimising the connectivity and cost disadvantages faced by island communities and those in remote rural and rural areas" is prioritised, addressing the barrier of inaccessibility described by participants (Transport Scotland, 2020).

- Ensuring that Scotland's 2017 R100 strategy to deliver superfast broadband to all homes and businesses including in remote and rural areas is prioritised. This initiative is set to miss its 2021 target and has introduced a voucher scheme to cover the shortfall. This voucher scheme should be advertised to individuals and practitioners who use online support services (Scottish Government, 2017c).

- Online support and services for alcohol problems such as online counselling are reviewed and evaluated to ensure high standards and quality of service are achieved. The experiences of service users and providers should be taken into account in doing this.

HEALTHCARE AND SERVICE IMPROVEMENT

The following recommendations are aimed at the Scottish Government, ADPs, twelve-step fellowship programmes, visible recovery communities, mutual aid groups, medical professionals and NHS and third-sector service providers:

- Alcohol treatment services in all localities should be mapped and publicised, to make them accessible to GPs and A&E staff so that appropriate referrals can be facilitated and support given to ensure uptake and continuity for individuals with alcohol problems and their families. This information should be clear and accessible for other service providers in the NHS also and third-sector service providers. It should also be made available to the general public.

- Young people should receive information about alcohol harms and support available in school, building on the substance misuse programme included as part of Curriculum for Excellence. Support and education should be tailored to local circumstances and needs to be linked in with communities, families and local youth services.

- Links should be improved between the NHS, treatment and support services, mutual aid groups and visible recovery communities. This includes raising awareness about what is available in terms of service and support for alcohol problems, addressing gaps in care and resourcing recovery communities to offer peer support.

- Where appropriate, linking between twelve-step fellowships and healthcare and service providers should also be established or improved in order to raise awareness of these groups and point people towards AA and Al-Anon for help and support.

- Funding models should be reviewed and updated to address the reality that although rural areas have fewer people, it is often more costly to provide

services. Individuals in rural communities should have access to services including alcohol rehabilitation, detox beds and counselling.

- Alcohol services should be resourced to conduct assertive outreach, recognising that this may be challenging in some areas due to distances and stigma. This includes proactively taking care to patients, following up with patients who drop out of services and removing punitive measures such as withholding services if a patient misses appointments. This should help to address the disassociation that some participants felt with services available to them and will benefit both patients and service funders in the long term by offering early intervention.

- Ensuring adequate provision of training, education and networking opportunities for service providers and healthcare professionals on trauma-informed approaches, avoiding stigma, support for people with alcohol problems and their families and information on available services and support. Training opportunities must be inclusive, including either an online option or travel budget for rural workers.

- Working with the Medical Royal Colleges and Medical Schools to explore ideas in relation to improving professional competencies, training and expertise with regards to alcohol problems in rural communities. Expansion of programmes such as the *Widening access to medicine* initiative (Scottish Government, 2018d) which helps students from remote and rural backgrounds to study medicine and the *Scottish Graduate Entry Medicine* (University of St Andrews, 2020) programme which focusses on rural medicine and healthcare improvement.

- Working with recovery and mutual aid groups to promote the use of community hubs to act as a "one stop shop" for advice, services and social interaction.

ALCOHOL-FREE SPACES

The following recommendations are aimed at the Scottish Government, ADPs, Local Authorities, Local Licensing Forums, third-sector organisations and recovery communities:

- Ensuring that rural economic development strategies are developed with public health considerations in mind, particularly when it comes to the promotion of the alcohol, tourism and hospitality industries.

- Supporting investment in alcohol-free recreational activities and spaces in rural areas, including those targeted specifically at young people. Research on the feasibility of the Youth in Iceland Model for Scottish rural contexts may inform this (University of Stirling, 2019).

- Actively encouraging support for and investment in social spaces that do not provide or market alcohol. These spaces could include sports clubs, community centres/hubs, cafes, leisure centres etc.

- In reviewing licensing regulations, ensure that the particular needs of rurality are addressed, including the consideration of how online and telephone purchasing should be regulated.

- Ensuring that funding is allocated to recovery groups in order to increase the variety of activities and events they may offer. Examples include investing in initiatives such as the model used by the active Forth Valley Recovery Community. This group offers various activities to people in recovery, including recovery cafes, outdoor activities and an app which highlights events and services available in the local area, in collaboration with recovery and mutual aid groups.

RESEARCH

Scottish Health Action on Alcohol Problems (SHAAP) and the Scottish Alcohol Research Network (SARN) and/or other relevant research-focussed bodies should be tasked with establishing a research plan to propose to the Scottish Government. This should include:

- Conducting further research into the needs of rural communities for alcohol harm prevention and support.

- Working with Public Health Scotland's Data and Intelligence team to improve data-gathering in order to audit and evaluate the quality and effectiveness of interventions. The evidence can be utilised to support future policy and service development in rural areas, closely linking to the *Rights, Respect and Recovery* workstream.

- Partnering with the Royal College of General Practitioners (RCGP) to develop understanding of the challenges of recognising alcohol problems and supporting patients in their recovery in rural communities, as primary care is often the first contact for those seeking help with alcohol problems. This builds on previous research regarding Alcohol Brief Intervention (ABI) training for GPs facilitated by RCGP (Holloway & Donaghy, 2017).

- Collaborating with the recovery community and local papers, radio and other media in rural areas to help change perceptions through an outreach programme. This could include running a series of positive real life stories from those with lived experience to help change public opinion and reduce stigma in communities.

3. ACKNOWLEDGMENTS

4. INTRODUCTION

The Rural Matters project was undertaken from January 2019 to September 2020. This project aimed to learn about the cultural and social context of drinking in rural areas and barriers to accessing services in rural Scotland, with the intention of providing recommendations for policy, practice and research, in order to prevent alcohol harms and improve support. A literature review was undertaken, and five community consultations and 25 semi-structured interviews were conducted with healthcare and service providers, individuals with lived experience of alcohol harm, young people and family members of people with alcohol problems.

Key partners:

- People in active recovery
- The Remote and Rural Working Group of the Royal College of Physicians of Edinburgh (RCPE)
- SHAAP Steering Group

SHAAP also worked with Alcohol and Drug Partnerships (ADPs), the Scottish Recovery Consortium (SRC), Scottish Families Affected by Alcohol and Drugs (SFAD) and Young Scot in order to recruit participants for our events and interviews.

We are grateful to the Scottish Government for commissioning and funding this project.

5. STRUCTURE OF REPORT

We will next describe the methods employed in this research, including the limitations of the study. We will then summarise key points from reviewed literature and draw on our analysis of the 25 semi-structured interviews and five community consultations. These include perspectives from people with lived experience, young people, family members and service providers. Through our analysis, we will explore the following themes:

- Cultural and social norms around alcohol in rural areas
- Experiencing alcohol problems in rural areas
- Services and barriers to accessing services in rural areas
- Support for recovery in rural areas: challenges and recommendations

We will draw some summary conclusions and then provide recommendations for policy and practice and research based on our findings.

6. METHODS

A desktop review of relevant literature was undertaken, followed by a qualitative research exercise which spanned 2019 and part of 2020. This included five community consultations which took place in Glasgow, Aberdeen, Huntly, Edinburgh and Inverness. Consultations were held in urban centres as a result of feedback from participants in advance of the events informing organisers that this would be easier in terms of transportation links from various communities. Video and teleconferencing options were also used to engage with participants from island communities in Shetland, the Outer Hebrides and Orkney. SHAAP worked with ADPs situated in areas with rural populations in order to advertise the consultations and network with service providers and people with lived experience. In one instance, a consultation took the form of a written questionnaire given to attendees of the Highland ADP Conference in Inverness on 18 June 2019.

In total, 84 people participated in the consultations:

- 15 in Glasgow (from North Ayrshire and Arran, East Ayrshire, Dumfries and Galloway, North Lanarkshire, South Lanarkshire)
- 17 in Aberdeen (from Aberdeenshire, Angus, Shetland, Orkney, Outer Hebrides)
- Seven in Huntly (from Aberdeenshire)
- 13 in Edinburgh (from Scottish Borders, Perth and Kinross, Stirling, Clackmannanshire, Forth Valley, Falkirk)
- 32 questionnaire responses in Inverness (Highland)

The consultations were then followed by 25 semi-structured interviews (24 individual interviews and one group interview with eight NHS staff members) with a total of 32 participants:

- Eight individuals in active recovery
- Three young people (18 years of age and under)
- Two family members
- 18 NHS Staff (ADP and Healthcare providers)
- Two third-sector service providers

Of the 32 interview participants, 17 were women and 15 were men. All reside in rural communities in Scotland, including Shetland, Orkney, the Outer Hebrides, Argyll and Bute, Highland, Scottish Borders, Clackmannanshire, Stirling, Moray, Perth and Kinross and East Ayrshire. One participant self-identified as a member of the LGBT+ community.

Interviews lasted between half an hour to two hours. Transcription was undertaken confidentially by a professional external service. Thematic analysis was used to analyse what we were told during consultations and interviews and draw conclusions and make recommendations (Guest, MacQueen & Namey, 2012). The interview schedule is presented in Appendix A. Personal notes were made after each interview, reflecting on key themes that emerged, so that the analysis would include some the researcher's reflections on what they had been told. It was agreed with the

research participants that we would take all reasonable measures not to identify individuals in our report.

We are very grateful to all for generously giving their time and for their openness and honesty in sharing their perspectives and experience.

The limitations of this study include the following:

- Given the time-limited nature of the project, the resources to complete a systematic review of the literature were not available.

- There is no universal experience of rurality: there is a great deal of diversity within Scotland's rural areas and therefore it is difficult to capture all of these experiences in a single report.

- Study participants either work as service providers or are members of twelve-step programmes or visible recovery communities. Therefore, the perspectives of people who are not already in contact with a service or support group have not been included.

- Given that the bulk of the semi-structured interviews took place during the COVID-19 pandemic "lockdown", there were some added challenges in recruiting and interviewing participants as many healthcare and service providers were unavailable due to additional strains on the National Health Service (NHS) and services due to the pandemic. Though in person meetings had originally been planned, all interviews except one (which took place in 2019) were undertaken by phone or online. For the most part, this format worked well, however a level of insight gained by visiting rural areas and meeting in person with participants was no doubt lost.

7. LITERATURE REVIEW

7.1 Alcohol harms in Scotland

Alcohol use represents a major public health challenge in Scotland, carrying risks of physical and mental health problems, as well as social and economic harms to individuals and society (Scottish Government, 2017a). Within the UK, Scotland has the highest alcohol sales *per capita*, with consumption levels reported as 9% higher in 2019 than in England and Wales (Giles & Richardson, 2020). In 2018, 1,136 people died in Scotland due to a cause wholly attributable to alcohol (alcohol-specific), an average of 22 people per week. Scotland has the highest rate of alcohol-specific deaths in the UK, with death rates twice as high for men in Scotland compared with England and Wales, and 87% higher for women (Giles & Richardson, 2020). In relation to alcohol-attributable deaths (deaths where alcohol was a factor), Scotland recorded 3,705 deaths in 2015 (Tod et al., 2018). For more information on the definitions of alcohol-attributable and alcohol-specific deaths please see the Glossary and Abbreviations section on page 65 of this report.

Turning to hospitalisation rates, 23,751 people in Scotland were admitted to a general acute hospital with an alcohol-related diagnosis in 2018/19, with a total of 35,685 alcohol-related inpatient stays. Rates of alcohol-specific death and alcohol-related hospital stays were more than twice as high for men as women and were highest in the 55-64 years age group (Giles & Richardson, 2020).

Significant inequalities by area deprivation are reflected in the data: in the 10% most deprived areas of Scotland, rates of alcohol-specific death were more than 4.5 times higher and alcohol-related hospital stays around seven times higher, when compared with the 10% least deprived areas (Giles & Richardson, 2020). Along with the burden of death and disease, alcohol-related harms also bear a heavy economic cost. In 2010, the Scottish Government estimated an annual cost of £3.6 billion related to costs involving alcohol problems in healthcare, social services and law enforcement (Tod et al., 2018).

The Scottish Government has framed its action to prevent and reduce alcohol-related harms with two strategies: *Alcohol Framework 2018: Preventing Harm* and *Rights, Respect and Recovery: Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths* (Scottish Government, 2018a; Scottish Government 2018b). The *Alcohol Framework 2018*'s four pillars of action are Protecting Young People, Tackling Health Inequalities, Improving National Systems and a Whole Population Approach (Scottish Government, 2018a). One of the major policies outlined in the Framework is Minimum Unit Pricing (MUP). This policy has been in effect since May 2018 in Scotland, and set the floor price of alcohol at 50-pence per unit. Comprehensive evaluation of MUP's impact is on-going (Giles & Richardson, 2020). The Framework also addresses licensing, marketing and advertising, public education and family/community support.

Rights, Respect and Recovery focusses on treatment and support for recovery. It also addresses the need to recognise the link between deprivation and inequality and harmful substance use (Scottish Government, 2018b). It outlines the role of bodies such as Alcohol and Drug Partnerships, Health Boards and Councils and non-governmental organisations as well as families and individuals in reducing harm from alcohol and drug use. It centres on a rights-based approach to recovery and pledges to support a public health approach to the justice system (Scottish Government, 2018b).

Neither strategy makes mention of tailoring an approach specific to the needs of the rural and remote populations of Scotland.

7.2 Understanding remote and rural Scotland

This report uses the Scottish Government's definition of rurality:
- 'Accessible rural' is defined as being within a 30-minute drive of a settlement of 10,000 people or more.

- 'Remote rural' refers to areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more (Scottish Government, 2016).

When the terms 'rural' and 'remote' are used, it is these definitions which are being referenced. 17% of Scotland's population can be classified as living in a *remote rural* or *accessible rural* location and these areas represent 98% of Scotland's landmass (Scottish Government, 2018). Scotland's rural population is growing, mostly due to internal migration (Scottish Government, 2018).

Scotland's 2017 Household Survey report, cited in *Rights, Respect and Recovery* (Scottish Government, 2017b) shows that adults living in rural areas of Scotland are less likely to report that they are satisfied with local health services than their urban counterparts, mostly due to lesser satisfaction with public transportation. No specific mention of alcohol is made.

Research compiled by Alcohol Focus Scotland found that alcohol outlet availability is related to health and crime outcomes for both on-sales and off-sales outlets, and that this is true in both urban and rural local authorities (Alcohol Focus Scotland, 2018).

7.3 Measuring and experiencing deprivation in rural Scotland

Social and economic deprivation contributes to alcohol-related harms. People living in the most deprived areas of Scotland are six times more likely to be admitted to an acute general hospital with an alcohol-related condition than in the least deprived areas (ScotPHO, 2020). Furthermore, inequalities by area deprivation were stark: in the 10% most deprived areas of Scotland, rates of alcohol-specific death were more than 4.5 times higher and alcohol-related hospital stays around seven times higher when compared with the 10% least deprived areas (Giles & Richardson, 2020). Given the added burden of ill-health and death in deprived areas due to alcohol use, it is useful to understand poverty across rural and remote areas of Scotland and how this compares to urban areas. However, measuring and understanding poverty in rural locations can be challenging (Atterton, 2019).

Overall, figures show that the percentage of people living in low-income households in rural areas of Scotland is similar to urban areas (McSorley, 2008). However, the experience of poverty in rural areas may differ from urban centres in several ways: there is a larger number of people in seasonal, part-time and low-paying jobs; income is on average lower in rural areas than the rest of Scotland which is coupled with a higher cost of living; there is a shortage of affordable housing in rural areas,

particularly in smaller properties, such as flats; and accessing services, education, training and employment opportunities is more difficult (McSorley, 2008).

How deprivation is measured can play a role in misunderstanding poverty in rural areas. The dominant understanding of a 'rural idyll' paints a portrait of picturesque villages and beautiful scenery where hardship is hidden (Atterton, 2019). As a wealthy, ageing population moves to rural Scotland, housing prices increase which can displace the original population. Furthermore, schemes for affordable housing can be dismissed as being at odds with the rural idyll, further increasing the squeeze on affordable housing (Atterton, 2019). Other issues include limited employment opportunities in rural areas, fear of stigma around poverty leading to a reluctance to claim benefits, higher likelihood of experiencing fuel poverty and a lack of services. Research shows that young people and the elderly are most likely to experience difficulty in accessing opportunities for education, employment and services in rural areas, alongside those who are in self-employment, minority groups and those with disabilities (Atterton, 2019).

Place-based measures of deprivation, such as the Scottish Index of Multiple Deprivation (SIMD), may fail to identify the localised pockets of poverty in rural areas, which are both dispersed (unlike poverty which may be concentrated on urban housing estates, for example) and interspersed amongst pockets of wealth (Atterton, 2019). In terms of understanding the demographics of rural areas and how that relates to deprivation, the Rural Scotland in Focus report in 2014 from Scotland's Rural College (SRUC) highlights the following issues: (Skerratt et al., 2014):

- An ageing population and out-migration of young people are seen as key characteristics of rural Scotland's demography.
- In the next 20 years, the proportion of rural populations of pensionable age is going to increase markedly in three rural Local Authorities: Aberdeenshire (by 49.7%), Shetland (47.5%) and Orkney (34.5%). Other rural local authority areas already have aged populations but nonetheless are predicted to see an increase.
- In rural Scotland, young people, single pensioners, single parents, those with disabilities, those with mental health difficulties, minority ethnic populations and (seasonal or long-term) immigrants, all face distinct challenges in relation to their experiences of rural poverty and disadvantage.

It is crucial to understand how demographic and other characteristics then intersect with each other, to either enhance or reduce poverty and disadvantage.

7.4 Research on alcohol and rural Scotland

In terms of academic literature regarding alcohol use in rural Scotland, the body of academic research to draw from is relatively small, with only seven sources found which specifically focussed on this issue (Burns, Parr & Philo, 2002; Daly, 2014; Kloep et al., 2011; Martin et al., 2018; Martin et al., 2019; Jayne et al., 2010; Galloway et al., 2007). 'Grey' literature produced by third-sector organisations and the Scottish Government was also reviewed in order to gain greater understanding on this issue (Chandler & Nugent, 2014; Giles & Richardson, 2020; Scottish Government Social Research 2009; Scottish Government, 2015; Scottish Government, 2016; Scottish Government, 2017a; Scottish Government, 2017b; Scottish Government, 2018c). Research reviewed on alcohol in rural Scotland (Burns, Parr & Philo, 2002; Daly, 2014) is focussed on the Highlands and Islands, excluding other rural areas of the country which may have different relationships and issues surrounding alcohol use. Research on mental health and poverty in rural Scotland that prominently featured alcohol use significantly was also included (Burns, Parr & Philo, 2002; Daly, 2014).

7.5 Social and cultural dimensions of alcohol in rural Scotland

The use of alcohol is bound up with emotion, belonging, reward and leisure opportunities, tradition, celebration and hospitality (Jayne et al., 2010). Frequent use of alcohol plays a central role in socialising in many Western countries and is specifically valued in Scotland and the UK more widely (Burns, Parr & Philo, 2002). In a study conducted in 2002 regarding alcohol and mental health in rural areas, particular symbolic, historical, social and economic factors were identified as underscoring the role of alcohol even further (Burns, Parr & Philo, 2002). One example of this was lack of other recreational activities, making drinking one of the only forms of social interaction (Burns, Parr & Philo, 2002). This was illustrated by the following comments from participants: *"Socialising up here automatically means drinking"* and *"Drink is …virtually the only social activity is drinking, know what I mean?"* (Burns, Parr & Philo, 2002).

Participants also expressed that they found heavy drinking to be widely accepted in their communities, while abstainers were far more likely to be met with negativity, and seen as anti-social (Burns, Parr & Philo, 2002). Participants also said that they felt that the Highland culture around drinking differed to other parts of Scotland. For example, elsewhere it would be customary to invite neighbours or guests for a 'cuppa', whereas in the Highlands it was instead a 'wee dram' [of whisky] which would be offered. There was a feeling of insult or slight associated with refusing offers of alcohol (Burns, Parr & Philo, 2002).

A wide array of experiences were described in the literature in terms of determining reasons and motivations for drinking. Positive portrayals describe alcohol as a

'normal' part of growing up in a rural community, a confidence booster (Chandler & Nugent, 2014) and a fun social activity (Burns, Parr & Philo, 2002; Galloway et al., 2007). Negative descriptions recognise alcohol use as a 'coping mechanism' for dealing with trauma and mental health issues (Chandler & Nugent, 2014; Martin et al., 2019) and the high social acceptability of excessive drinking (Burns, Parr & Philo, 2002).

7.6 Young people and alcohol in rural Scotland

Four of the academic sources reviewed regarding alcohol and rurality focused on adolescent drinking (Martin et al., 2019; Martin et al., 2018; Galloway et al., 2007; Kloep et al., 2011). The emphasis on young people in the literature and the gaps regarding older and middle-aged drinkers reflect broader concerns about 'out-of-control youth', ignoring the problems that alcohol causes across the whole population.

Young people's drinking in Scotland is a pressing public health matter given that Scotland ranks fifth out of 42 countries in Europe for the number of 15-year-olds that have been drunk at least twice (Martin et al., 2018). According to the 2015 Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS), there were no statistically significant differences in the proportion of pupils aged 13 and 15 who drank alcohol in the last week by whether they lived in an urban or rural area. However, those living in rural areas were more likely than those living in urban areas to have ever had an alcoholic drink (Scottish Government, 2015).

Accessible small towns and remote rural areas are both places where there were higher odds of drunkenness than in urban centres (Martin et al., 2018). The reasons behind this were still not apparent after controlling for social conditions and Alcohol Outlet Density (AOD), indicating that there may be other reasons for this difference. It was hypothesised that in rural areas and accessible small towns, adolescent alcohol use may be normalised and used as a form of "cultural capital''. Comprehension of different drinking trajectories across the life course, in terms of urban/rurality, is needed to explain this pattern (Martin et al., 2018).

In a 2001 study comparing young people across Scotland, Norway and Sweden, the authors state that little evidence exists to suggest there is a difference between adolescent drinking behaviour between urban and rural areas in these countries (Kloep et al., 2001). Given this, the researchers endeavoured to understand the behaviour of rural-dwelling teenagers in these three countries to determine whether there were cultural differences and to understand more about the motivations behind the behaviour as well as to gain further insight into details such as quantity consumed and drinking locations. The main locations were friends' houses (without

the presence of parents), streets, woods, pubs, nightclubs and discos. The Scottish teenagers reported difficulty getting into pubs, as they were known in their communities to be underage. 42% of the Scottish cohort stated they had drunk with their parents compared to only 16% of Norwegians (Kloep et al., 2001). They also measured other factors such as time spent on other leisure activities and parental involvement in their lives. The self-reported data showed that Scottish teenagers living rurally drank more than their rural Scandinavian peers (Kloep et al., 2001).

A 2007 article from the Glasgow Centre for the Study of Violence (this group has since reformed as the Violence Crime and Justice Group at Glasgow Caledonian University) drew on the experiences of street drinking from both urban and rural contexts. In rural contexts, street drinking was defined as drinking outside of the home or licensed premises. Examples of locations included fields and parks. The study did not draw many significant conclusions about differences between urban and rural street drinking of teenagers but did make mention of young people in rural areas, citing the reason for their drinking as being linked to boredom and a lack of other recreational opportunities (Galloway et al., 2007).

7.7 Alcohol and mental health in rural Scotland

Alcohol use and mental health were referenced in four of the sources surveyed (Burns, Parr & Philo, 2002; Daly, 2014; Martin et al., 2018; McSorley, 2008; Chandler & Nugent, 2014).

McSorley's research suggested that issues of mental ill-health, suicide and alcohol problems were experienced differently in rural than in urban areas, due to rural culture and the higher 'visibility' of individuals in rural communities, implying stigma and difficulty around privacy (McSorley, 2008).

The unique experiences of rural communities with regards to mental health and alcohol problems was further demonstrated in Daly's 2014 research which looked specifically at the Highlands and Islands, stating that since there was felt to be a fairly rigid code of conduct in small rural communities in this part of Scotland, those who did not fit into it were liable to experience difficulty (Daly, 2014). A suggested reason for this was the often strong role of religion in the community, leading to a 'heavy moralistic tone' which pervades social life. Another was the fact that ties between families and inhabitants of many of these small communities go back multiple generations, leading to historic tales and grudges that carry over into present day interactions.

Participants from Daly's study also expressed that while alcohol consumption was widely accepted in the Highlands, mental health problems were viewed in a very different light: *"People will sometimes mask mental ill health with alcohol misuse and*

that is quite commonplace, so you could almost 'fit in' by being someone who misuses alcohol….it's not even considered misuse or problematic…and it's acceptable, it's completely acceptable". Those presenting with mental health problems or characterising their problems as being related to mental health as opposed to alcohol were more likely to be viewed with contempt and suspicion rather than acceptance (Daly, 2014). The social tone in these communities was described as 'repressive' by participants (Daly, 2014).

This view was reinforced further by a comment from a participant of Chandler and Nugent's 2014 study saying that having a problem with alcohol was seen as preferable to having depression. Another way rurality is linked to alcohol and poor mental health was illustrated by one participant describing a traumatic period in their life and saying *"…Nobody helped. So, I turned to the drink".* With a lack of other mental health supports in terms of work, social network and available services, substances may be used to "self-medicate" (Chandler & Nugent, 2014).

Participants from Burns and colleagues' study held unexpected views regarding rehabilitation for alcohol-related problems, which differed depending on gender. For men, going to the local rehabilitation centre was seen as almost a badge of honour, and they felt that when patients returned to the local town they were given a hero's welcome. For women, it was seen as far more problematic. One woman described the stigma she felt at being labelled an 'alcoholic' and how attending treatment and returning home from the live-in centre was an isolating and traumatic experience for her. It was reported that Highland women were expected to bear their burdens with 'stoicism' and using alcohol as a coping mechanism in public places was not seen as appropriate. Though participants in the study recognised the gender bias and unfairness of these views they felt that they were ingrained in the society of the Highlands (Burns, Parr & Philo, 2002).

Poor mental health was also found to be a potential motivator for drinking alcohol in rural areas specifically for young people (Martin et al., 2019). Martin and colleagues' 2019 study examining the interaction between neighbourhood characteristics and drinking motives found that adolescents living in accessible small towns had higher coping motives than their peers living in large cities. That is, their drinking was more likely to be felt to be a coping mechanism, a means to alleviate problems and worries than was the case for their urban counterparts (Martin et al., 2019).

7.8 Lack of recreational options in rural Scotland

Much of the literature questioned what motivated drinkers of alcohol in rural places to drink. An answer which appeared multiple times, and not just in regard to the habits

of young people, was that drinking was a fun, sociable activity and that there was simply not much else to do in rural environments.

> *"All I know is that I think there is so little to do in the winter time particularly, that a lot of people just go down to the pubs and they don't seem to have a life beyond that … whereas in the city you might go out to the theatre and you might go out to a musical thing or something"* (Burns, Parr & Philo, 2002).

Research among street drinkers in urban and in rural environments (in rural contexts this was defined as drinking outside of the home or licensed premises in locations, such as fields and parks) published in 2007 explores the experiences of young people with regards to recreation. Several focus groups conducted in rural areas from this study raised this issue, with participants stating that there was simply nothing else to do (Galloway et al., 2007). Other leisure activities were lacking, and young people could see few alternatives for socialising. Some groups referenced deeper and more complex reasons beyond simply a lack of leisure activities for their age cohort. According to one group, the absence of "something good" in their lives led to street drinking as a way of filling this gap.

> *"Tell you what it is, there's nothing for us round here, nothing to dae [do]. And I think the reason we all drink is because it's something good in our lives. Makes us feel good. I don't think we'd drink as much if we had something else."* (Galloway et al., 2007).

Main themes to emerge from the literature review demonstrated that for the most part, the cultural and social norms surrounding alcohol use resemble those elsewhere in Scotland. Alcohol plays a large role in socialising and those who do not drink are liable to be seen as anti-social or excluded from certain activities. Levels of drinking in young people in rural areas appear to be similar to those living elsewhere, though the locations in which they drink may differ. Literature also tied in mental and alcohol health and made a connection between stigma and small communities given the lack of privacy for individuals experiencing either mental ill-health or an alcohol problem. Much of the literature also tied drinking in rural areas to a lack of recreational activities. Both this and difficulty accessing support and services in rural areas were cited as ways in which rural and remote communities may have some distinct features when it comes to alcohol use.

8. COMMUNITY CONSULTATIONS

After the literature review was conducted, community consultations were organised in order gain greater understanding of the issues raised. Organisers liaised with ADPs, the SRC, AA and our network of colleagues and researchers across Scotland

to reach as many people as possible and ensure that we spoke with people in as many different rural locations as possible. Consultations were roughly organised by splitting participants geographically into North-West, North-East, South-East and South-West groups in order to facilitate travel and group together areas with similar backgrounds. Organisers also endeavoured to have a diverse group of people involved with each event in order to hear different perspectives and ensure that people with lived experience were represented.

8.1 Glasgow

The first community consultation took place on 13 June 2019. Participants from North Ayrshire and Arran, East Ayrshire, Dumfries and Galloway, North Lanarkshire and South Lanarkshire were in attendance, as well as participants from the Scottish Recovery Consortium (based in Glasgow).

There were 15 participants in total:

Healthcare: Two (Nursing and Occupational Therapy)
Service providers: 10 (ADPs, Addaction (now We Are With You), Turning Point Scotland, Arran Community and Voluntary Service, Drug and Alcohol recovery Service, Liber8 Lanarkshire, NHS Lanarkshire)
Scottish Recovery Consortium: Two
Service user: One

The format of the consultation was to group participants together based on their geographical areas and then to have roundtable discussions which were then fed back to the larger group.

Question 1: How do the following themes play into alcohol use in your communities?
- Gender
- Identity
- Demographics
- Culture
- Religion
- Prevalence
- Stigma
- Services/barriers to access
Responses:

East Ayrshire: Participants from East Ayrshire shared reflections on the role of alcohol in the context of industrial decline in their communities and what they felt was a void of culture, community, identity and camaraderie left by widescale unemployment. Given that men had been the primary workers in heavy industry they felt that this had a particular influence on them; alcohol and other substance use had contributed to social problems and community breakdown. This history is still relevant today as alcohol remains fused with gender and identity and the

intergenerational effects of social breakdown remain present in these communities. Participants also noted difficulties around resourcing for support services, given that funding is allocated on a *per capita* basis, but services are actually more expensive to deliver in rural areas, mostly due to large distances and limited transport.

North Ayrshire and Arran: Participants from North Ayrshire and Arran discussed the role of alcohol in their communities, given the importance of tourism and hospitality to their economies. They described alcohol as being a universal part of socialising, causing particular problems during the summer months when seasonal workers and tourists would cause extra strain on services and A&E despite there being no extra resourcing in peak season. One participant commented that the police had extra resourcing in the summer, but the NHS did not. Furthermore, participants pointed to widespread stigma attached to alcohol problems, and a reluctance to discuss or come forward to seek assistance given fear of consequences socially, professionally or for their families (for example, the removal of children).

North and South Lanarkshire: Participants from North and South Lanarkshire echoed the comments made above regarding industrial decline and the consequences this had had in their communities. The erosion of social cohesion means that the pub has become disproportionate in importance because of a general lack of other recreational activities. Participants also noted that they felt that licensing boards should be informed by a public health approach which they did not feel was currently the case.

Dumfries and Galloway: Participants from Dumfries and Galloway noted the importance of farming in their area and that the cultural and social norms of the farming community were particularly linked with alcohol. Many social occasions, including festivals and galas are heavily centred around alcohol and crime rates tend to go up on these days. Participants also noted that stigma was a significant barrier to accessing services given the nature of small communities, meaning that anonymity was difficult if not impossible to maintain if seeking help and support. Participants highlighted stigmatising language and portrayal of people experiencing substance use problems by local media, which could be especially damaging in small communities where everyone tended to know the individual named in the media story.

Question 2: What suggestions would you like to provide us with as we move forward with this project?

In terms of recommendations for how best to improve prevention of alcohol problems and support for people in recovery, participants suggested the following: increased use of online services; contact with and education in schools regarding not only substance use but how to seek assistance; a joined-up approach for sign-posting and accessing services including "community connectors" in GP services and A&E; making use of the expertise of people with lived experience for acting as knowledge brokers, activists, guide and community mappers.

In terms of recommendations for SHAAP's research process, participants recommended conversations with individuals with lived experience, family members,

young people, healthcare providers, and other service providers. They also suggested asking participants to ask where they get support, if they need it for alcohol-related issues, and if they are aware of the resources that are available in their area, and their experiences of accessing support.

8.2 Inverness

This consultation had a different format from the others as written responses were provided by participants. SHAAP staff made a presentation regarding the Rural Matters project and our research aims at the Highland Alcohol and Drug Partnership Conference on 18 June 2019. The analysis of these questionnaires was qualitative and thematic. Participants were given the opportunity to respond in writing to three questions:

1. **What should we know about alcohol in rural areas?**
2. **What barriers keep people from accessing support?**
3. **Who do we need to speak to in order to find out more?**

32 people responded to the questionnaire. Their responses are collated in the tables below:

Question 1: What should we know about alcohol in rural areas?

Theme	Responses
Alcohol use has high acceptability. It is used culturally and socially for most social occasions	14
Alcohol use is linked to geographic and social isolation	13
It is difficult to access services (lack of knowledge of services, transit, not anonymous, poor internet making online access difficult)	16
Alcohol is easily obtained (locally and cheaply)	10
There is a lack of other recreational activities	7
Stigma is prevalent	4
Home drinking is prevalent	3
Drink driving is prevalent (poor public transport, low police presence)	2
Alcohol is linked to depression	2
Alcohol is advertised in pubs and shops	2
Alcohol is purchased for under 18s by family members	2
Pre-drinking in the home before going out is common	1
A person is seen as 'weird' if they don't drink	1
Alcohol does have positives for the local towns (pubs/breweries/distilleries)	1
There are more pub lock-ins than in towns or cities	1

Question 2: What barriers keep people from accessing support?

Theme	Responses
Transport difficulties	18
Stigma	18

Lack of choice in services, and a perception that services are not available	14
Everyone knows everyone/lack of anonymity	12
People do not know or accept that they have a problem	8
Relationships with practitioners – they may know them socially/be a part of the family	4
Cultural norms	4
Getting support may influence their job/school/community standing/parenting	4
Expense	2
Fear of intervention	2
Centralisation of services	1
Peer pressure	1
Lack of support	1
Religion	1

Question 3: Who do we need to speak to in order to find out more?

Theme	Responses
Local grassroots professionals / services / front line workers	12
People in recovery/ service users / ADP forums / AA	9
Hospitals /Doctors/ NHS/ nurses	8
Families of those affected by alcohol	6
Clergy /religious groups	4
Schools	4
Councils	3
Children	2
Adolescents	2
Police	2
Local shop owners and publicans	2
People in active addiction	2
Funding agencies	1
Food banks	1
Farming associations	1

Issues raised by participants in Highland reflect findings from the literature and the first consultation in that there was a strong emphasis on cultural and social norms being linked to alcohol use. Participants also highlighted issues around high availability and advertising of alcohol and parental facilitation of youth drinking.

In terms of barriers to accessing services, the most common answers were limited transport, lack of services or a lack of knowledge about services, and stigma. Lack of privacy in small communities, including knowing their doctor or service provider was another answer provided linking to fear of stigma.

Participants suggested a wide array of actors to speak to in order to find out more about alcohol in their communities, with the most common answers including services providers, people with lived experience, medical professionals and family members of people affected by alcohol.

8.3 Aberdeen

The third community consultation took place on 21 June 2019. Participants from Shetland, Orkney, the Outer Hebrides, Aberdeenshire and Angus all attended, with a mix of in-person attendance and participation via video-conferencing from island participants.

There were 17 participants in total:

Service providers: 16 (Health and Social Partnership, Huntly Central Forum, Turning Point Scotland, Alcohol and Drug Partnership staff, Aberdeen Council Employability Service, Tayside Council on Alcohol, Aberdeenshire Council)
Local Government: One (Aberdeenshire Council)

The format of the consultation was to group participants together based on their geographical areas and then to have roundtable discussions which were then fed back to the larger group.

Question 1: How do the following themes play into alcohol use in your communities?

- Gender
- Identity
- Demographics
- Culture
- Religion
- Prevalence
- Stigma
- Services/barriers to access

Responses:

Participants from both groups discussed root causes of alcohol problems including boredom, loneliness and social isolation. Participants also discussed a lack of recreational activities as being part of the problem, and that activities that were available were often centred around alcohol use. People who do not drink are often considered anti-social, unfriendly or "a bit odd".

Furthermore, it was suggested that stigma attached with seeking help for an alcohol problem is made more difficult in small communities where people fear they will be recognised or identified by someone that they know if they seek help from their GP or a service provider. People also spoke about a reluctance to attend AA meetings for fear of not really being anonymous in this local context. Several participants stated that they felt that there was a larger stigma attached to seeking assistance for alcohol-related problems than there had been for having a problem in the first instance.

Aberdeenshire and Angus: Participants discussed the link between certain professions and harmful levels of alcohol use such as the oil and the fishing

industries. Work patterns in these industries often result in a pattern of binge drinking (defined as consuming eight units of alcohol in a single session for men, or six units for women (National Health Service, 2020)) when workers return to the mainland on leave. It was also noted that farmers and their associated traditional and cultural events have a large drinking culture attached to them. Participants also noted that as a group, Eastern Europeans were a hard-to-reach population due to cultural and linguistic barriers, but that this was a group recognised by service providers as having high rates of high-risk drinking.

Shetland, Orkney and the Outer Hebrides: Participants from the islands discussed particular difficulty in accessing services, particularly outwith the main towns where there are few or no public transport options, and that ferries or water taxis can be expensive and unreliable in bad weather conditions. This is particularly problematic during the winter months.

Participants also discussed the presence of alcohol being inextricably tied to traditions and cultural events and celebrations which are very important to the local community and which often include families and young people. Young people's drinking was thought to be associated with a lack of recreational opportunities and parental facilitation of underage drinking.

Participants felt there was a reluctance of local decision makers to address overprovision of alcohol licences. They felt that they were incentivised personally or through their personal networks to ensure alcohol provision at events for social (not wanting to be a kill-joy) and financial reasons.

Discussion was also held around the perception of services or twelve-step programmes/fellowships. In some communities, alcohol support services were provided by religious organisations which participants said acted as a deterrent some people needing help, particularly young people and members of the LGBT+ community.

Question 2: What suggestions would you like to provide us with as we move forward with this project?

Responses: In terms of recommendations for how to improve prevention of alcohol problems and provide support for people in recovery, participants made suggestions in terms of improving services with plans for assertive outreach. This entails bringing services to people in the form of mobile units and home visits, not punishing people for missing appointments, and greater follow-up with people who drop out of services. Furthermore, greater training and incentives for healthcare and service providers living in remote and rural areas should be provided, given the difficulty in recruiting and retaining staff. Participants also had suggestions for improving access to services, which included investment in improved transport links to make them more affordable and frequent, that bus passes be provided to service users and making teleconferencing or videoconferencing available where relevant.

Suggestions to SHAAP as to how best to learn more about alcohol use in rural communities were to consult young people, healthcare professionals, social workers, trade groups and shop-keepers, and people in active recovery.

8.4 Huntly

The fourth consultation was hosted by the Aberdeen ADP's Central Forum in Huntly on 21 June 2019. SHAAP was invited to join their Friday recovery group meeting and the consultation took the form of an informal discussion with forum members regarding alcohol use in the community, services and barriers to accessing services and how improvements could be made.

There were seven participants in total:

Central Forum Members: Six (Service providers, volunteers and recovery community members)
Local Government: One

Discussion: Participants shared information about the recovery group. The Recovery Hub and Café operates every Friday and is a peer-led initiative focussed on support, friendship and building new skills. The group meet weekly to prepare and share a meal together. During our meeting with the group we discussed difficulty accessing services, including expensive and infrequent public transport, and stigma. Several group members shared their experiences relating to stigma in their community and with their healthcare provider. The group actively works to engage service providers and healthcare providers with information about the Recovery Hub and Café by spreading information by word of mouth, online, with posters and leaflets in the community and in GP surgeries.

8.5 Edinburgh

The fifth and final community consultation took place in Edinburgh on 7 September 2019. Participants from Perth and Kinross, Forth Valley, Stirling, Clackmannanshire and the Borders attended, as did participants from Alcohol Focus Scotland, Scottish Families Affected by Alcohol & Drugs and the Scottish Recovery Consortium based in Glasgow/Edinburgh.

There were 13 participants in total:

Service providers: 10 (ADPs, Forth Valley Recovery Community, Turning Point Scotland, Tayside council on alcohol)
Scottish Families Affected by Alcohol & Drugs: One
Alcohol Focus Scotland: One
Scottish Recovery Consortium: One

The format of the consultation was to group participants together based on their geographical areas and then to have roundtable discussions which were then fed back to the larger group.

Question 1: How do the following themes play into alcohol use in your communities?

- Gender
- Identity
- Demographics
- Culture
- Religion
- Prevalence
- Stigma
- Services/barriers to access

Forth Valley, Stirling, Clackmannanshire, Falkirk: Participants described a changing demographic of people with alcohol problems. Where previously, few women had been referred to services for alcohol problems now there is a more even gender split as women's drinking is on the rise. Lack of services tailored or deemed appropriate to the LBGT+ community was also discussed, with participants saying that LBGT+ individuals frequently feel that twelve-step programmes are not welcoming spaces for them and that it is hard to set up specific activities and meetings for this community given small numbers in rural areas. Participants also described the difficulty of accessing services and support in smaller villages and towns. An example was provided of people in Balfron are asked to travel to Stirling to access services when they are actually closer to Glasgow.

Participants from Forth Valley described the active Forth Valley Recovery Community and their various activities offered to people in recovery, including recovery cafes, outdoor activities such as walking and climbing and a recent app which they developed to help let people know what is available in their local area and when. The app is called The Forth Valley Recovers App.

Perth and Kinross: While larger towns in Perth and Kinross such as Crieff, Kinross, Aberfeldy and Pitlochry have recovery cafés, smaller towns do not. There are issues with linking up services and with different areas working together to provide care that is as convenient as possible for users. In terms of aftercare, people are largely left to their own devices and are usually not provided with information about mutual aid, recovery communities and other psychosocial supports available.

Borders: Participants discussed the difficulty of getting into contact with people with alcohol problems given that people are very reluctant to admit to having a problem and reluctant to go to services given issues around stigma and difficulty maintaining their privacy.

Question 2: What suggestions would you like to provide us with as we move forward with this project?

Respondents developed the following recommendations for improved prevention and support:

- Provide free phones and credit to maintain connections
- Use technology like telehealth, video-conferencing and email to keep in touch and provide counselling

- SMART Recovery meetings and recovery cafés in rural counties are needed and funding is needed for premises, bus passes and resources for activities
- Address caseloads for family support workers and other service providers
- Create a hub with resources and activities in order to destigmatise accessing services. A recovery hub could include resources such as a nurse and an alcohol and drug counsellor but also activities such as yoga, meal preparation, a café, *etc.*
- Assertive outreach and mobile support teams

9. ANALYSIS OF INTERVIEWS

This section summarises key themes that arose in the interviews. The interview template can be found in Appendix A of this report.

9.1 Context of drinking in rural areas

Participants were asked to describe where they were from and what role alcohol played in their lives and in their communities more broadly. Stemming from these questions came discussions of the particular risk of alcohol problems in rural areas, deprivation and alcohol in rural areas, cultural and social norms, and gender and alcohol use.

Rurality and risks of alcohol problems

Participants were asked if they felt that living in a rural area came with any particular risks related to alcohol problems that perhaps would not be present in a city. Many responded by saying that they felt that alcohol was ubiquitous in their daily lives. While acknowledging that this may be true in urban areas also, many expressed that it was particularly the case in rural areas given a lack of alternatives for recreational activities. This was seen as an issue which drove people towards substances, and also in some cases held them back from entering recovery once they had encountered problems.

Several participants described boredom and the lack of other activities in rural areas, particularly in the winter months as a motivator to use drugs or alcohol recreationally:

> *It drives you to boredom, there's a lack of stuff to do. There's nothing, you know, there's no Costas* [coffee shop], *you can't just go to a shopping centre or go to a retail park or go and have coffee or go…Just bowling or anything. That's the difference, people do just tend to fly towards drink or drugs, but recreationally, not problematic, not because they have issues or there's a bad childhood, but they just do it for fun. (P8)*

> *So, obviously, in the winter, we have very, very little light, and that can impact on people's wellbeing, it can impact on their motivation to do things. And then the weather, on top of that, can be pretty wild at times, and people are sort of confined to their own home. (P2)*

The social pressure to keep drinking was another point raised by participants, who referenced the lack of other activities in rural areas as a reason for this. Both of the following participants described the challenge of moving away from alcohol and having a support network to assist a person in doing this when everyone in your community continues to consume alcohol and it remains closely tied with social interactions.

> *The clever stuff, getting people detoxed…DTs [delirium tremens], et cetera, it's all very good, but what you need is someone in the community to keep you away from the booze, and there is actually no incentive in this area to do that. There is no cinema to go to, there is no theatre, all of the entertainment will take place in an alcohol environment. So you will have your bands playing in pubs or in halls where alcohol is served. In a way, there is no culture without alcohol. (P10)*

> *One thing that's really apparent in some of these communities is that there was a lot of pressure to pull people back into the world of drinking – there was no sort of set up that was trying to keep them in a sober world. So that issue of social networks and how sober social networks might reach into smaller places, you know, maybe needs some attention. I think the peer pressure to come back into the pub and back into houses where people gather to drink often is stronger than any sort of desire for that person to remain sober and [they] don't have enough social support for sobriety in a rural area, whereas in a town or city, you know, it's easier. (P15)*

Participants also described their experiences trying to extricate themselves from a social network centred on drinking and how it was difficult to escape from this pattern.

> *It's very, very easy to fall into the wrong crowd and get in the wrong situations and put yourself in trouble, so at my age I just keep to myself now anyway. (P7)*

> *Once you arrive here and settle in, you become involved with the local drinkers and sometimes it can be difficult to extract yourself from that scenario. The trend is more [that] people don't drink so much in pubs nowadays. It's more home drinking now. Drinking with like-minded people. So, it's even more difficult to escape. (P5)*

Drink-driving was brought up by several participants as an issue which they felt affected rural areas more given a lack of transportation options, challenging geography and lack of police presence in remote areas.

> *The risks are probably different, and one is drink-driving. Because country roads are dangerous firstly and also there's a lack of police presence in a lot of our rural communities. In our island communities, there is no police. So people will go to the pub and drive home…You know, if the police come on the ferry, the ferrymen phone the pub. You know, everyone knows that. The police know that. So, it's really difficult. (P6)*

Another participant spoke about the challenge of losing a driver's licence in a remote area and how this affected them.

> *If you get a reputation as a drinker that kind of sticks with you… In my drinking days I used to get lifted all the time, drunk driving, et cetera, and that's part of it. You lose your driving licence and then you lose your job. Then you're isolated, then you're drinking more because you... The depression, anxiety, the mental health stuff, you know. There was a, kind of, domino effect, I would say. (P16)*

Deprivation

Participants discussed the difficulties around identifying poverty in rural areas, saying that while indices such as SIMD would show that there was little to no deprivation in an area because of on-average middle-class and wealthy lifestyles, there were what were described as tiny or small pockets of deprivation which remained hidden. This issue of hidden deprivation was linked to alcohol use and wider societal problems. Many participants described their local area as peaceful, beautiful or idyllic but then said that there was a darker side to the area which they felt very few people talked about.

> *I live in a very affluent town, bit posher than you'd think. There are some social problems here, what I observe is mostly with cocaine and ketamine, but also alcohol can be an issue as well, but not as overt as some areas. So, it's not clearly visible when you walk through the town that there may be problems, it's very well hidden. (P22)*

Measuring deprivation in rural areas needs more specific measures such as qualitative research and closer investigation beyond current metrics according to one participant who felt strongly that current measurements did not capture the pockets of deprivation in their community.

> *It looks like, this area's fine because we don't have a poor area according to the national statistics. I think there's a real need for qualitative data relating to deprivation and also the opportunities that some young people do and don't have… It's almost like "A Tale of Two Cities". There's very, very extreme wealth and then you cross the road and there's real, real poverty. And they can see each other's houses out the window. But everybody goes to the same school. So it's really easy to create this idea that there isn't the deprivation because they live so close to each other, the wealth outweighs the poverty. And the school results are good. (P6)*

One participant described how the stereotype of the 'rural idyll' might get in the way of accurately measuring and assessing levels of deprivation.

> *I think the deprivation isn't as visible to the outside. If you walk through a very deprived council estate in a big city, it's quite obvious to the person walking through there that the level of deprivation is there… Whereas in the rural parts*

of the Highlands, you can kind of get blown away by how beautiful the scenery is and that kind of hides the poverty of the people living there. (P12)

Several participants noted that they felt that historical deprivation, dating back to Scotland's industrial decline, was at the root of many contemporary social problems including drug and alcohol use.

In the '80s when…deindustrialisation was going on, I was in contact with various communities who had lost their purpose, lost their focus, lost their income, lost their self-respect, lost the camaraderie that they had with their workmates. A lot of these places had working men's clubs and basically a lot of them just fell away because there wasn't the income and there wasn't really a great deal to celebrate anyway round here so people were really depressed. People in North Ayrshire and Lanarkshire and obviously in the Highlands. So that's never been recovered. Nothing's replaced it… People presenting with alcohol problems were trying to fill some kind of emotional, social, psychological, spiritual, whatever…trying to fill some kind of hole that had been developed in their lives. (P20)

The industry that was in my town when I was little was the woollen industry, farming industry, there was mining and quarrying, just around my old village. So, when I was a kid, everybody worked, everybody I knew, their mums and dads worked… But throughout the '80s, everybody, one by one, lost their jobs at the woollen mills, and the mines were closed down, so there's no working mines in Clackmannanshire anymore. I don't think there's any mills. My younger brother, his occupational advisor at the school said to him to be prepared to be unemployed for the rest of his life. I think a lot of people then turned to drink and using drugs, you know? I think the situation has changed a bit today, but I think those years were really damaging to the whole culture of that area…. That whole ethos, the hard-drinking, partying, drinking until you drop sort of thing is still part of the culture in this area. (P17)

Cultural and social norms

Participants spoke of alcohol as being engrained in their lives given the economic landscape of where they lived, given that industries such as tourism, hospitality, breweries and distilleries dominate many of their local areas and alcohol is very much tied up in these.

Alcohol, particularly in here, because of the association with the production of alcohol, is very much part and parcel of the culture and the area. It's heavily embedded in tourism; tourism and malt whisky production are intrinsically linked. We have, you know, whisky festivals, whisky tours, with all the bed and breakfasts and hotel trade relying on the whisky industry for income. And historically there's been a lot of people who either have worked with and in distilleries in the production side, or the associated trades. (P21)

This is the home of the whisky industry, the amount of employment that is based on either production or selling of alcohol is huge, and […] then you add

all the kind of tourism, hospitality, parties, pubs et cetera. We're dependent on it, kind of economically as well as socially, so it's very much embedded. (P12)

Other industries have their own ties to alcohol, such as farming, fishing, oil and tourism. Participants described patterns of behaviour linking alcohol to these professions related to work patterns, cultural norms, stresses and being away from friends and family.

Oil and gas comes in waves. So, they'll come and they're on a rotation, they're here without their families. So, there does tend to be that, kind of, drinking alcohol after work quite a lot because they just live in a hotel. There's also a lot of locals that work fishing. They go away for…sometimes, like, months. And then they do come back and go on benders when they're home. (P6)

When you speak to the older guys about it, when they were on the boats and that, they would always have a half bottle they were always drinking, just drinking at work, drinking at home, drinking any day, all the time, it was just part of their life. (P8)

Participants also described difficulties with certain cultural groups who were working in the area and experiencing alcohol problems. These groups were described as hard to reach and that problems got to an extreme level before any healthcare was sought.

You get pockets of alcohol problems in the area because this is more of a tourist sort of area with lots of castles and hotel staff. We've also had a pocket with the Polish community where we had a period of time, a couple of years ago, we were using interpreters a lot, because we had a fish farm in the area that was employing Polish people. But they weren't doing much to help them integrate or doing anything in that point of view. So, once they hit problems with alcohol and they didn't have the job anymore it was quite difficult. As soon as they stopped functioning, then they were wheeled in and we had to sort them out. (P14, Group)

Participants indicated that they felt that all social occasions, such as weddings, funerals, birthdays, traditions etc. in their communities were all centred on alcohol. Many indicated that this made it challenging for non-drinkers to participate in these activities.

Everyone has that entrenched, engrained culture of 'alcohol is what you do of a night'. Whether you're going out or not is irrelevant, there's a lot of home drinking in our more remote areas because there's less pubs and clubs. There's an expectation that alcohol features in your family celebration, and so even if you're somebody in the family who doesn't want to drink, the rest of the family do drink and you're almost isolated if you don't join in. And it's quite difficult in a small community to set up anything quite different to that, because that's what everybody does. (P13)

Alcohol plays a very significant role in the culture. It's associated with weddings, with milestone birthdays. It's associated with funerals and it's just associated in general, like at the end of the week everybody gets completely blazing drunk…It's been normalised to get completely off your face. I'm teetotal so I can't go to weddings because I'd look like a rude…you know? It's expected. If you don't drink you stand out as being abnormal in some way and it ruins your social life basically. So, there is a huge pressure. (P3)

We also have a sort of unique ballgame which happens at Christmas and New Year. It's kind of like a mass brawl, there's no rules, you just have to get the ball from one end of the street to the other, depending on what your goal is. So, when the Boys Ba' has started getting more popular, the parents have quite a strong pressure on them to provide a party for the boys. So, we know that we have a couple of hundred young kids, under 16, in a shed, or a garage, with vast quantities of alcohol. (P2)

Gender

Several participants mentioned differences in how alcohol problems present in men and women, and how gender affected people's perception of alcohol problems.

Getting drunk is seen as something which is a badge of honour, a 'manly' thing to do and worthy of praise rather than concern. (P1)

From a female perspective, we do know that there's a point where the kids have all left home, the relationship with your partner is maybe not what you thought it was, there's a sense of isolation, there is that kind of, "how do you get a connection?", and in some of your remote areas, there might be very limited routes for you in your mid-forties, early fifties, to engage. (P13)

Participants also noticed a different presentation of stigma when it came to women's drinking, noting that services and communities treat women with alcohol problems differently to men and that some support systems are not set up to support women.

There's such a stigma against women who drink here because… There's still a tradition of seeing women like it used to be in the 1950s. The women I work with say that they can't go to AA because it's not appropriate to their needs. I think they've just started a women's group, but they say what happens is that the places is opposite a shop that's open practically 24/7… They said if you go into the building they tell everyone who's going in and out to the AA meeting. (P4)

I think there is definitely gender disparity when it comes to the support of people who have issues with substance. I think the kind of support that's offered it's obviously lacking but the responses…they're so judgmental to women and where it's a woman who's got a substance issue, the children are removed. Where it's a man, he has unsupervised contact. (P3)

9.2 Young people and alcohol

The young people interviewed for this project agreed that alcohol was a problem for some of their peers and/or themselves, which was echoed by service providers supporting young people.

Participants described a variety of settings where young people would consume drugs and alcohol.

> *But there's definitely quite a few that I can see having serious problems. Because it's like not even ten metres from the school gate there's this place in a woods where some people go and they're just like…I actually found out they do lots of different drugs, they're always smoking weed and whatnot and lighting fires in the woods, this is on lunch break and stuff as well. (P18)*

> *Mainly drinking on the streets is a big thing for [Town]. And loads of people like underagers would be doing that and like going to sit up [Hill name] hill; And we would just sit up there and drink and stuff like that. (P24)*

> *I used to be a [Scouts] Explorer but my old leader left and with the new leader, he couldn't keep a cap on people, and there were people doing everything from ketamine to…like obviously drinking, but that was just like the bottom line of what they did on camps. So, I sort of stopped hanging around with them. (P18)*

Reasons for drinking echoed comments of participants regarding drinking in general, with most people saying that a lack of recreational opportunities was one of the main reasons behind underage drinking, and the problems with sustaining alcohol-free spaces in their community. These spaces were identified as being particularly important for youth perceived to be 'at-risk' of alcohol problems, such as those identifying as LGBT+ or coming from challenging family circumstances.

> *There's a very big problem with a lot of the young people up here don't have access to a lot of social and recreational activities. I mean, obviously with lockdown but even before that, they were going to close down the one thing which was the youth café, that's the one thing for very vulnerable young people, they were just going to take it away. They've had to like panic, like try to get funding for this, local authority won't fund it. And these are for our very vulnerable young people who are socially isolated or stigmatised for whatever reason. These are ones who belong to LGBT+. These are ones who come from chaotic families, different things like that. They often tend to, and not to sort of label them, but they do tend to have a higher risk of substance misuse and alcohol consumption. (P3)*

Safety of young people was a concern brought up by several participants. One participant described predatory behaviour towards young women who had been drinking and then had no way to get back home again.

There are older predatory males who supply alcohol to young girls, that's a very regular thing, not something that's been actively tackled. I mean, all that really happens is the police will seize the alcohol and pour it down the drain and it's like "job's a good 'un" but it's not, because this guy's still there doing this and supplying to very vulnerable girls… It's happening still. (P3)

Another participant expressed that underage drinking was seen as normal and even funny.

There are young people from the age of 13 who are getting drunk. There are young people who end up in A&E sort of 15, 16 [years of age] *because they've drank so, so much but it's seen as funny. It's seen as…you know, it's not seen as the massive like very dangerous problem that it is. (P3)*

Parental facilitation of alcohol was mentioned by young people and service providers.

There are issues of concern around the access to alcohol with young people especially, the parental facilitation of it. It's not seen as a big issue, you know, give your kids a pack of lager, or a bottle of vodka, and send them on out for the night, or send them round to somebody's house that they can have a party for the night, you know. It's not seen as anything concerning. (P1)

The parents have a lot, I think, to blame as well, with the fact that if they're having cupboards specifically for alcohol that aren't guarded, children can open them, see them, and see the impact. Or their parents are buying alcohol for them… (P19)

It just seems like the school ignores it and then parents just sort of say, "Ooh, all kids do that." (P18)

All three of the young people who participated in this project agreed that education around alcohol and drug problems and what to do in order to get support could use some improvement. They described their experiences at school and made suggestions as to how education could be made more effective in supporting and preventing substance use problems.

I mean, we have PSE [Personal and Social Education] *classes, which is social education, but we didn't really speak about drinking and we basically just got told not to do drugs and then learned how to put a condom on a banana, that's about it. (P18)*

This is they should be teaching in PSE. I should, so should my peers, know what services are out there… Just like we know the number for Childline, because every year we get an assembly on that, and just like we know the Samaritans and things like that. That kind of information about alcohol and drugs and smoking, all health issues, they should be at the front and centre. (P19)

However, for one young person it was in fact their school which referred them to a service which helped them with the problems they were experiencing.

> *With my experience anyway it was actually the school that picked up on it when I was still in high school and they referred me to Action for Children. But I really don't think if the school never picked up on me then I wouldn't have got any help. (P24)*

9.3 Family support and alcohol

The majority of participants identified family support for those affected by alcohol problems as a gap in services.

> *Family support is volunteer run, so it's run by one of the specialist nurses that works in the NHS recovery service. She runs it alongside somebody from the carers, like people that look after carers. They're all adults that receive that support. I do think there's not enough support for families. And like I say it's volunteer run. It's not something that has, like, its own funding stream. And there's a will to make it work. But there's not as much proper resources for that as we would like. Equally there's no specialist support for children affected by parental substance use. Or children and young people with their own substance use problems. (P6)*

> *What I've seen is that there is absolutely no support for families here, none at all. It is tokenistic. So, SFAD* [Scottish Families Affected by Alcohol & Drugs] *don't do any work here because they're not commissioned to do that by the local ADP. There have been other services that are commissioned by the ADP that are supposed to do some family work but don't really, so it is very lacking. And I know from my own experience and the experience of my own family that that would have been really helpful for them to have some support from a family service, but that just doesn't happen. And the services that are commissioned here, if I can be completely frank, they're pretty awful. I'd love to see some proper evaluation of the work they do because it's crap. (P23)*

Further challenges in offering peer support through fellowships was the lack of interest, due to small numbers and few people recognising that they themselves could use support in relation to a loved one's alcohol problem.

> *This lady tried to set up an Al-Anon group about two years ago, but she wasn't successful. We have only one Al-Anon lady. She has been a staunch follower of Al-Anon, but she's on her own. I think the trend is that parents or wives or husbands of alcoholics, don't really see that they've got a problem, it's the partner that's got the problem. They make sure* [their partner] *goes to AA and they don't really see that they have any problem… It takes a bit of self-analysis to see that you are deeply affected by the partner's alcoholism (P5)*

A participant who was in touch with Scottish Families Affected by Alcohol & Drugs described her experience as positive and described the various supports that were offered in her area.

> *I used to meet up with the local support worker for the area, there was quite a large Forth Valley area, she would come, and we would meet somewhere that was central, and just sit and have a chat for an hour or so. And it was good, I always enjoyed having the one to one interaction with her and being able to talk about things or what's going on in my head or going on at home. There's support groups as well which run once a month. Last year we ran a kind of…a trip, a weekend, an overnight stay to somewhere as well, filled with activities like yoga and stuff like that, so they are doing…and they sent us all a wellbeing pack, actually, I got a lovely wellbeing pack during lockdown as well. They have a phone line which you can go and chat to people at certain times as well, they are doing a really good job, I would say. (P9)*

Another participant described the difficulty she had experienced as a family member in being included in her mother's recovery process as she navigated services and law enforcement.

> *Last week [the service] phoned the police, and no one got in touch with us. And, you know, we talk about having a next of kin and a next of kin only gets to know something if somebody's actually passed away, don't they? And there should be the thought process of, if my mum is threatening to jump off a bridge, because that's what she was threatening to do, to a service and they know that that's my mum, I want them to get in touch with me and tell me that. I don't understand why they don't. But then I think they should still have a responsibility and phone a family member and say, look, we've had to phone the police because this is how your mum is, we just wanted you to know. (P25)*

A participant described a family service operating in Ayrshire that they were hoping to bring to their own community.

> *There's a Recovery Café, I volunteered with them a couple of times and they offer family support as well. They take families away on retreats about three to four times a year. They do sound healing and offer tai chi, reiki and activities, so there's very much a focus on family recovery there. That's something when I get involved with Serendipity that I thought we may be able to start implementing down here, but it's just lockdown has got in the way... (P22)*

9.4 Services

When asked to describe services available to them, should they need them, participants identified four categories of support for alcohol problems: the NHS, third-sector services, AA and visible recovery communities.

NHS

Participants described their community addictions teams, A&E staff and GPs and various strategies for prevention and support of alcohol problems.

Service providers differed in their perceptions of services and availability. A healthcare provider and a service provider from the same area held two opposing viewpoints on the availability of services. The first described a real effort to provide services appropriate to individuals and signpost them accordingly.

> *What we do as a service is in order to create as many opportunities for people to come into service as possible, we have open referral. So, we don't say that somebody has to go through their GP. They can get referral through any service, so if they happen to be in criminal justice or in housing or at the Job Centre, they could be referred in by them, or they can refer themselves. We do a quick 15 minute standard screening chat with them to say, what is it you're looking for, how do we help you, are we the right service or is there another service that might be better placed to do it, and how do we help you get there? (P13)*

In contrast to this description, a consultant physician working at a rural hospital from the same area described a very different reality for his patients. Whether this contrast is due to a lack of understanding by services who are in more central towns and cities, or a lack of knowledge on the part of healthcare professionals about what is available for their patients warrants further investigation. This healthcare professional suggested that a lack of aftercare, psychosocial support and detox beds are major obstacles for providing effective care for his patients.

> *Well, the official line would be that the patient presenting to his general practitioner and saying, look, I've got a problem with alcohol, would be able to get into some service. The reality is that service is based is 65 miles away, and for the most part, there is no alcohol service at all… So you could argue that the job of a physician here is to get you ready to drink again from which is quite frustrating for everybody. There is one alcohol CPN* [Community Psychiatric Nurse] *in the area and there is an organisation which is private, and these try to do their best but without access to services and proper psychological counselling, it's not useful. I really don't take people unless they're in full-blown DTs* [delirium tremens] *to detox them, partly because of the lack of beds, but more because there is no follow-on for them. So, if you put someone through the horrors of a proper detox, you have nothing for them to go out to afterwards, so you actually in a way put them at greater risk, because you detox and get them out there, they're going to start to drink again. And I've put them through hell in their detox for nothing. So that is a major frustration, the lack of community-based alcohol services. (P10)*

Other participants echoed these concerns around availability of rehabilitation spaces and detox beds, saying that these were difficult to access or not available in their community.

> *So, we have our NHS recovery service that does prescriptions. We do in-hospital detox in the hospital. We also do have a budget set aside for off island residential rehab. And that's used not often, but it could be used no*

times one year and then, like, three times the next. There used to be a residential rehab here, it was residential rehab that was on one of our rural island communities actually, so people did go to it and stay. But it's been closed for quite a while now. (P6)

These participants went on to describe a 'medicalised' model for support with little in the way of social supports for people with alcohol problems. Available support is delivered by a service oriented towards opioid substitution therapy for people using drugs in the community.

I would say the main support service is the specialist treatment in the NHS. It's unfortunately called the Substance Misuse Recovery Service. They're on the prescription service for people on opioid substitution therapy but also for people with problem alcohol use. I can't think that there's really anything else formal but there is Alcoholics Anonymous. But we're really lacking that social support. We currently have a really medical model. (P6)

There was concern over how to appropriately develop and implement assertive outreach from one participant because of concerns that people would not make use of them because of the fear that their standing in the community would be damaged by accessing services. They went on to describe the difficulty of getting people into a rehabilitation service which in this instance was outside of the island community.

We had a pilot project, on assertive outreach… I think we wanted to trial it because it's a difficult one… A lot of people have got a position in the community which would prevent them from even accessing services. So, what you might get is people phoning in saying, we want private rehab for this individual. And of course, we don't have residential rehab on the island, we have to send people away. And there's a bit of a protocol around that, so they would need to have tried everything. So, we would have wanted hospital, local hospital detox, we'd have wanted community detox in their own home, we'd have wanted a sort of commitment through the drug treatment, and alcohol treatment service. And these people just don't feel able to go through that because of, they might be a teacher, or a doctor, or something in the community, and just unable to do that. And that's difficult. So, you can see people just having a massive spiral, a downwards spiral, unless they just, through funding actually, are able to go away. (P2)

A participant with lived experience of alcohol-related problems described their experience of not knowing where to turn for support, demonstrating a greater need for signposting, accessibility, flexibility and the option to self-refer.

So, my route into it was just desperation, not knowing what to do, eventually just looking through the internet to find out who offers these services, ringing up and seeing if you can get an appointment. And it was difficult. For me the services from that perspective were there, but I didn't know they were, and I didn't know how to get into them… There were lots of barriers put up by services for me to actually start engaging with them properly. But once I got sort of over those barriers the support was there. For me the issue was

understanding how you get into those services because it was exceptionally difficult for something that should be really easy. (P23)

One service provider gave an explanation of how alcohol and drug services supported GPs in order to provide information and support to them in being able to provide care for their patients with substance use problems.

Linking in with GP practices is crucial. The team manager at the [integrated drug and alcohol service] *has worked extremely hard in terms of looking at how to support the GP practices. You know, there's no point in criticising GPs because of what they're not doing. You've going to start from the pressures that they're already under and look at how the systems that you're providing can be tweaked to be supportive of the GPs so that you're making it attractive for engagement. The way to do it is saying, how can we help you? That's very different to saying, what are you going to provide? (P21)*

Third-sector services

Participants mentioned the following third-sector organisations in their interview responses:

- We Are With You (formerly Addaction)
- Turning Point Scotland
- Change Grow Live
- Women's Aid Orkney
- Orkney Alcohol Counselling & Advisory Service (OACAS)
- Scottish Families Affected by Alcohol & Drugs
- Scottish Recovery Consortium
- Food for the Way
- Action for Children
- Action on Alcohol
- Arrows
- Samaritans
- Love n Light Recovery
- Serendipity

Alcoholics Anonymous (AA)

All research participants were familiar with AA. Depending on the region, there was diversity in how active local fellowships were. Participants differed in their opinions of how AA would work for them, or how effectively they viewed it as working for others. Some referenced the religious origins of AA, saying that in their community it retained this element which made it unappealing to them.

I'm not religious, I'm an atheist, and the whole religion part of it I just couldn't get my head 'round that. I know in big cities AA meetings are quite different, but in rural places they're so steeped in those traditions. And this area is steeped in every tradition you could possibly imagine… It wasn't for me. But I found my own way with the help of some other people. That's why we started

the little recovery movement here because it's just another pathway for people and it's a lot less challenging and it's just dropping in to have a cup of tea and a chat with people, as opposed to a meeting, if you know what I mean. (P23)

Other participants acknowledged that some areas have more active groups than others and this depends on the environment and the individuals involved at the time.

You have AA groups that work really well, depending on who's round it as well as AA groups that are maybe smaller or not so well attended, just depending on the environment that they're set up in (P13)

There's variously inactive Alcoholics Anonymous, people drinking tea, great self-support, great support within those groups, but they kind of wax and wane, you won't see them advertised, it's very hard to get people to actually engage, but occasionally they've been very, very valuable, useful (P10)

One participant praised the various twelve-step programmes available in his area but raised concerns about how best to connect with more people in need of support. He expressed particular disappointment that his GP would not work directly with him and take leaflets for the GP surgery, though the GP did say he referred patients to these groups.

There's quite a strong fellowship of AA, Cocaine Anonymous (CA) and Narcotics Anonymous in the area… I'm a member of CA and I have spoken to my GP and they are not happy to take in leaflets which is really crap. However, they've said they definitely recommend people to come to us. I think from our side in CA we need to do a bit more raising awareness stuff to let folk know that we are here. (P22)

Visible recovery was another point raised by a participant, saying that in order to address shame and stigma in rural areas, it is helpful for people in recovery to be assertive and visible to others.

I think in rural centres it's got to be assertive. They have to see people out there saying, I am sober and bursting that shame bubble and celebrating recovery so that the wider community can start to see that. You can be anonymous within the AA context, but it doesn't mean to say that you can't bring your lived experience out into the wider community. That is happening more and more. That's happening all over the place. (P20)

'Recovery communities'

Participants with lived experience of alcohol problems were all in agreement that peer support from someone who themselves has had alcohol problems in their life at some point is one of the most powerful tools for helping people recover. Many agreed that while other professionals may have been helpful, meeting people who were in recovery who had once been at the same low point as themselves was a crucial turning point.

One of the things I really needed to find in order to get recovery in myself was that having an example from somewhere like the fellowship. That's quite difficult to get if you just don't know anybody. The only people you know drink but don't have a problem with it, or drink and do have a problem with it and, like, don't know what you're talking about and think there's nothing wrong with me or you. (P17)

Participants described the value of people with lived experience sharing their stories and expertise as a starting point for finding common ground and seeking advice, in contrast to people who have simply "read it from a book".

The people that've done it, that are a few years in, when you talk about stuff, they know what you mean, they know what you're on about. They haven't just read it from a book, do you know…? The people that are 30, 40 years in or even five, they have the best knowledge. They know how deep down the hole it can get…if there was more people...like lived experience people in the service, then you would have something in common, you would know, you would chat about the same thing. (P8)

One participant spoke about the feeling of comfort in a safe space provided by the recovery community in his area, saying that he derived an immediate connection with the people supporting him as they had all experienced similar trauma to his own.

Let's try and help this person, and that's what the recovery community does. They never make any judgement. I felt safe amongst the wee drop in…people there were just like hoping for recovery. Looking to get out of their flat, their loneliness, because they've lost everything, and they're on their own, same as me. They're all like me. We've all been through […] the horrors of addiction and withdrawals. We've all been through losing family and loved ones and losing their houses and losing our jobs, losing our driving licences. There is a common feeling and a language here for that stuff. You know, it's not about the words that people say, it's the feelings behind it. (P16)

Similar comments were made about the need for more people with lived experience offering support.

There's not enough people who have been through it that are giving you advice. You know, who've got the badge, I've been there, I know what you're like, son, I remember I used to be like that, and we could do with more people like that. I go to AA which helps because that gives you a chance to talk to people who have been through it… But I'm a wee bit older and I'm sure if there was somebody who's been through it, they just put the arm round them and say, look, this is what I used to do and all that. (P7)

Recovery communities provide invaluable support after people are no longer in touch with services. This participant described his experience of being signed off by his psychologist and support worker but continuing to need support. He described the values of connecting with others in recovery for mutual support and understanding.

What I also found as I moved on through my recovery was that there was very little beyond that. So, I got to the point where I was signed off by the support worker, signed off by the psychologist as saying I didn't need any more intervention from them, but actually I needed some more support to stay sober. And there was at that point very little there. So, there were some very small support groups available, so I did manage to find one that I eventually got over myself and went along to and figured out that actually talking to other people in recovery was a really positive thing for me to do. And actually, when I started to do that, I made another leap forward. (P23)

Recovery Community members outlined a variety of activities that they engaged in to make members feels welcome and to bring a sense of purpose and joy back into their lives. Participants from Forth Valley, Highland and the Borders mentioned recovery cafés, gardening, rock-climbing, rambling and cooking. In light of the COVID-19 pandemic, many of these activities have been halted and communities are using social media, WhatsApp and Zoom as a means of catching up with one another.

And I think ultimately we want to get people up and out of their houses and learning new skills and getting connected and socialising and working on their recovery and a big part of that is doing our volunteer training and giving back as a volunteer and learning how to live your life without a substance. But I think it's the first step that we didn't realise the power of. (P17)

With the [recovery] cafés, we could do food, we could have a family night, we could have barbecues, we could have live mic nights, all of that kind of stuff. When we redesign and we do a relaunch, I want it to be a little bit more like a hub feel. So, we'll have a quiet part where you can sit and read and there'll be a resource part where you can get resources and look at things… I want to try and get some laptops from the Connecting Scotland Fund. I've just bought two tablets [mobile computers] *so that people can do that kind of thing. (P25)*

We do a lot of outdoors stuff because I guess what you've got in smaller communities is the shame. So, what we've done up there is look at, well, would you want to come out and do some outdoor work? And there's that way which they can just have a conversation with you and then get in via a different route. (P13)

Forth Valley's model for connecting people experiencing alcohol problem with peer support is one that has lived experience integrated within the NHS service.

I think one of the unique things in Forth Valley is that we have people embedded in our service as practitioners who have been addicts themselves in the past who are in recovery, through an organisation called Change Grow Live. I mean that's really refreshing and maybe those practitioners can work on people's motivation better than I can. You know, "I was once like you, but look at me now". We have these practitioners who are at our weekly caseload discussions who work in harmony with us. (P15)

While visible recovery communities are flourishing in some areas, they face real challenges in smaller areas. Several participants from island communities reported that there were no visible recovery groups that they were aware of.

> *Having a recovery community would suit some individuals, especially people who have maybe been used to that in another area, who've decided to move here. But for people who are managing a dependency privately, whilst trying to carry on with a career, and support a family, live in a small community, it might be kind of difficult for them to go and attend some of these things, even though it would be very beneficial for them. (P2)*

> *We have no recovery community that I know of… We're really lacking that social support. But we are about to launch a Recovery Hub. We're hoping that that'll also fulfil that tier for a drop in, casual, safe space for people, you know? (P6)*

Other participants described various difficulties that recovery communities and AA have in linking up with NHS staff in order to provide support for people. Accessing people who were in need of help or getting the funding in order to run their activities were both brought up as issues.

> *We have a kind of mixed relationship with the NHS. We used to have the hospital, it was solely for detox, and they had a couple of wards in there. And when an alcoholic came in there, they used to phone the AA and say we've got somebody here for you and we'd go up and see them and bring them to meetings and things. But that relationship with the NHS kind of soured about 15 or 20 years ago when, because of confidentiality, they stopped referring people to AA and they offered alternative solutions… If we had a better relationship with NHS we could circumvent their secrecy situation. (P5)*

One participant expressed frustration at funding allocation to recovery communities, saying that in the end the funding had not been invested directly in the community but rather in an existing service which had not made any innovations.

> *There was some money last year to support the recovery communities. And rather than sitting down with some representatives of the recovery community who would have been more than willing to go and sit down and talk about it, there wasn't even a conversation about it. That money was just given to a service provider and they appointed a person who used to work for them as a recovery community development person. And that person has done nothing. So, for me that's just lazy commissioning and with no accountability. They ticked the box. But nobody is evaluating their work properly, nobody's holding them to account; they just do whatever they always have done. The engagement with the recovery community is tokenistic at best. (P23)*

9.5 Barriers to accessing services

Participants shared experiences of the difficulty of getting both mental health and substance use support, describing situations where they were shunted between mental health and addictions services and fell through the cracks.

> *There's no service here that directly can work with everything that you've got wrong with you. So, if you go to a drug and alcohol service, and actually you're not using enough substances, and it might be something about your mental health, they'll bump you to mental health. Or if you go to mental health and you've got drug and alcohol issues […] as well as mental health, they bump you to drug and alcohol because they'll say that they can't do anything with you while you're still under the influence, you know. And there's that whole tug of war thing that happens all the time. (P25)*

Participants also reflected on the challenges of linking up services, or on supporting people with drug and alcohol problems who may be referred from or to other services, such as youth or housing services.

> *My worry is sometimes people just feel like, oh, well, that's not really my job or that's not really important to me, you know, and concentrate solely on the job at hand. I've had referrals come to me that say, drugs and alcohol, yes, and then nothing. And then I'll push it back and I'll go, so, you're going to fill in a Section 5* [a nurse or doctor stopping you from leaving the hospital under the Mental Health Act] *and you're telling me that somebody's got drug and alcohol problems so you must have had the conversation surely to know more…I don't want War and Peace, but I at least want to know if they're in treatment services, if they're not in treatment services, who's supporting them, you know, where do they think they are with their drug and alcohol use. You know, are they somebody then that's actively in recovery and do they need support. It's not rocket science. (P25)*

Participants shared experiences of challenges with wait times for services. A family member described the experience of their loved one not receiving timely care and comparing their local hospital's resourcing to that of a larger city.

> *My son is waiting to go into hospital for a detox and has been waiting since February. Though we have just found out that he was not actually officially referred until July. Since the max waiting time is three months we've been told it could be up until October before he is admitted. In the meantime, I am watching his health deteriorate every week. Admissions for detox rely on there being a place available in their mental health unit. There is no separate ward/unit for detox patients. This would be bad enough at any time, but I believe that due to COVID-19, there has been an increase in patients requiring in-patient treatment for mental health issues. In Glasgow however, and I am assuming perhaps in other city areas, there is a dedicated ward/unit available solely for patients to be admitted for detox. (P9)*

Challenges for service providers and healthcare professionals

One participant mentioned the challenges of providing a service in a small community where you also live with your family and are liable to seeing patients outside of working hours.

> *And that's a wee bit of awkwardness because…and this might be a kind of rural problem for people, if you live and work in the same area you may well know the clientele from the local scene where you live, you know. I've had to sort of side-step some patients. (P15)*

Recruitment and retention of staff was another obstacle raised by several NHS staff members, some of whom highlighted their belief that there is a perception in medicine that rural postings are less desirable or prestigious than in urban centres.

> *I would like to change the medical profession's perceptions of what people do in areas like this, because it's usually when you can't do anything down there, you couldn't get a job anywhere else and you work out there. And this perception is entirely wrong, but is one that is actually propagated constantly, so I would actually, through experience and through representation, try and give the actual vision of what people do when they work in rural areas. (P10)*

The problem lies wider than just the individual postings but also the economic opportunities for their family members. In light of the COVID-19 pandemic perhaps there will be a greater opportunity for remote work which could go some length towards addressing this problem.

> *My biggest headache is recruitment. You can try and recruit for posts for months and months and months, it's just that there's nothing to attract people. About people's partners, we advertised a job in Campbelltown for 18 months. We got somebody suitable for the post. She accepted the post, but then she couldn't come because she couldn't get a job for her husband. So, the people are there, the people are there that want the jobs, but there's got to be more to go round it, there's got to be more for people to come to. (P14, Group)*

Staff also expressed that they felt they were under-resourced for all that they were asked to do, and they felt that their job descriptions continued to expand while their salaries or teams did not.

> *I feel there needs to be a more robust structure for staff, the governance isn't what it should be, I think, working in rural/semi-rural. And I think encompassed in that is remuneration packages for staff, paying staff for their skills and the qualities that they've got, rather than keep adding on parts to your job description. And that would attract more staff as well…I don't think* [the NHS Health Board] *values their staff as well as they should do, and they rely on good will and a dedicated public service ethos that we all have. (P14, Group)*

Healthcare and service providers also mentioned that they felt that because they were based in rural areas, they did not have access to the same resources that those based in urban centres would have. Training and education opportunities were refenced by several participants:

We struggle to get the same training opportunities and opportunities for networking for our services. We have got a really small service and it's really hard to get staff across the board in health and social care in Shetland. So, we can't be sending our staff away for three days for a one-day conference because our core services will be chronically understaffed. (P6)

We had some volunteers from [Local counselling service] *who were qualified counsellors, well, a lot of them had had a six-week training course. We are desperately short of counsellors, but we can't get the training because to get the training you have to be able to fly to Aberdeen every Wednesday to do a day's training over two years. Well, I work full-time, and then to pay the flights to and from Aberdeen… So we can't get the training to enable us to offer specialist support. (P4)*

Difficulty for professionals in participating in meetings was also expressed. Given the COVID-19 pandemic this has been addressed by fully online meetings and given the difficulties for island communities in particular to attend in person this is a welcome change.

So, if you think about just very basic things, like the Scottish Government will hold quarterly meetings for staff to attend, but we have to make our own way there, and that comes out of your allocations. So, we get the smallest allocation of money from the Government, but it costs us the most money to get to that meeting in Edinburgh, if we want to attend in person. (P2)

Online services

Discussion surrounding online services included reflections about accessibility. Concerns were raised lack of internet connectivity in remote and rural communities and how this could affect equitable service provision.

Networks are a problem, broadband is a problem…But also just because people carry a smartphone doesn't mean it's got data. (P13)

In contrast to this, for those with access to quality internet several service providers said that they felt that continuing this trend of online services would be beneficial for people in rural areas as it addressed issues of stigma and transportation.

Essentially, start doing remote working, and making the most of the technology. And we were discussing it earlier, that a lot of folk are actually happier having access to technology and accessing services that way. And we've had some feedback from the CMHT [Community Mental Health Team] *that, you know, their clients feel comfortable doing that. So perhaps, modern technology will offer us a means of overcoming it. (P1)*

So one of the things that we've found has been an advantage to people through the COVID-19 crisis has been that people can engage on Zoom meetings, and don't have to leave the house to do it, they don't have to tell anybody that they're going, they don't have to catch the bus that's only one

every three hours, they don't have to spend all day getting somewhere for an hour and a half meeting and then travel all the way back again. (P17)

Transportation challenges

Almost all participants mentioned transport as one of the significant challenges that people face in accessing services due to high cost, lack of frequent service and length of time for journeys. Island communities reported particular difficulties.

> *The geography of the place presents challenges…With regard to the services, we do tend to be quite Mainland centric. Mainland is the main island where everybody lives. Anybody who's outwith, on one of the outlying islands who has an issue with substance use, to access third-sector statutory stuff, a lot of the time it would have to be coming into the mainland, which involves a ferry or a water taxi, perhaps, or catching a plane. Those are dependent on the weather; the weather up here is temperamental to say the least.* (P1)

> *Access to recovery services is extremely difficult, particularly in our area. The nearest services are an hour and a half away if you drive. If you rely on the bus service it's fairly hopeless. It's two buses away and probably two hours away on buses to get to the where the main services are.* (P23)

Lack of transport options can also lead to dangerous situations for people who have been drinking and now have no means of getting home safely as evidenced by this description:

> *We have taxi companies, but if it's a really cold, winter's night, and you need home desperately, you will take a lift home from anybody. And what we're seeing is a sort of set of young males, I'm afraid, with their cars, and they'll just circle the nightclub, the pubs, looking, and offering people a lift home. They obviously are looking for women that are a bit worse for wear, and maybe a bit younger, a bit vulnerable. And there has been incidents of them driving to a sort of very remote and rural location and being taken advantage of. Or driving too fast and scaring the wits out of them.* (P2)

Transport and long distances poses problems for service providers and healthcare professionals who are trying to reach their patients. This healthcare worker described the distance and time involved doing assertive outreach to their patients and how this resulted in home visits rarely being undertaken.

> *Assertive outreach is challenging, like home visits and such… One of the problems is that it takes up a whole day, nearly, doing it...three-hour round trip to see one patient in the remotest part of the catchment area. I mean COVID has changed that, these kind of outreach…I mean we still do the occasional visit but there has to be compelling reasons for it.* (P15)

Stigma

When speaking about stigma, most participants highlighted that they felt that stigma against those with alcohol problems is a problem all over Scotland, not just in rural

areas. However, many mentioned that they felt that it was exacerbated by the lack of anonymity in rural areas, and the fact that everyone knows everyone and will remember and judge those experiencing problems. Stigma was reported as a problem faced in the community, in healthcare settings, in the media, and online.

Stigma in the community

All but two participants described stigma against those with alcohol problems in their area as a major issue. These two participants shared their view that they felt that stigma was not a major issue for them, or that at least it had lessened over the years.

> *Everybody knows everybody basically, and you can't really hide away. I mean, I've been to jail and that and everybody knows I've been to jail, but nobody bothers about...you don't get stigmatised for it, nothing like that. (P7)*

> *There is certainly a bit of stigma, but AA, the people there, the function of AA is becoming a lot more widely accepted. It's quite often on television programmes. So, the attitude towards AA has sort of mellowed a lot over the years. (P5)*

A further two participants acknowledged that stigma still presented a challenge in their community, but that they had seen positive steps being taken thanks to shifting perceptions of recovery and visible recovery community.

> *Over the years, I have seen a remarkable change with stigma. I think it's because there is more of a focus on recovery rather than just sharing, regurgitating your problems and recovery has taken on a dramatic change in perception of what it is. It's not just abstaining from alcohol because that tends not to work on a long-term basis. It's the fact that there are other ways of beginning to fill your life. (P20)*

> *I remember the woman that manages one of the community centres that we use for our recovery café, she came to me one night and she said, "I just wanted to tell you…You're not who I thought you were at all. I thought when you said that there was a recovery community and it was recovering from addiction, I thought there was going to be people sitting under the influence, lying on the floor and ODing [Overdosing] in the toilet and being sick and causing problems and you were going to have to be gate-keeping", and she said, "it's not that at all. You're all lovely people, and I'm so sorry." She said, "it's not what I thought it was going to be at all, I cannot believe that I thought that." (P17)*

For other participants, stigma still plays a central role in how people with alcohol problems are viewed in their communities.

> *The interesting thing about the approach to alcohol here that it is involved in everything. Every town and little village is based around alcohol. But the most amazing paradox in alcohol is if you drink far too much and you're Jack the Lad, everybody loves you and you're a big man in the village. But the moment*

you get a problem related to alcohol, you're ostracised. The moment you get your liver disease, turn yellow, or you have mental health problem and you can't hack it anymore, you go right down the slide of popularity in villages. (P10)

The issue around stigma is the fact that in little places everybody knows everything… Everybody in the village knew that I was a bit of a drunk and I was always staggering around pissed. And I still struggle with that now, many years later, some people's fears and opinions. I try not to let it bother me, but it does. But I'm quite outspoken about recovery and I'll speak to anybody; I've been on the TV and all sorts of things speaking about my recovery. And I'll challenge people's perceptions about what an alcoholic looks like. (P23)

These concerns around reputation were echoed in these comments regarding the difficulty in remaining anonymous affects their own or other people's ability to seek help for alcohol problems.

I know it's a big barrier in rural areas because I used with people when I worked for [Service name] *who would say, well I'm not going to meet you there at that place because everybody knows that's where all the alkies go or all the junkies go – to use their terminology – and I'm not going there because I don't want to be perceived as being one of those people. (P23)*

Being recognised by a service provider or a GP with whom you may have a social or familial relationship was also cited as a barrier to accessing services and support.

People would rather come into town and be supported there, rather than going somewhere in their locality, because of the stigma and what people might think… It's that they don't want to be seen. Often what will happen is, if you walk into a service, often the people who are providing that service in rural areas will actually know that member of public very well. And they don't want to go and see their friend or their neighbour, they want to go and see someone who they know they can talk to in confidence. (P21)

So, I think that would be the norm across Scotland is you go and confess to your doctor, and most people will do that. Again, of course I didn't, because I didn't want my GP to know that I've got a drug problem. Once my life was so chaotic I eventually ended up at my GP, but for a long time. I found I had to cope because I was in a small area and again my GP knew my family and my mother and my children were registered at that doctor's, so I think that can be quite difficult. (P17)

Stigma in healthcare settings

Many participants in recovery or supporting a family member discussed the at times negative experiences of seeking help from healthcare professionals. As demonstrated in the previous section, a first point of contact for people seeking support for an alcohol problem is often a GP. However, these comments from participants demonstrate that they sometimes feel that their GPs are not always well-equipped to deal with supporting patients experiencing substance use problems.

To be honest, even medical staff, I've noticed them being very judgemental at times as well. You know, even GPs, my son's GP has been very negative and very…you know, just wanting to get rid of him, basically, and stuff like that. My son was ill last year, he was so rundown and he was depleted of everything, couldn't move, he was taking strange turns, so I phoned the GP, you know, and the GP was just, oh, you know, he knows what he's doing to himself, it's maybe time for some tough love. (P9)

Even otherwise positive interactions with GPs have left some participants in recovery feeling that that their doctor did not fully understand their problem and could perhaps use another specialist or further training.

My doctor is absolutely wonderful, helped me greatly, but she'll say quite clearly to me, "I don't believe you're an alcoholic because you can stop", and that's a very limited view. What happens with me when I drink is that I lose control. I can have periods where everything is great, it's rosy in the garden, but then the wheels come off and I'm on it all the time and life gets miserable. So, it's a thought I can't entertain, you know. So maybe having an addiction specialist in each GP surgery would help. (P22)

One participant, a healthcare professional, described a scene where a medical professional was openly breaching the confidentiality of his patients who struggled with a substance use problem at a meeting with other professionals, leading another community member to have to intervene.

I went to a talk a while back, and the local GP who was chairing it was totally indiscreet, he said "We all know who the local alcoholics are", you know, and he started to name names. And a minister of religion who was there said, "you can't be revealing confidential information" you know. So, there is that kind of problem… (P15)

Experiences with alcohol services have also left people seeking assistance feeling judged and like they do not want to continue with services based on negative responses to their attempts to get support, including judgemental attitudes and inappropriate comments from staff.

I got referred to statutory services by my GP, which was really not a good experience at all. It was awful, it was an awful experience. You had to go to the local hospital for an appointment with a nurse practitioner who was quite judgemental, unhelpful, accusatory. Anyway, for me I just wanted to run away and never, ever engage with that service again after that experience. They talked about getting social work involved, safeguarding my children, and all that. And it was just a really frightening experience for me. And for me that was like the first barrier straightaway - I'm not doing that again; I'm not going back. (P23)

The number of women I've worked so hard with because they have been using alcohol and have taken an overdose of paracetamol and I say to them, we have to get you to hospital. I've begged them until they have said, okay, I'll

go in. Then…they have been left there. They have been ignored. They have been left without anything or sometimes they have gone in and then have walked straight out and each time it's because the way A&E staff have spoken to them or the way they've been treated. I had another woman who was told when she was admitted for a detox, "Why don't you go to Saudi Arabia and live there, that would stop you drinking." (P4)

People working in healthcare also described a certain hierarchy of care which sometimes came into play when people with substance use problems sought treatment or healthcare for other medical problems. Staff reported that people using substances were sometimes seen as having "brought it upon themselves" and were therefore less worthy of treatment than other patients.

I think when we're talking about stigma, that stigma exists within professionals as well. And I sometimes think, we struggle a little bit in the NHS, even to get, you know, our drug and alcohol nurses will say, it's so difficult just to get a room in outpatients to see their patient, because the priority is way down the list compared to somebody else coming in to outpatients. (P2)

You know, if you are an addicted person there's probably a bit of stigma [that] *comes with that; the mental health unit is probably a wee bit more wary of you as a patient. There's the kind of feeling maybe that, you know, if you've got a mental health problem and you're using alcohol or drugs, well, you've kind of brought it on yourself might be the underlying prejudice there. Although we're trained not to be judgmental but there's kind of an element of that from what I've seen in* [this area]*. I mean that's something that is quite deep-rooted, I think… (P15)*

I think there's massive stigma around addiction. We did some stigma training recently and I know that there is hostility. Our detoxes are done in the hospital in [Town] and there definitely is hostility. People that work in the hospital feel frustrated about people that maybe come in for an assisted detox repeatedly. That's definitely been expressed to us. You know, I don't think that there is any place for stigma at all. But I can also understand that, like, our health services are really stretched. And there's a culture being created in the hospital where it's maybe that some patients are more worthy than others. (P6)

Stigma from healthcare professionals may have especially grave consequences as there is a higher likelihood of service users being recognised at their local hospital as is illustrated by this next point.

So, if you're an A&E nurse, and you're approaching retirement after 30 or 40 years, and you've seen an individual come in that revolving door, every weekend for the last 30 or 40 years, your motivation to support that individual is probably not very high… I think it's very difficult to ask some of these A&E nurses to look afresh at this individual. Sadly, there's been complaints from people experiencing poor treatment in our hospital, because they felt a stigma attached to why they were in there with alcohol issues. And again, no amount of training can sometimes eradicate that. And that goes back to, because

people know individuals, they know their families, they know things about them, and it's quite difficult. Whereas, in a big city area, you might not have that, you just take that individual at face value. (P2)

A participant in recovery shared a story of experiencing delayed care given what he perceived to be the attitudes of healthcare workers at the local hospital who recognised him and knew his history. As a consequence, he was not taken seriously, and his care was delayed for several days.

Broke my leg once…I didn't get a hospital appointment for two or three days afterwards. Then I got to the hospital and they said, oh, we have to get an x-ray, so I had to come back again, and clearly said to them, look, my leg is broken. But they're just thinking, oh, it's him, he's just been pished again, he's just fallen over, he's done it again, you know. Then finally they x-rayed me too, and say oh, you broke your leg. Yeah, I could have fucking told you that three days ago. (P8)

Service providers also describe a vicious cycle of a lack of support leading to further substance use problems, and then support being withheld because of these very problems as shown in this instance:

I was working with women who would be unconscious on the floor and there was nothing for them at all. Doctors would just say, oh, she's drinking, the mental health team would say, well, she's using we can't give her a CPN [Community Psychiatric Nurse] *until she's committed to making a change. Our argument was she needs support to overcome the trauma and to have in place sufficient coping strategies to enable her to make the change. (P4)*

Stigma in the media

Service providers discussed challenges with local media running stories publicly which name people experiencing substance use problems and open them up to scrutiny in the local community.

We do have some challenges – putting it politely – with the local press, and the coverage of what goes on in the Sheriff Court. This tends to be tittle-tattled about in the press, the local paper here, they'll do a big spread on whatever's gone on in the Sheriff Court. So that obviously feeds into the stigma, as well, because if your name is being splashed about in the local press, then you're going to be a topic of conversation for the week, until it's somebody else's turn next week, you know what I mean? (P1)

Participants also pointed to the difficulty of garnering any positive news coverage of people in recovery as there is little appetite for this in the media. Despite the fact that there are many people who have positive and optimistic stories to share they may feel reluctant to do so given the potential reaction in the media.

It's so hard to get the local media [to] do a positive story about recovery in the local papers. They just don't want to do it, when actually there are lots of stories where lots of people get better. But that sort of stigma means there are

very few people who want to speak about their recovery because they don't want people to know what they've been through. (P23)

One participant in recovery discussed the effects of negative media portrayal of people with substance use problems and how this affected him.

According to the newspapers and the TV documentaries, I was one of those people, and it's still...it's quite embarrassing to be...trying to walk about maybe down in the town centre and thinking that people are looking at you and thinking, he's a waster. He's an addict. He's an alkie. He's a junkie, and he's a benefit scrounger. You know, they don't see behind the line. (P16)

Stigma online

Online shaming and the use of stigmatising language was mentioned by two participants who shared examples of images being circulated of people who were severely intoxicated.

There was a picture circulating Facebook over the weekend of somebody that I know very well who I used with when I was using, who's really a very poor lost soul, who was lying so drunk he was unconscious and had urinated and young lads had taken pictures of him and posted them up on Facebook. Pishy something or other and…and I just felt…oh my god, you know? This is your family, you know? It just sounds so cruel, doesn't it? And I think it tells you something about the mentality of living in a place like that is that the unacceptable becomes acceptable, you know? (P17)

Further stigmatising comments online about the opening of a drug and alcohol service in their town were reported by another participant which demonstrated the extremely adverse reaction some people held about people seeking assistance with a substance use problem.

I've seen things on social media…For instance when this new service was opening up their premises in [Town] there was something on social media about their planning application for change of use for the building. And there was so many negative comments on this thread that I was reading, people with…some weird perceptions, you know, saying, oh, that's too near the local schools…They were saying 'And you'll have all the paedophiles, you'll have all the needles lying around, you know, it's disgusting, you know, thinking about putting it there.' (P9)

10. DISCUSSION

This project has drawn on literature, consultations and interviews to try to understand the context and role of alcohol use in rural areas of Scotland. The experiences of service providers and people with lived experience of alcohol harms, family members and young people are all reflected in this report.

"Rural Scotland" is diverse geographically and culturally. While there are shared experiences, each community has its own set of challenges, assets and needs when it comes to preventing and addressing harms from alcohol. The needs of island communities are particularly distinctive given added challenges around extreme weather and public transport (both to mainland Scotland, or to the main towns such as Lerwick (Shetland) or Kirkwall (Orkney) where services are based.

While alcohol harms are complex in their origins and development just like anywhere else in Scotland, there are certain factors associated with remote and rural communities which may exacerbate alcohol harms. These include isolation, lack of recreational activities, lack of transport links, strong economic and cultural ties to alcohol and heightened stigma due to the nature of living in a small community where "everyone knows each other's business". Furthermore, several participants linked alcohol problems in areas such as Ayrshire, Lanarkshire and Clackmannanshire to industrial decline and the resulting high levels of unemployment and deprivation. Comments were made by these participants about alcohol being used to a fill a void that had previously been filled by having an identity and sense of camaraderie derived from a profession. Participants also commented on the links between deprivation and alcohol use and the difficulty of measuring deprivation in rural areas, as small pockets of deprivation are often not reflected in national statistics.

Other factors which may explain the significance of alcohol in many remote and rural communities are their particular connections to tourism, hospitality, alcohol production (breweries and distilleries). All of these sectors mentioned above are important and growing sectors for rural Scotland, but it must be acknowledged that there may be unintended public health consequences of having them inextricably linked to alcohol.

One of the main themes to emerge from this research is how strong a barrier to accessing support stigma represents. This may be especially damaging in rural communities where participants are more likely to know their healthcare or service provider. This acts as a barrier to seeking help in the first instance for fear of being recognised and having their standing in the community compromised. Participants also described instances of facing discrimination in healthcare settings as they were recognised by healthcare providers as having had repeated alcohol-related problems and were therefore denied timely or quality care. People living in rural areas may also have limited options for seeking other assistance if their healthcare provider does not provide adequate support. Stigma was also reported to be present online on social media and in local media, including local newspapers.

Lack of adequate funding and resourcing was a major theme brought up by service providers. Many commented on the difficulties of the current funding model where funds are allocated on a *per capita* basis which does not reflect the reality of how expensive it is to provide services in remote and rural communities (Population Health Directorate, 2019). Others reported being stretched thin and not having access to detox beds or rehabilitation facilities in their areas, or that these resources existed only in central towns which were not accessible to patients. In terms of commentary about how better to organise and deploy existing funding, one ADP co-ordinator described their strategy for linking services with GP practices as a matter of

reaching out to GPs and asking them what they need in order to support patients. Better linkages with GPs and A&E staff and ensuring that they are aware of the different supports and services for their patients is a key area for improvement identified by this project.

Assertive outreach is another manner in which resources can be deployed in order to better serve people with alcohol problems. This includes proactively taking care to patients, following up with patients who drop out of services and removing punitive measures such as withholding services if a patient misses appointments. Different communities faced different realities with regards to assertive outreach. In some areas this was standard practice for services, whereas others reported major challenges in conducting assertive outreach. One of these challenges is the long distances involved in operating a mobile unit or conducting home visits. Another major problem was reported with regards to stigma and fear that assertive outreach might impinge on people's privacy and disincentivise them from engaging with services.

Several participants expressed that they felt that healthcare providers in rural areas would benefit from additional training on substance use issues and on services and supports that were available to people with alcohol problems. This might also go some way in addressing the problems surrounding recruitment and retention of healthcare and service providers reported by several participants. A rural medical school, increased placements for medical students in rural areas, or a quota for rurally based medical students (and nursing students) may address this. Part of the overall training for rural practitioners must address support for substance use, trauma-informed approaches and training on avoiding and reducing stigma.

Some areas have more active recovery communities than others. Forth Valley Recovery Community is an example of a highly organised and relatively well-resourced network which leads a variety of social activities and supports for people in recovery, including recovery cafes, hill-walking, climbing, yoga and gardening. Participants had successfully made links with local leisure and community centres in order to hold events and activities for their members. Healthcare professionals from this area described how community members with lived experience were embedded within the substance use service via the organisation Change Grow Live which was a model they praised for its direct linkage with people experiencing problems to people in active recovery so that they could serve as role models.

Based on evidence from participants, the Scottish Borders appear well placed for further development and investment in their recovery community, though frustration was expressed by some participants, who felt that funding was being allocated to services that they felt were ineffective and lacking in innovation. They also reported frustration that funding set aside for recovery community development had been given to a service without consultation of active, visible recovery members. Despite this, a small group of active recovery advocates are in place in the Borders and events such as recovery cafes are organised.

This is in stark contrast with what was reported in other areas where there are few visible recovery community members and apparently significant barriers to creating them. Based on responses this was particularly true in Shetland and Orkney where

participants reported high levels of stigma and doubts that visible recovery events and cafes would be appealing to people given the fear that they may suffer social or professional consequences from addressing an alcohol problem. In spite of this, the Shetland ADP is preparing to trial a recovery hub project. Both Shetland and Orkney have active Alcoholics Anonymous chapters.

Fostering recovery communities and psychosocial support for those in recovery is crucial to helping communities stay safe and healthy. Individuals with lived experience of alcohol harms should have their expertise harnessed by service providers and healthcare workers at every stage of the care pathway, from prevention to aftercare. The responses from participants show that recovery from alcohol problems can be a winding and challenging path. However, what shines through far more than the difficulty of their journeys is the joy and vibrance of people who have overcome immense obstacles and now serve as inspiring examples of optimism, connection and friendship.

11. RECOMMENDATIONS

The Scottish Government recognises the need to address social inequalities as a way of addressing health inequalities in their strategies for alcohol, *Rights, Respect and Recovery: Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths* and *Alcohol Framework 2018: Preventing Harm.* Issues of structural inequality and how these influence how alcohol use and problems are understood and dealt with in rural communities were highlighted by participants in this study. These issues include deprivation, de-industrialisation, lack of housing, gender discrimination and lack of access to services and recreational activities. Addressing these issues is a key component for alleviating the harms from alcohol on our society. With this in mind, we have endeavoured to provide specific and relevant recommendations for research, policy and practice in order to work towards the above aims, and the aims of our overall ambitions. These recommendations follow directly from evidence provided by healthcare and service providers, individuals with lived experience of alcohol harm, young people and family members of people with alcohol problems.

OVERALL AMBITIONS:

To ensure that:

- The specific issues related to alcohol that affect individuals, families and communities in rural Scotland are recognised and understood by policy makers and providers of all services. These issues include lack of infrastructure for alcohol-free activities, stigma in both community and healthcare settings, and lack of support for recovery groups in many areas.

- Explicit strategies are put in place to meet the needs of individuals, families and communities in rural Scotland when it comes to alcohol prevention, treatment and support for recovery.

- These strategies extend to all policies, including housing, criminal justice, economic development and transport, prioritising public health with a focus on reducing health (and other) inequalities.

- In line with *Rights, Respect and Recovery*, all processes for planning, developing, implementing and evaluating alcohol services for people in rural Scotland should be guided by people living in rural communities, including people with lived experience, to support recovery.

- Prevention and early intervention are recognised by all decision makers as a means of not only saving suffering and indignity but also making savings in cost, productivity and efficiency in the long term.

- Population-level measures (affordability, accessibility and availability) are emphasised as the most effective means of alleviating problems caused by alcohol, particularly when combined with more targeted strategies for specific areas as described in this report.

RECOMMENDATIONS

A FOCUS ON ALCOHOL AND RURAL COMMUNITIES

- The Scottish Government should designate the responsibility of ensuring that there is a rural component to alcohol strategies with a named Lead Officer. Many of our recommendations are cross departmental and take a holistic view. Actions to be prioritised in order to address the unique needs of remote and rural communities by the Scottish Government should include the recommendations which follow below.

ACCESSIBILITY AND INFRASTRUCTURE

The following recommendations are aimed at the Scottish Government, Local Authorities and Alcohol and Drug Partnerships (ADPs):

- Ensuring that the stated intention of the 2020 National Transport Strategy, "Minimising the connectivity and cost disadvantages faced by island communities and those in remote rural and rural areas" is prioritised, addressing the barrier of inaccessibility described by participants (Transport Scotland, 2020).

- Ensuring that Scotland's 2017 R100 strategy to deliver superfast broadband to all homes and businesses including in remote and rural areas is prioritised. This initiative is set to miss its 2021 target and has introduced a voucher scheme to cover the shortfall. This voucher scheme should be advertised to individuals and practitioners who use online support services (Scottish Government, 2017c).

- Online support and services for alcohol problems such as online counselling are reviewed and evaluated to ensure high standards and quality of service are achieved. The experiences of service users and providers should be taken into account in doing this.

HEALTHCARE AND SERVICE IMPROVEMENT

The following recommendations are aimed at the Scottish Government, ADPs, twelve-step fellowship programmes, visible recovery communities, mutual aid groups, medical professionals and NHS and third-sector service providers:

- Alcohol treatment services in all localities should be mapped and publicised, to make them accessible to GPs and A&E staff so that appropriate referrals can be facilitated and support given to ensure uptake and continuity for individuals with alcohol problems and their families. This information should be clear and accessible for other service providers in the NHS also and third-sector service providers. It should also be made available to the general public.

- Young people should receive information about alcohol harms and support available in school, building on the substance misuse programme included as part of Curriculum for Excellence. Support and education should be tailored to local circumstances and needs to be linked in with communities, families and local youth services.

- Links should be improved between the NHS, treatment and support services, mutual aid groups and visible recovery communities. This includes raising awareness about what is available in terms of service and support for alcohol problems, addressing gaps in care and resourcing recovery communities to offer peer support.

- Where appropriate, linking between twelve-step fellowships and healthcare and service providers should also be established or improved in order to raise awareness of these groups and point people towards AA and Al-Anon for help and support.

- Funding models should be reviewed and updated to address the reality that although rural areas have fewer people, it is often more costly to provide services. Individuals in rural communities should have access to services including alcohol rehabilitation, detox beds and counselling.

- Alcohol services should be resourced to conduct assertive outreach, recognising that this may be challenging in some areas due to distances and stigma. This includes proactively taking care to patients, following up with patients who drop out of services and removing punitive measures such as withholding services if a patient misses appointments. This should help to address the disassociation that some participants felt with services available to them and will benefit both patients and service funders in the long term by offering early intervention.

- Ensuring adequate provision of training, education and networking opportunities for service providers and healthcare professionals on trauma-informed approaches, avoiding stigma, support for people with alcohol problems and their families and information on available services and support. Training opportunities must be inclusive, including either an online option or travel budget for rural workers.

- Working with the Medical Royal Colleges and Medical Schools to explore ideas in relation to improving professional competencies, training and expertise with regards to alcohol problems in rural communities. Expansion of programmes such as the *Widening access to medicine* initiative (Scottish Government, 2018d) which helps students from remote and rural backgrounds to study medicine and the *Scottish Graduate Entry Medicine* (University of St Andrews, 2020) programme which focusses on rural medicine and healthcare improvement.

- Working with recovery and mutual aid groups to promote the use of community hubs to act as a "one stop shop" for advice, services and social interaction.

ALCOHOL-FREE SPACES

The following recommendations are aimed at the Scottish Government, ADPs, Local Authorities, Local Licensing Forums, third-sector organisations and recovery communities:

- Ensuring that rural economic development strategies are developed with public health considerations in mind, particularly when it comes to the promotion of the alcohol, tourism and hospitality industries.

- Supporting investment in alcohol-free recreational activities and spaces in rural areas, including those targeted specifically at young people. Research on the feasibility of the Youth in Iceland Model for Scottish rural contexts may inform this (University of Stirling, 2019).

- Actively encouraging support for and investment in social spaces that do not provide or market alcohol. These spaces could include sports clubs, community centres/hubs, cafes, leisure centres etc.

- In reviewing licensing regulations, ensure that the particular needs of rurality are addressed, including the consideration of how online and telephone purchasing should be regulated.

- Ensuring that funding is allocated to recovery groups in order to increase the variety of activities and events they may offer. Examples include investing in initiatives such as the model used by the active Forth Valley Recovery Community. This group offers various activities to people in recovery, including recovery cafes, outdoor activities and an app which highlights events and services available in the local area, in collaboration with recovery and mutual aid groups.

RESEARCH

Scottish Health Action on Alcohol Problems (SHAAP) and the Scottish Alcohol Research Network (SARN) and/or other relevant research-focussed bodies should be tasked with establishing a research plan to propose to the Scottish Government. This should include:

- Conducting further research into the needs of rural communities for alcohol harm prevention and support

- Working with Public Health Scotland's Data and Intelligence team to improve data-gathering in order to audit and evaluate the quality and effectiveness of interventions. The evidence can be utilised to support future policy and service development in rural areas, closely linking to the *Rights, Respect and Recovery* workstream.

- Partnering with the Royal College of General Practitioners (RCGP) to develop understanding of the challenges of recognising alcohol problems and supporting patients in their recovery in rural communities, as primary care is often the first contact for those seeking help with alcohol problems. This builds on previous research regarding Alcohol Brief Intervention (ABI) training for GPs facilitated by RCGP (Holloway & Donaghy, 2017).

- Collaborating with the recovery community and local papers, radio and other media in rural areas to help change perceptions through an outreach programme. This could include running a series of positive real life stories from those with lived experience to help change public opinion and reduce stigma in communities.

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GLOSSARY AND ABBREVIATIONS

AA
Alcoholics Anonymous

ABI
Alcohol Brief Intervention: *"…a short evidence-based, structured conversation about alcohol consumption with a patient/service-user that seeks in a non-confrontational way to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm"* (National Health Service Scotland, 2010).

'Accessible rural'
Being within a 30-minute drive of a settlement of 10,000 people or more (Scottish Government, 2016)

ADP(s)
Alcohol and Drug Partnership(s). *An ADP is a multi-agency group which is responsible for the strategic planning of alcohol and drug service provision in areas of Scotland*

AFS
Alcohol Focus Scotland

Alcohol-attributable deaths
Alcohol-attributable deaths are deaths caused wholly or partially by alcohol consumption (Tod et al., 2018). It is a wider definition than alcohol-specific deaths. For a full explanation of this definition, please see the 2018 ScotPHO report *Hospital admissions, deaths and overall burden of disease attributable to alcohol consumption in Scotland*

Alcohol-related hospital admissions
The definitions of alcohol deaths and hospital admissions referenced in this report are from *'Alcohol-related hospital statistics, Scotland 2018/19'* published by Information Services Division (ISD, 2019). More information on alcohol-related hospital statistics can be found at: **www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications**

Alcohol-specific deaths
The National Statistics definition of alcohol-specific deaths includes only those cases that are a direct consequence of alcohol misuse, otherwise known as wholly attributable. Most of the conditions included in the definition are chronic (longer-term) conditions associated with prolonged misuse of alcohol. The definition of alcohol-specific deaths does not include diseases that are partially attributable to alcohol, such as certain cancers, where the evidence shows that only a proportion of the deaths are caused by alcohol (Giles & Richardson, 2020). For a full explanation of this definition, please see the 2018 ScotPHO report *Hospital admissions, deaths and overall burden of disease attributable to alcohol consumption in Scotland*

Al-Anon
Groups for families and friends of people with alcohol problems.

AOD

Alcohol Outlet Density

A&E
Accident & Emergency, *also known as the Emergency Department (ED)*

CMHT
Community Mental Health Team

CPN
Community Psychiatric Nurse

DTs
Delirium tremens

GP(s)
General Practitioner(s)

LGBT+
This describes Lesbian, Gay, Bisexual, Transgender/Transsexual plus; the 'plus' is inclusive of other groups, such as queer, intersex and asexual

'Lived Experience'
"…*the experience(s) of people on whom a social issue, or combination of issues, has had a direct personal impact."* Source: Sandhu (2017), in: 'Stand up and tell me your story' (SHAAP, 2020)

MESAS
Monitoring and Evaluating Scotland's Alcohol Strategy, *a programme of work delivered by Public Health Scotland and NHS National Services Scotland Information Services Division (ISD), aimed at monitoring and evaluating the Scottish Government's alcohol strategy*

MUP
Minimum Unit Pricing/Price

NHS
National Health Service

OACAS
Orkney Alcohol Counselling and Advisory Service

ODing
Overdosing

PSE
Personal and Social Education

P##
Participant ##

RCGP
Royal College of General Practitioners

RCPE
Royal College of Physicians of Edinburgh

'Remote rural'
Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more. Source: Scottish Government (2016)

SALSUS
Scottish Schools Adolescent Lifestyle and Substance Use Survey

SARN
Scottish Alcohol Research Network

ScotPHO
Scottish Public Health Observatory

SFAD
Scottish Families Affected by Alcohol & Drugs

SHAAP
Scottish Health Action on Alcohol Problems

SIMD
Scottish Index of Multiple Deprivation, *a measure of relative deprivation of an area*

SMART Recovery
Self-Management And Recovery Training. SMART Recovery meetings are run by trained facilitators and follow a standard structure. The focus of the meeting is on the addictive behaviour and not on the substance itself. They use evidence-based tools and techniques (Cognitive Behavioural Therapy (CBT), Motivational Interviewing) (UK SMART Recovery, 2020).

SRC
Scottish Recovery Consortium

SRUC
Scotland's Rural College

'Street drinking'
In rural contexts this was defined as drinking outside of the home or licensed premises, such as fields and parks

UK
United Kingdom

APPENDIX A: TOPIC GUIDE

SHAAP Rural Matters Research Project

Give them the information sheet and explain: SHAAP is leading a piece of research to feed into the Scottish Government's strategic planning, as well as our own strategies and work programmes, to explore meanings of the concept of lived experience.

Administrative details:

1. Describe organisation briefly
2. Explain confidentiality arrangements
3. Record date and time
4. Record name and pseudonym for anything to be shared
5. Record gender
6. Agree interview can be recorded
7. Check if any questions before starting

Research areas to explore:

1. Where do you come from and what's it like? How long have you been there? Who do you live with?

2. What does alcohol mean to you? In what ways is it part of daily life where you live? *Prompt for specifics if necessary.*

3. Is that good or bad? What do other people think? What is the culture around drinking in your area? *Prompt for specifics if necessary. Check out if connected to celebration, tradition, socialising, trouble, violence, depression.*

4. Does everyone drink? Where do they drink? If you don't drink, where do you go to socialise without alcohol being around? Is that important?

5. Do you think that there are more risks of problems related to alcohol in rural areas compared to elsewhere? Can you give some examples?

6. What do people think about people who have alcohol problems? Is it easy to get help if you need it? If not, why not? *Prompt for practical reasons as well as socio-cultural.*

7. Would it be a problem if people knew you had a problem and/or used a service? How could that be reduced?

8. What services are there for people in your area who are worried about their own or someone else's drinking? Do people know about them? How easy are they to access? Are they any good? What's good? What could be improved?

9. Can you list for me of everything that you know that is available in your areas to support people with alcohol problems. *Prompt if necessary re GPs, third-sector, fellowships.*

10. What about national services? *Prompt to ask if they know of SRC.*

11. What about support for families of someone with an alcohol problem? *Prompt to ask if they know of SFAD.*

12. What works well in offering support and what doesn't? Why? How could that be improved?

13. What would your top three recommendations be to improve prevention and support for people in rural communities around alcohol issues? *Prompt to make these as specific as possible. Who for?*

14. Is there anything else that you want to say to me?