Healthcare in Remote and Rural Areas: SHAAP consultation response

Scottish Health Action on Alcohol Problems (SHAAP) is a partnership of the Medical Royal Colleges in Scotland and the Faculty of Public Health and is based at the Royal College of Physicians of Edinburgh (RCPE). 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.

Q1. Are there any immediate issues unique to remote and rural communities which the National Centre will need to focus on to improve primary and community care in these areas?

Alcohol harms are one of Scotland's most pressing public health and social issues, evidenced by the latest alcohol death figures from the National Records for Scotland (NRS). The figures show an increase from 1,245 alcohol-specific deaths in 2021 to 1,276 in 2022.[i] Additionally, in 2021/22, there were 35,187 alcohol-related hospital stays.[ii] This means that every day in Scotland, more than 3 people lose their lives and almost 100 more are hospitalised because of alcohol. All of these devastating harms are avoidable.

Alcohol contributes to Scotland's major health inequalities, as those living in the most deprived communities are worst affected: there are 4.3 times as many deaths from alcohol-specific causes in the most deprived communities as in the least deprived[i] and anyone living in one of our most deprived areas are six times more likely to be hospitalised because of alcohol-related conditions.[ii]

While these figures convey the scale of harm caused by alcohol in Scotland, they mask the damage and pain caused in the lives of people who are living with an alcohol problem, as well as that in the lives of their loved ones and in wider communities. This harm is immeasurable.

Alcohol harm also has major impacts on public services and the Scottish economy. Alcohol consumption is a causal factor for more than 200 disease and injury conditions and puts an immense strain on our overstretched NHS. Alcohol harm is estimated to cost Scotland £5-10 billion every year.[iii]

Whilst alcohol harms are not unique to remote and rural communities, people living in rural areas have a unique social & cultural drinking context and experience major barriers in accessing alcohol support & treatment services.

Remote and rural communities across Scotland 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, as well as policymakers.

Consideration should be given to the following:

- **Social norms in rural communities**
    - Alcohol use is disproportionate in rural communities, given the lack of alternative recreational activities and increased risk of social isolation.
    - Alcohol is entrenched in cultural & social norms due to traditions, hospitality and economic dependence on tourism & alcohol production.
    - SHAAP research from our 'Rural Matters' report found that participants argued that non-drinkers often feel ostracised from social gatherings and few alcohol-free spaces, if any, exist in their communities.
- **Challenges in accessing alcohol services in rural communities**

  - Local service provision is limited and where travel is required to access services, public transport is infrequent and expensive – particularly problematic for island populations.
  - Healthcare & service providers face difficulty in recruiting/retaining/developing staff in alcohol service specialisms.
  - Funding models often related to population size, which does not account for the added costs of providing services in a rural population of fewer, harder to reach people.
- **Stigma**
  - Stigma is made worse by living in a small community where privacy is difficult; this is a major barrier in accessing services.
  - Participants in our 'Rural Matters' study expressed fears of social, professional or family consequences 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.
- **Recovery**
  - Recovery communities offer opportunities for social interaction, support & provision of safe, alcohol-free spaces & activities for people in recovery, but are less common in rural communities.

SHAAP is supportive of the development and implementation of the National Centre for Remote and Rural Health and Care. It is essential that this centre addresses the issues above in order to protect the health of the remote and rural populations of Scotland.

Individuals living with alcohol problems should be considered as a group with specific needs by the Centre, who are faced with particular barriers to accessing services, including those resulting from stigma. The Centre should also give consideration to *prevention* of alcohol-related problems in remote and rural areas. Island populations and their unique environment should also be considered as a sub-group with specific needs.

SHAAP recommendations:

- Alcohol and Drug Partnerships should carry out a needs assessment of rural communities and work with the Centre to ensure that people living in rural communities can access specialist care and support. This should then lead to the mapping of alcohol treatment services in all localities to make them accessible to GPs, primary care teams and A&E staff so that appropriate referrals can be facilitated and support given to ensure uptake and continuity for individuals with alcohol problems. Support for families should also be mapped. This information should be clear and accessible to all service providers and should be shared with public and third sector partners, and the 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.
- It is essential to provide adequate 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.
- Investment should be supported in alcohol-free recreational activities and spaces in rural areas, including those targeted specifically at young people.
- Support for and investment in social spaces that do not provide or market alcohol should be actively encouraged. These spaces could include sports clubs, community centres/hubs, cafes, leisure centres etc.

The Centre should play a vital role in all of the above by establishing clear service specifications that can be adapted by local areas to meet the needs of the rural communities they serve. It should also provide a network for sharing support, expertise and learnings in relation to the provision of services for people affected by alcohol problems living in rural communities.

Q2. Are there any issues which the National Centre will be unable to address, which may require further policy action from the Government?

Although the National Centre should strive to address alcohol harms within remote and rural areas as far as possible, a population-wide approach to reducing alcohol harms would be more effective in preventing alcohol harms/problems from developing on a wider scale, including in remote and rural areas.

Based on the World Health Organization 'best buys' to reduce alcohol harms, SHAAP would like to see action from the Scottish Government around the pricing, marketing, and availability of alcohol on a population-wide scale.

Our specific asks would be:

Pricing – Minimum Unit Pricing (MUP): SHAAP is calling for MUP to be uprated to at least 65p, in order to optimise the policy in its ability to reduce harms and save lives. High levels of inflation since the policy has been introduced have significantly eroded the impact of MUP and uprating is essential to optimise the effectiveness of this policy.

Marketing: SHAAP strongly believes that the Scottish Government must introduce a comprehensive package of restrictions on alcohol marketing across a variety of channels, including: sports sponsorship, in-store marketing, and outdoor/public spaces as a vital public health measure in response to Scotland's alcohol crisis. Exposure to alcohol marketing influences drinking decisions and non-consensual exposure to such marketing in our daily lives must be stopped. The introduction of health labelling on alcohol products should also be considered.

Availability: In reviewing licensing regulations, it is essential to ensure that the particular needs of rural communities are considered in relation to public health.

Increased connectivity would also reduce barriers for treatment for alcohol-related problems. 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” should be prioritised, addressing the barrier of inaccessibility described by participants in our ‘Rural Matters’ study.

The proposed UK clinical guidelines for alcohol treatment includes suggestions around offering digital interventions for individuals in remote and rural areas, which may alleviate some of the connectivity issues. However, services should continue to offer in-person support where the person prefers it, and especially where it will encourage ongoing engagement with treatment, and digital interventions should not replace the option of in-person treatment. Strengthening the third sector digital interface in its ability to provide digital services and interventions would also be beneficial.

Rural economic development strategies should be developed with public health considerations in mind, particularly when it comes to the promotion of the alcohol, tourism and hospitality industries.

Finally, ADPs should be adequately resourced to work with the National Centre in providing services that meet demand and the specific needs of people in rural communities.

Q3. What would you like to see included in the Scottish Government’s forthcoming Remote and Rural Workforce Strategy?

The Remote and Rural Workforce Strategy is a welcome opportunity for the Scottish Government to address the health and social care needs of rural populations in relation to alcohol-related harms. It is essential that healthcare professionals, communities addictions teams, A&E staff, GPs etc. are adequately resourced and trained to prevent and address alcohol harms in a response appropriate to the current scale of the issue.

SHAAP would like to see a needs assessment being carried out as part of the Remote and Rural Workforce Strategy which specifically assesses the need for alcohol services and available workforce in remote and rural areas.

SHAAP recommends that the forthcoming strategy should focus on the areas of funding, training, and barriers to services.

SHAAP workforce recommendations:

- **Staffing:**
    - A needs assessment should be carried out to inform the staffing requirements of remote and rural areas, including more specialist alcohol-related services.
    - Services must be appropriately staffed to address the scale of need, in order to combat against long wait times experienced by people with alcohol problems in remote and rural areas. Recruitment and retention of healthcare staff to remote and rural areas is an increasing challenge. Rural health boards must review their strategy for recruiting staff. The traditional approach of doctors applying for fulltime substantive post perhaps needs to be reviewed, as more staff are considering hybrid working etc.
    - The generalist nature of the work in remote and rural areas can hinder doctors applying for vacant posts – there has been an increasing trend towards specialisation of the workforce in recent years and this has negatively impacted the recruitment of doctors in remote and rural areas where the training does not match

the job they required to undertake. There are initiatives to enhance the generalist skill set such as:
        - Rural Surgical Fellowship
        - Rural GP Fellowship
        - Credential in Rural and Remote Health (Unscheduled and Urgent Care)
    - Recruitment and retention of staff was an obstacle raised by several participants in our 'Rural Matters' study. There was some belief that remote jobs were less prestigious/desirable than in urban areas and that there were less economic opportunities for family members in these areas. This must be addressed in order to address staffing uptake and retention.
    - Staff interviewed in our 'Rural Matters' study expressed that they felt they were under-resourced for all that they were asked to do, and felt that their job descriptions continued to expand whilst their salaries and teams did not. Staffing and salaries should be reviewed at appropriate intervals to ensure appropriate reward for staff, and improve retention.
    - The positive evaluation of the Primary Care Alcohol Nurse Outreach Service in Glasgow should be used to inform pilots of similar models adapted for rural communities, so that people who do not engage with traditional services benefit from specialist, tailored support.
    - The implications of the positive evaluation of the Planet Youth model should be considered with a view to maximising its benefits in all rural communities.
    - The intersection between mental health and alcohol services must also be appropriately modelled and staffed to ensure that there is a 'no wrong door' policy in place in remote and rural areas so individuals do not fall between the cracks of services.
    - Remote and rural areas have a reliance on locums and hybrid workers in order to provide frontline services. The benefit-in-kind tax is reportedly having a detrimental impact on willingness of doctors travelling to remote and rural areas to work. Health boards must therefore consider increasing pay rates to compensate for this.
    - Staff have also reported a lack of suitable and affordable accommodation in remote and rural areas and this acts as a barrier for attracting and retaining staff. Rural health boards should review their accommodation strategies to address this.
- **Funding:**
    - The findings of the needs assessment suggested above should also be used to inform the level of funding appropriate to the scale and need of investment in health and social care services to address alcohol-related problems in rural areas.
    - Funding models should be reviewed and updated to address the reality that, although rural areas have smaller populations, it is often more costly to provide services per capita.
    - Individuals in rural communities should have access to services including alcohol rehabilitation, detox beds and counselling. Funding must be allocated for the provision of these services appropriate to the scale of need.
    - 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.

- **Training:**
    - Throughout our 'Rural Matters' study, 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. Participants reported that, because services in rural areas are so understaffed and under so much time pressure, it is difficult for staff to take time out to attend training – especially when this requires travel.
    - The workforce strategy should ensure 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.
    - Being a Local Education Provider (LEP) is a key role for remote and rural boards because it brings:
        - Trainees into the area to experience remote and rural practice making it more likely they will return in future to work.
        - External scrutiny, which in turn improves quality of care provided.

      Recruitment challenges can place additional strain on existing trainers and brings fragility to LEP status of remote and rural health boards. Health boards should consider the use of the extended team to ensure that LEPs are in place.
    - The strategy should consider 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, 2018) 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.
- **Barriers:**
    - The workforce strategy must specifically address the need and methods to reduce barriers to treatment and support in remote and rural health and social care settings.
    - Health and social care staff should be trained in avoiding stigmatising attitudes and language regarding substance use.
    - As GPs often act as the first point of contact for individuals seeking help for an alcohol problem, it is essential that GPs in particular are equipped with the skills to deal with supporting patients with substance use issues.

Q4. What specific workforce related issues should the strategy look to resolve?

As above.

Q5. Are there any workforce-related issues which the creation of a Remote and Rural Workforce Strategy alone will not address. If so, what are these issues and what additional action may be required to address them?

[i] National Records of Scotland (2023). Alcohol-specific deaths 2022.
[ii] Public Health Scotland (2023). Alcohol related hospital statistics.
[iii] Bhattacharya, A. (2023). Getting in the spirit? Alcohol and the Scottish Economy.