North Ayrshire
Community Planning Partnership

CPP Senior Officers Group

Thursday 21 January 2021 at 10.45 a.m. via Microsoft Teams

AGENDA

Time	No.	Page	Item	Presenter	Ask of CPP Partners
10.45 - 10.50	**1.**	-	**Welcome and Apologies**	Ian McMeekin, Area Commander, Scottish Fire and Rescue Service	
10.50 – 11.00	**2.**	Pg. 3	**Minutes and Action Note from Last Meeting** Discuss Minute and Action Note from meeting on 19 November (copy enclosed)	Ian McMeekin, Area Commander, Scottish Fire and Rescue Service	Is this an accurate record of the meeting? Have all actions been completed?
Safer North Ayrshire					
11.00 – 11.15	**3.**	Pg 10	**Draft Local Police Plan** Receive report on draft local police plan	Superintendent Derek Frew, Police Scotland	Contribute to the consultation and support wider engagement
11.15 – 11.30	**4.**	-	**Community Justice Ayrshire** Receive presentation on the work of Community Justice Ayrshire and 2021 plans	Annie Torrance, Manger, Community Justice Ayrshire	Identify links with other areas of partner work
Healthier North Ayrshire					
11.30 – 11.45	**5.**	Pg 11	**Arran Alcohol and Drugs Study** Receive report on Investigating the Experiences of Alcohol and Drugs on Arran, Health and Social Communication and Barriers to Care.	Vikki Yuill, Chief Executive Officer Arran Community and Voluntary Service	Identify links with other areas of partner work and actions to respond to findings
11.45 – 12.10	**6.**	-	**Community Food System** Receive presentation on the development of a North Ayrshire Community Food System	Rhona Arthur	Identify opportunities to support system

**For further information please contact Morna Rae, Snr Manager,
North Ayrshire Council, Cunninghame House, Irvine, KA12 8EE
Tel:(01294) 324177 Email: mrae@north-ayrshire.gov.uk**

Thriving North Ayrshire					
12.10 – 12.20	**7.**	Pg 114	**Childrens Services Strategic Partnership** Receive report on update of work of the CSSP	Lauren Cameron, Policy Officer and Audrey Sutton, Executive Director, North Ayrshire Council	Make links with other areas of partner work
Building Stronger Communities					
12.20 – 12.30	**8.**	-	**Events Support for Community Organisations** Receive presentation on supporting community organisations to run events	Lesley Forsyth, Senior Manager, North Ayrshire Council Audrey Sutton, Executive Director, North Ayrshire Council	Consider impact on partner work
12.30 – 12.45	**9.**	-	**AOCB** • Inviting additional attendees to CPP SOG • Decision tracker and 2021 planning (copy enclosed)	Michael Breen, Vice Principal, North Ayrshire College Morna Rae, Senior Manager, North Ayrshire Council	Discuss proposal to involve additional attendees
For Reference					

	10.	Pg 118
		Pg 119
			• LOIP on a page
			• SOG Tracker
			• Link to Minutes of CPP Board
			• Links to Locality Partnership minutes
			  • Arran
			  • Garnock Valley
			  • Irvine
			  • Kilwinning
			  • North Coast
			  • Three Towns
			• Link to Integrated Joint Board minutes Nov 20		

Dates of 2021 meetings: • 8 March 2021 • 22 April 2021 • 3 June 2021 • 19 August 2021 • 7 October 2021 • 25 November 2021					

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North Ayrshire Council, Cunninghame House, Irvine, KA12 8EE
Tel:(01294) 324177 Email: mrae@north-ayrshire.gov.uk

North Ayrshire
Community Planning Partnership

Meeting:	**CPP Senior Officers Group**
Date/Venue:	Thursday 19 November 2020 at 10.45 am via Microsoft Teams
Present:	Ian McMeekin, Scottish Fire & Rescue Service **(Chair)** Rhona Arthur, North Ayrshire Council Michael Breen, Ayrshire College Supt Derek Frew, Police Scotland Kenny Hankinson, Scottish Fire and Rescue Service Craig Hatton, North Ayrshire Council Barbara Hastings, TACT Caitriona McAuley, North Ayrshire Council Mark Newlands, Scottish Enterprise Morna Rae, North Ayrshire Council Audrey Sutton, North Ayrshire Council Elaine Young, NHS Ayrshire and Arran **In attendance** Jacqueline Greenlees, North Ayrshire Council Vikki Kewney, Scottish Enterprise Greig Robson, North Ayrshire Council Michelle Sutherland, NA HSCP Jennifer McGee, North Ayrshire Council (Notes)
Apologies:	Andrew McClelland, North Ayrshire Council Russell McCutcheon, North Ayrshire Council Alison Sutherland, NA HSCP Karen Yeomans, North Ayrshire Council Vikki Yuill, TSI Laura Barrie, KA Leisure

No.	Item	Responsible
1.	**Welcome** The Chair welcomed everyone to the meeting and apologies for absence were noted. A Sutton advised Chief Officers that she would circulate a copy of the Inspiring Scotland Link-up National Report.	**Noted**

2.	**Minute of Previous Meeting and Action Note** Minutes from the meeting held on 8 October 2020 were agreed and the following updates were provided. A Sutton advised Chief Officers that she would circulate a copy of the Inspiring Scotland Link-up National Report.	**Noted** **A Sutton**
3.	**Kickstart Programme** G Robson, Senior Manager (Employability & Skills) provided Senior Officers with an overview of the Kickstart Programme. G Robson advised that the Programme provides funding to create new job placements for 16 to 24-year olds on Universal Credit who are at risk of long-term unemployment. Employers of all sizes can apply for funding which covers: • 100% of the National Minimum Wage (or the National Living Wage depending on the age of the participant) for 25 hours per week for a total of 6 months • associated employer National Insurance contributions • employer minimum automatic enrolment contributions Employers can spread the start date of the job placements up until the end of December 2021. A Kickstart Scheme application must be for a minimum of 30 job placements. If a single employer cannot provide this many job placements, they can find a Kickstart gateway, such as a local authority, charity or trade body for help applying. G Robson highlighted that North Ayrshire Council has applied to be a gateway with the intention to support 300 vacancies, to date, over 300 roles have been identified by the Private Sector alone. It is hoped that the first lot of vacancies will be advertised in December 2020 pending DWP approval. Every young person who joins will get wrap-around support through council provision. The Council is keen to top up wage levels to Scottish Living Wage, rather than National Minimum Wage. The team will now look to public and third sectors for contribution. G Robson highlighted the work commissioned by Government during the first lockdown looking at what could be done for young people. The Young Persons Guarantee which is 2-year ambition to have every 16-24 yr old in employment, training, education, volunteering, work experience. £30m of funding has been distributed to all Scottish Local Authorities to help support this work. G Robson advised that types of services likely to be funded were: • Enhanced key worker capacity • Digital devices and skills • Top up KickStart to Scottish Living Wage • Employer Recruitment Incentives K Hankinson highlighted that SFRS have a link in with the third sector for volunteering, however, struggle for daytime availability at local stations. He asked G Robson if it they could discuss separately the opportunity to train up	**Noted** **K Hankinson/G Robson**

	people to become retained firefighters. G Robson confirmed that this would be a great opportunity and would tie in with K Hankinson to discuss further. Partners agreed to consider opportunities within their own organisations and will contact Greig to discuss further. The Chair thanked G Robson for his presentation.	**All**
4.	**Community Health and Wellbeing** A Sutton provided an update on supporting Community Health and Wellbeing. A Sutton highlighted that the key priorities are: • Continue to embedding a more strategic and coordinated commitment to mental health improvement locally and nationally; • Ensuring GIRFEC principles inform how services work together for mental health (recognising that it was not simply a 'health service' issue); • Understanding the complex spectrum of issues with which children, young people and their families need support, including emotional distress; • Ensuring the workforce has the skills and capacity it needs to address these issues; and • Providing the full range of support for those issues, including primary care, community support and alternative services to CAMHS in many communities. A Sutton highlighted that last year the Clearer Minds young people's mental health project in the North Coast was granted funding via the Community Investment Fund. This continues with the school, some of this is arts-based work as well as peer support and training for young people and staff in the school. In September 2020 Arran LP and Cabinet approved almost £50k of funding from the Community Investment Fund to Arran Youth Foundations to support peer support and training across the community on Arran. There are also of number CIF application developments ongoing around social isolation and mental health. In terms of new and ongoing opportunities: • Scottish Government Health Improvement Project: putting children at the heart of all our work and ensuring their voices are heard; • Youthlink funding: last week North Ayrshire Council were allocated the maximum amount of funding to look at how we can support young people's mental health and wellbeing through outdoor youth work. • National Galleries – again maximum funding support allocated to support young people's mental health and well-being through arts-based work. • Scottish Government Community mental health and young people funding: development of approach at CSSP to explore a much wider range of opportunities and activities for young people which might not be directly related to mental health and wellbeing, but will have a direct impact on the outcomes around that. A Sutton asked partners to reflect the asks on the final slides and send any feedback to J McGee. A Sutton advised that she would circulate more details of the projects to partners to help identify the opportunities to collaborate.	**All** **A Sutton**

	A Sutton highlighted that she would like to come back to the Senior Officers to provide an update and to seek partner involvement to join the steering group. The Chair thanked A Sutton for her presentation.	**A Sutton**
5.	**Wellbeing Conversations** M Sutherland advised Senior Officers that over the next 18 months, the HSCP will be speaking to people who live and work in North Ayrshire, to find out what matters to them. The North Ayrshire Wellbeing Conversation is their new programme of engagement, which aims to: • Find out what people usually do to keep well, so that we can support them to do more of it. • Ensure people's voices and experiences are at the heart of our strategic planning process. • Build a network of people who are keen to help us shape and design the future of health and social care in North Ayrshire. • Target specific groups and individuals who are often marginalised and ensure their voices are listened to and acted upon. The survey has two, quick and easy questions to ask people. Those who complete the survey are also asked if they would like to be involved in a longer piece of work around brining their views to issues which arise during the consultation. Since the launch 300 individuals who have taken part in the conversation, with over 100 indicating that they would like to be a part of the longer piece of work. M Sutherland advised that report will be produce reports at 6,12 and 18 months which will pull out all the themes. M Rae advised that she links in Michelle's team and will use any relevant community feedback to influence other areas of CPP work. The Chair thanked M Sutherland for her input.	**Noted**
6.	**Independent Review of Social Care** M Sutherland advised Senior Officers that this a Government led review which will focus on developing a deep understanding of the needs, rights, and preferences of people who are using social care services. It will examine how and in what circumstances these are currently being met well and what needs significant improvement to ensure people's outcomes are consistently met on a personalised basis across Scotland. The review will be broken down in to three parts, the first focussing on engagement with a wide range of stakeholders. The deadline for responses has been extended to 26 November 2020. M Sutherland asked for any feedback to be sent to her as soon as possible.	**Noted** **All**
7	**Cost of the School Day** A Sutton provided Senior Officers with an update on the work on the cost of the school day (CoSD). A Sutton advised that a short life working group had been set up and is chaired by Councillor Foster. The working group is focusing on:	

	• What contributes to the cost of the school day and the impacts this can have on families; • Actions which can help reduce the CoSD ; • Examples of high-level structures, guidance and policies which have been put in place elsewhere including Dundee City Council's statements of intent around the CoSD; • The importance of officers taking up roles which focus on implementing and pushing policies in respect of the CoSD; • The requirement for visibility of policies and communication with families; and; • The Cost of the School Day website where information, toolkit resources and practice examples are available. The aim of the working group is to agree an action plan/policy for Cabinet approval in 2021. E Young highlighted that the young people's input at the first meeting was fantastic. She also highlighted that Public Health conducted CoSD work in Auchenharvie and Garnock Academy's and both schools have put things in place to help reduce the cost of the school day. E Young advised that now what is needed is consistency across all schools and an overarching policy to properly embed this work. I McMeekin highlighted that one of the Watch Commanders from the North Ayrshire area that would be keen to be a part of this work. A Sutton confirmed that the group would be delighted for them to come along. I McMeekin advised that he would pick this up separately with A Sutton after the meeting. It was agreed that the A Sutton would provide an update at a future meeting. The Chair thanked A Sutton for her presentation.	**Noted** **A Sutton/I McMeekin** **A Sutton**
8.	**Governance** **a) Locality Priorities and Profile Refresh** M Rae advised that the all six Locality Partnerships are conducting a refresh of their priorities. Discussions have already taken place at LP meetings which was then followed up with a survey. To assist with this work, we are going to draw from the wide range of engagement currently taking place. Plans are being progressed to have online conference which will look at the current priorities, what needs refreshed and the increasing ambition to address poverty and inequalities at a local level. In terms of the locality profiles, online dashboards are being created which will provide data such as population and crime stats at locality level. The dashboards will be hosted on the CPP Website and will be available for partners and community members to use. M Rae highlighted that she has been in contact with Council colleagues regarding data and that she will be in touch with partners in due course. **b) FFA Review** M Rae advised that she had been looking at how we make the FFA Strategy more focused on particular issues relating to poverty for example food. M Rae highlighted that she is working on the new draft Strategy and will bring this to a meeting of the Senior Officers in the new year. Partners were supportive of this approach.	**Noted** **M Rae**

	c) Community Engagement Centre of Excellence J Greenlees advised Senior Officers that the online Engagement Hub page has been developed and is hosted on the Community Planning website. Within this section includes an overview of all open and closed consultations as well as engagement and consultation resources. J Greenlees highlighted that further resources are in development including an Engagement Toolkit, a 'Jargon Buster', survey development information and building on work carried out alongside partners and the Consultation Institute. It is planned that these resources will be launched on the Engagement Hub section of the website throughout December 2020 and January 2021. J Greenlees also highlighted that: • A Teams site had been created which will act as a hub for all North Ayrshire Engagement Champions to share resources and information and develop an ongoing dialogue around engagement and consultation. • The Community Engagement Network (CEN) meets quarterly to provide opportunity for partners to come together and share news, skills and experience in relation to their work around consultation and engagement. • Throughout 2019-20 each meeting of the CEN centred around a LOIP strategic theme. • The CEN will welcome a new chair, Carol Norton from Arran CVS. • Moving in to 2021, the focus for Centre of Excellence work will be using the skills and expertise of the CEN and Engagement Champions to finalise and publish online resources for the Engagement Hub. Partners agreed to promote these materials within their own organisations. The Chair thanked both M Rae and J Greenlees for their updates.	**All**
9.	**AOCB** No other business was discussed. **Date of next meeting:** Thursday 21 January 2021	**Noted** **All**

Community Planning Senior Officers Group Action Tracker 2021

Date of Meeting	Action	Responsible	Notes
19.11.20	Circulate Inspiring Scotland Link-up National Report	A Sutton	Complete. Link sent 11.01.20
19.11.20	Discuss employability options for SFRS	K Hankinson G Robson	Update to be given at January meeting
19.11.20	CPP partners consider Kickstart and youth employment opportunities within own organisations	All partners	Update to be given at January meeting
19.11.20	Community health and wellbeing – feedback for A. Sutton to be sent to J. McGee	All partners	Update to be given at January meeting
19.11.20	Community health and wellbeing – update to be provided to a future meeting and partners to be invites to working group	A Sutton	Agenda item planned for April CPP SOG
19.11.20	Independent Review of Social Care - feedback to be sent to M. Sutherland	All partners	Complete – feedback deadline expired
19.11.20	Cost of the School Day – SFRS officer to join group	A Sutton I McMeekin	Complete
19.11.20	Cost of the School Day – update to be provided to future meeting	A Sutton	Agenda item planned for March CPP SOG
19.11.20	Fair for All review update to be provided to a future meeting	M Rae	Agenda item planned for March CPP SOG
19.11.20	Community Engagement Centre of Excellence – promote within partner organisations	All partners	Update to be given at January meeting

POLICE SCOTLAND
Keeping people safe
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Our vision | Policing for a safe, protected and resilient Scotland
Our purpose | Improve the safety and wellbeing of people, places and communities in Scotland
Our values | Fairness, Integrity, Respect, Human Rights

Support for Operational Policing

Protecting Vulnerable People

Working with Communities

Our Local Policing Priorities	Our areas of focus	
Serious & Organised Crime	Violence/Homicide	Drug Supply, Sexual Crime
Safer Communities	Hate Crime	ASB/Disorder, Domestic Abuse
Acquisitive Crime	Housebreaking	Robbery, Fraud
Community Wellbeing	Substance Misuse	Youth Engagement, Welfare Concerns
Road Safety	Drink / Drug Driving	Speeding, Disqualified / Uninsured Driving

Strategic Outcomes

- Threats to public safety and wellbeing are resolved by a proactive and responsive Police service.
- The needs of local communities are addressed through effective service delivery.
- The public, communities and partners are engaged, involved and have confidence in Policing.
- Our People are supported through a positive working environment, enabling them to serve the public.
- Police Scotland is sustainable, adaptable and prepared for future challenges.

Tackling Crime in the Digital Age

Paradise Explored: Investigating the Experiences of Alcohol and Drugs on Arran, Health and Social Communication and Barriers to Care.

Heather Still

Managed by ACVS, Funded as part of a grant by the Corra Foundation. Grant put together through the steering group, consisting of Arran professionals and North Ayrshire charities, ADP and recovery services. No conflicts of interest to declare by the author.

Heather Still

Your Drink. Your Drugs. Our Problem.

Recommendations

1. Education to what addiction “looks like”, including the different presentations of addiction in rural and more affluent communities.

2. Continued opportunity for people with lived experience on Arran to talk about their experience, with anonymity being a priority.

3. Having an Arran resident representative on the stigma communication strategy for the ADP.

4. a) Frequent checks in pubs and golf clubs, monitoring recording of toilet checks, drug use and violence.
   b) Scope publican’s perception of drug use in their establishments, and whether they need support in policing and monitoring incidents.

5. The Arran Economic Group should scope employer’s perception of drug and alcohol use in their employees.

6. Incorporate parental addiction in youth mental health & wellbeing services.
   a) Trauma informed practice to be rolled out to public sector workers
   b) Trauma based counselling should be offered as a treatment option either privately or through the Mary Davies Trust.

7. Utilise the Arran link worker as a communicator between recovery and Arran services.

8. A dedicated, part time recovery worker on Arran is a priority. A named outreach worker who works within the community may be more likely due to the housing market on Arran. This person would also be responsible for:
   a) Tracking and communicating drug and alcohol harm
   b) using innovative methods to evidence harm due to the disparity of equipment and staff.

9. Family members to offered to be a part of the decision making if applicable.
   a) Family members to be offered support independently.
   b) If family members do not have permission on their loved one’s treatment, be honest with them and offer support and signposting, as this has the potential to be hugely distressing.
   c) Family members to have a support group set up and maintained on Arran, or virtually.

10. Signposting, expertise, empathy and welfare checks were indicators of good care and should be encouraged.

11. Involve family members and service users in service development as part of their recovery.

12. GPs need further training on cocaine dependency and addiction, alcohol and cocaine, what services to signpost onto and a named contact should they have further questions.

13. Distress Brief Interventions should be a treatment option as there is little available support during emergencies on Arran.
    a) Informal welfare checks to be carried out after a crisis by those who had some input to an individual's care, including after a mainland hospital stay.

14. The ferries are a serious barrier to accessing care and a short, medium and long term plan of action should be put in place. This includes:
    a) maintaining contact with the person when the face-to-face appointment is cancelled due to the ferry to avoid disengagement.
    b) an assertive outreach set up to encourage ferry use, as anxiety is significant for some residents. Assertive outreach will also help when an appointment is cancelled so people are not alone and maintains privacy whilst on the ferry. Assertive outreach could go beyond appointment attending and integrate into general recovery.
    c) Investing in mental health, addiction and recovery education and qualifications on Arran to train existing staff and younger generations who wish to make a career in helping others but are currently unable to do so.

15. A volunteer program (assertive, outreach, social) for people with lived experience. Again, this would be set up and maintained with people on Arran. The volunteer does not have to be about harm reduction or the addiction itself.

16. Cafes on Arran are seasonal, and some sell alcohol. A safe space for people with lived experience (and family members) to go to that does not have alcohol or tolerate drug use is desperately needed. Ideally, somewhere to physically go during an emotional crisis would also be beneficial to avoid taking a bed up in the hospital.

Contents:

Acknowledgements.

My main thanks for this research go to the participants who gave their time and experiences to this research. It was sometimes hard to find themes when your experiences were more different than I was expecting, since not everyone had recovery experiences, and not everyone had recovery experiences at all. I hope I do your words justice.

I also wish to thank the steering group who gave me a particularly good context to your work, and it allowed me to see a more well-rounded view. You were very honest of your personal limitations, and I acknowledge how hard that can be when you are the "expert". The care was there. My manager, Vicki Yuill, has also helped me enormously.

The funder, the Corra Foundation, for giving me this opportunity to research something I care very much about and giving Arran residents the chance to express their experiences. Matthew from Corra, who was again patient but also very understanding to some of the changes the original research was set to achieve.

1. Documenting Arran

This chapter will give an overview of Arran, alongside some of the challenges of presenting reliable evidence on social or lifestyle issues for the residents.

1. I) A Snapshot of Arran

Arran is classed as "remote rural" by the Scottish Government, meaning that it takes longer than 30 minutes to access a settlement with a population of over 10,000 people[1]. A 2017 estimate of Arran population is around 5,562, with most residents being retired (61%) and a lower than council average of people of working age (54.9 vs 61.8%)[2]. Arran's economy is heavily reliant on tourism and has a seasonal economy where a significant number of restaurants and cafes close after summer. Most young people work on Arran – youth unemployment is 1.3% compared to 5.5% North Ayrshire average[2] – meaning younger residents have disposable income. Young residents often live with their relatives or guardians. Higher Educational facilitates involve a Highlands and Islands college that offer courses such as horticulture, access to nursing, childcare and business administration.

Transport on Arran involves an hourly (less on evenings and weekends) bus service around the island, focusing more on the lower half of the island, which is the most populous part. Arran also has a MyBus community transport service for people who have difficulty accessing social events or clubs. The ferry service runs from Ardrossan to Brodick or from Claonaig to Lochranza. The Brodick- Ardrossan route has been an issue for many Arran residents, with an increase in cancellations over 2019 and early 2020. The ferry from Brodick – Ardrossan is a lifeline for many people, as the Lochranza- Claonaig route is often difficult to access and requires a car. A helicopter is used for emergency medical situations.

In terms of charity, there are local charities such as the Mary Davies Trust, Arran Youth Foundation, Ecosavvy, Arcas Cancer Support, with a significant proportion of people involved in community groups. Arran has a few groups, including the elderly forum, the economic group and the ferry action group. Arran also has a Third Sector Interface, the Arran Community and Voluntary Service.

1. II) Finding the evidence.

Documenting the "downside" of Arran is difficult. Rural Scotland is a "very good" place to live, with higher acts of volunteering and lower rates of littering and crime1.

Likewise, research into Arran has primarily focused on the positives of living on Arran, with the locality profile noting Arran's low smoking rates, low unemployment, low crime rates, high household income and high self-reported health[2]. A quality of life survey commissioned by the Arran economic group in 2019 suggested that Arran has the second highest quality of life in Scotland[3]. Most commissioning of research – including this study – has been conducted or commissioned through Arran residents and not those outside of Arran.

Grey literature:
Grey literature of Arran tends to paint a less flattering picture. Again the grey literature tends to be conducted by people who have a personal connection to Arran. A previous resident of Arran wrote two Guardian articles about the housing shortages of working people on the island as the driving force of working age depopulation of the island[4,4b]. A survey carried out by the local police that mimicked part of the national Scottish Adolescent Lifestyle Substance Use Survey (SALSUS) survey in 2019 saw that 43% of pupils aged between 13-17 on Arran had drunk alcohol 7 days or less prior to the survey being taken. This is in comparison to the Scottish average of 26% of 13-15 year olds as demonstrated by the 2018 SALSUS survey[5=]Furthermore, 31% of young people surveyed for the SALSUS survey had received alcohol through a relative, compared to 45.57% of young people on Arran receiving alcohol through a relative5.

Overall, evidence for the social aspects of Arran is minimal, and is usually taken within a greater North Ayrshire population.

1. *III) Urban Measurements and Methods in Documenting Rural Demographics.*

Rural poverty is missed in research (Atterton, 2019) [6]. According to the Scottish Indices of Multiple Deprivation, between 2004 and 2020 Arran has had zero residents living within the 15% most deprived status[7]. Because of this, mapping poverty on Arran is difficult. The North Ayrshire Community Planning Partnership who conduct the locality profiles for North Ayrshire use a postcode analysis called

ACORN (Appendix 1). ACORN, whilst being more methodically fine-tuned than traditional post code analysis, was built in London designed -perhaps unconsciously- for an urban population[8]. An example of this is that "urban adversity" is placed at the bottom of their postcode analysis, indicating that urban poverty is more acute or worse than rural poverty. This means when performing the Arran locality profile, the entire population automatically is categorised as "financially stretched" or higher. Participants in this study have spoken about having very little money and becoming homeless and living in their car on Arran, an indicator of severe poverty[9]. Potential participants have also confessed to homelessness or knowing people who did not have enough money to feed their family. These individuals were often helped by the community and subsequently missed in data collection.

1. *IV) Urban Bias in Co-Creating Recovery Services*

Co-creating or co-producing involves getting the community involved in the creation of services[10]. There are some good examples of community based coproduction research on urban populations[11,12,13] however, issues such as anonymity and privacy are not held in the same regard as rural populations[13,14,] making recruitment, training and facilitating of people with lived experience exceptionally difficult. This means services are shaped with an urban population in mind, as this has the highest empirical evidence, often supported by city universities who fund the research and theory. Rural issues are not seen with the same academic interest as urban issues [14,15]. *In* turn, this leads to rural studies and research lending to anecdotal evidence, a

general indicator of low-quality research, and less likely to be taken seriously or followed up[16].

1. *V) Differing Perceptions of Quality Care*

The centralising of NHS services - where services are placed in bigger institutions- was initially created as a policy response to the increasing scientific evidence that larger establishments with a larger percentage of medical equipment and expertise would allow patients to receive a higher quality of care[17]. "Quality" care involved medical benefit by pooling specialists in smaller geographical areas[17]. However, those receiving recovery treatment perceived high quality care as being treated with respect and would be willing to wait longer if it meant having this quality of treatment[18]. A further consequence of centralising services for rural and island service meant the availability of care during non-physical crisis[19], or even routine appointments are limited, resulting in people from rural locations more likely to be offered telehealth and telecare as a substitute[19,20]. This is a disparity of care provision, as it removes the choice of the patient's wishes on whether they want face-to-face or telehealth.

1. *VI) Addiction "looks different here***"**

Because "urban" poverty does not exist on Arran, the association society has got from what addiction looks like is difficult to compute with a rural island population. A qualitative study on heroin use in the Shetlands noted that the presentation of addiction looked different in island and very rural communities compared to urban Scotland[21]. There are barely any visible markers of addiction on Arran, except when a person is seen at a pub on a regular basis, or occasionally when someone appears intoxicated outside of pub opening hours. People who work in criminal justice and the health and social care services pick up more on addiction due to repeated callouts for emergency services, but this does not transfer to the public.

There is an accessible foodbank on the island that does not need a referral from a statutory service, meaning a person can access food relatively easily with minimal people knowing. Arran also has a successful foodshare program and honesty boxes,

as such people who are in need do not have to resort to stealing from public places. Taking food from food recycling schemes on Arran are not seen as symbol of poverty, as the environmental stance of foodshare initiatives can mask this and make it less shameful to take free food openly. Stealing alcohol or money from local shops is usually rare in rural areas and island communities. From interviews with the steering group, key workers, and the results from the police survey, stealing alcohol or money to fund drugs tends to occur within the family on Arran[21].

Whilst urban addiction remains associated with visible poverty, the association that having a substance or alcohol use disorder and being unemployed is prevalent within our society. In Scotland, people with alcohol use disorder who are in employment and attempt to get help from statutory services are at risk of being rejected as they are not seen as "severe" enough for support[22]. Since Arran has a high percentage of its working population in employment[2], there is a risk of serious issues being missed or allowed to worsen.

In regard to adolescents and young adults, the consumption of alcohol given by parents is higher in rural populations[23]. Likewise, the consumption of drugs in rural settings is often done more covertly, hazardous drug consumption is more likely to be taken legally, such as through legal opiate prescriptions in rural areas [24,25]. The "type" of illegal drugs consumed on Arran also tends to be associated more of affluence, counterculture, and partying, such as cannabis and cocaine, rather than deprivation and poverty. According to Scottish Families Affected by Alcohol and Drugs, cocaine is the most reported drug (after alcohol) to their helpline[26], suggesting that cocaine is having a significant burden on the family dynamic. These differing perceptions and presentations of addiction or increased use of drugs and alcohol in rural areas risks an underinvestment in treatment and accessibility[27]. Studies looking into alcohol use in older adults living in rural communities is hard to come by. A systematic review of alcohol use in older adulthood found mixed results in whether alcohol use increased or decreased during adulthood[28]. However it is important to note that the themes around this review were primarily about "enjoyment" and having alcohol integrated into the lives of retired adults[28]. When hazardous older adult drinking is discussed, it is usually around grieving from the loss or multiple loss, and the loneliness this grief can bring [29,30].

FINDING: THERE ARE DIFFERENT PRESENTATIONS OF ADDICTION THAT ARE CONTRIBUTING TOWARDS MASKING DEPENDANCY AND ADDICTION ON ARRAN.

RECOMMENDATION: EDUCATION OF WHAT ADDICTION "LOOKS LIKE" IN RURAL, AFFLUENT AND ISLAND POPULATIONS.

Education describing what addiction looks like is important for residents and staff to challenge their own assumptions of what addiction is, and to make it more relatable by using personal stories from people who have similar backgrounds to Arran residents. Working with academia and agencies such as SHAAP and the Scottish Drugs Forum, who use easy to understand terminology and critical approaches to their research and training, can help nurture our new found knowledge. Using Health Improvement teams to integrate this into the Curriculum of Excellence for children and young people will give access to this knowledge from an earlier age.

1. *VII) Arran is a Holiday Destination & of Affluent Means*

Arran is a highly popular tourist destination. Often people have visited Arran since they were children and have formed nostalgic, spiritual ties with the island and the community and have moved here for retirement. The nostalgic themes Arran brings due to its holiday type persona fog some of the issues Arran has had historically or is developing. This is a theme found in other tourist[31] and rural destinations[32]
Arran as a rule does have a higher quality of life and does have a high percentage of people with good financial means[2]. When studying health inequalities, people who are in the higher SMD indices tend to be used as a comparison for those in the lower indices, rather than subject matter in their own right, as the subject of study are populations with lower incomes. Despite this, there is a growing evidence base in Northern European countries that socioeconomic levels are not a strong contributor for alcohol consumption[33,34]. The SALSUS survey suggested that teenagers with the most money to spend each other (£30 per week or over) were three times more likely to drink alcohol than those with no spare money to spend[5]. Those in affluent families who have children or parents with drink or drug problems are much more likely to be missed in needing support as they are not monitored by social or health services or studied in the same way as those with less financial means[35]. Adverse Childhood Experiences – particularly neglect- are presented differently in people who come from higher socioeconomic background[36]. Workers in social services are also less willing to work with more affluent families, who can use their education and social connections to intimidate staff[35]. These factors contribute towards the hidden nature of drug and alcohol harm on Arran.

FINDING 2: CLASS AND SOCIOECONOMIC STATUS ARE BARRIERS TO DISCOVERING THE EXTENT OF DRINK AND DRUG CULTURES ON ARRAN

RECOMMENDATION: SUFFERING IS IMMUNE FROM STATUS. OPEN CONVERSATIONS AND MORE CHANCES FOR PEOPLE TO COME FORWARD ANONYMOUSLY SHOULD BE ENCOURAGED AND FUNDED.
Despite the association of stigma and community denial on Arran people were coming forward, often for the first time to ever talk about their experiences and that willingness should be encouraged. This could be part of service development, further research opportunities or embedded as part of the community planning partnership, where more in depth conversations about living on Arran could be encouraged as part of their locality planning.
Additionally, this could be made outside of the HSCP, for example, a part of local social oral history projects facilitated by arts funding could encompass other aspects of island life. Similar projects have been facilitated by the Wellcome Trust, Story Corps and the Human Library. The benefits of the interviews for some participants were noticeable, and it undoubtedly it impacted some for the better.

RECOMMENDATION: THERE WILL BE AN ARRAN REPRESENTATIVE IN THE ADP STIGMA COMMUNICATION STRATEGY.

1. *VIII) The Drowning of Evidence.*

Arran has a small population. This tends to get lost when presenting data for North Ayrshire as a whole, and it is unlikely that any differences in Arran demographics would sway the overall figures. An example of this is "access deprivation" in North Ayrshire (Appendix 2). Geographic Access to Service Deprivation measures how a community is "access deprived" to the following services: GP, Petrol station, post office, primary school, retail centre and secondary school[1]. This is measured through time (minutes/hours), not physical distance. According to this indicator, Arran is more Access deprived than the Scottish average, however it is drowned out by other areas of North Ayrshire who are not access deprived, showing an overall figure that North Ayrshire is actually less access deprived than the Scottish average (Appendix 2). This again impacts service provision, such as offering or developing assertive outreach (where a person or team visit you rather than you are visiting a service).

1. *IX) Drink/Drug Related Suicides on Arran.*

When someone deliberately ends their life in Scotland, the cause of death is often ruled as a suicide. Whilst their backgrounds are taken into consideration, including any drinking or drug history, as well as whether that individual was under the influence of substances, this is seen as a contributory factor to the suicide. An unfortunate number of residents on Arran know one or more suicides on the island over the last ten to fifteen years. Since 2008, the amount of suicides per population is higher on Arran compared to both North Ayrshire and Scotland (Appendix 3), with the amount of suicides rising substantially since 2011, similar to the rise in alcohol and drug related hospitalisations. Whilst it is very important to stress that not all of the suicides on Arran were impacted by any substances, both steering group members, participants and people who did not wish to be interviewed spoke about people on Arran who have ended their lives who had underlying substance use issues. Because these are not counted as "drug/ alcohol deaths" it is not necessarily picked up on. This documentation is more of a national issue, however Arran has a higher than average suicide rate, the reasons for this need to be explored to build preventative action and to limit the impact multiple suicides have on a small community. Arran High has already noticed this and has tried to create preventative workshops. Additionally, the trauma suicide has brought upon Arran residents has been noticeable and is in part a contributing factor to worsening drink and drug use on the island.

1. *X) Using paper to document A&E attendees/ General data quality*

Arran uses paper instead of electronic files to document A&E attendances. This automatically puts Arran at a disadvantage because the likelihood of human error increases whilst other areas of North Ayrshire do not have this risk. It also prevents

research outside of NHS staff due to ethical concerns of anonymity and GDPR issues. In a day-to-day capacity, because the doctors on Arran have an in-depth knowledge of their patients – which on its own is a very good thing- there are at risk of not fully documenting reasons for admission, lowering the accuracy of the total figures. This point was raised by the steering group.

Whereas general North Ayrshire data held in the public health observatory demonstrated a similar trend to Scotland, Arran data was a lot more erratic, and may present more island specific issues due to the small population. For example, between the years of 2011-2016 there was a substantial marked increase of alcohol (Appendix 4) related and drug related hospital admissions, followed by four years of substantial decrease (Appendix 5). These increases and decreases in alcohol, drug and mental health harm were brought up a steering group meeting with little understanding as to why there were these big differences in the data.

FINDING: MONITORING OF DRINK AND DRUG HARMS ON ARRAN HAS BEEN PATCHY

RECOMMENDATION 1: THERE IS A DEDICATED PERSON TRACKING ALCOHOL AND DRUG RELATED HARM DATA FOR ARRAN WHICH IS REPRESENTED IN THE ADP.
An individual with dedicated interest in alcohol and drug use who is able to access and understand the public health observatory trends would be needed to keep watch on any developments on Arran. A dedicated outreach worker would be ideal for this recommendation.
RECOMMENDATION 2: USE CREATIVE WAYS TO COLLECT DATA Arran is not incapable of collecting and presenting data whilst it catches up with the technology and expertise. Examples of this is working with the Coop on Arran in sharing the number of residents who have been banned from purchasing alcohol, tallying the reasons for Mary Davies referrals or tallying service users who have had underlying drug/ alcohol dependence over a certain period in a service. Collecting more data of what services people have accessed (such as patient journeys) would be useful in evidence collection as well.

1. *XI) What does this mean?*

Arran is marketed as "Scotland in Miniature" but to be a miniature version of Scotland without any of Scotland's unfortunate, complex issues with drugs and alcohol would be naïve at best and dangerous at worst. 19.6 units of alcohol are sold per adult per week in Scotland[37]. Between 2017 – 2018, there were 1,187 recorded drug related deaths in Scotland, a 107% increase from 2008, totaling 574 deaths[38]. Arran, whilst in a considerably better and safer position, is a part of Scotland, and therefore is not immune to the harms of alcohol and substances.

There are consequences when methods are urban based because it hides the extent of issues on Arran such as poverty and access, impeding service provision that incorporates people who live on islands or in rural populations. Likewise, there are consequences when data is not separated and questioned, because this too hides the extent of issues: whether that is high alcohol related hospital admission rates or poor data documentation of alcohol hospital admission rates. When there is a small amount of evidence or poor-quality evidence, it becomes less likely for services to become involved.

Is "hiding" of a whole picture of Arran is unintentional, however it contributes towards the collective denial that Arran does not have a sizeable proportion of people who have or are suffering from the effects of alcohol and substance use, as there is no tangible evidence to demonstrate otherwise (Appendix 15). This study hopes to rectify some of these misunderstandings.

FAMILY MEMBER: I get nervous…you know. I'm a lot more anxious now.

INTERVIEWER: Really?

FAMILY MEMBER: Yeah. A lot more anxious. I never had all of that before, that thing in your stomach. But that's constant now.

1. XII) *Policy Analysis*

A policy analysis was conducted on relevant policies related to recovery provision on Arran and how policies may impede or progress positive change on Arran.

Type of Policy	What it says	What it means	Impact on Arran	Impact on Drugs and Alcohol
Rights, Respect and Recovery; Scottish Government; 2018 *This policy was created to cement a kindness based approach to recovery, as opposed to criminal and stigmatised opinion of addiction. It suggests new ways to demonstrate care and recovery in Scotland.* Public Health Directorate, Scottish Government (2018). Rights, respect and recovery: alcohol and drug treatment strategy.	Individuals are fully supported within communities to find their own type of recovery - an evidence informed approach, which appropriately involves academic evidence, the voice of lived and living experience, family members, those with professional experience and other intelligence on alcohol and drug related harm and recovery	From the "within communities" line it appears to be decentralising services and returning them to communities. The type of help of which they receive is through their choice (although this choice needs to be evidence informed, paradoxically limiting choices. For example, AA was only recently included as an evidence based effective treatment since early 2020 (Kelly, 2020) and is not a resource traditionally offered in ADP information)	Currently Arran has limited capacity and resource to cope with decentralising services and having expertise on the island. This is impacted on part by availability of housing. Community capacity building is possible through innovation grants/ healthcare think tanks who can fund pilots. Overall responsibility for increasing capacity on Arran would need to be established.	Whilst those interviewed who attended rehabilitation did not mind travelling to mainland, light level, group and crisis type interventions were preferred to be on Arran. Finding preferred support is difficult on Arran when access and availability is limited, leading to a disparity of care provision.

Kelly, J. (2020). Alcoholic Anonymous and other 12 step programs for alcohol use disorder. Cochrane Database of Systematic Reviews. https://doi.org/10.1002/14651858.CD012880.pub2

Rights, respects and recovery pt 2: Families.; 2018	Outcome: Children and families affected by alcohol and drug use will be safe, healthy, included and supported	There will be services in place to help people who are affected by alcohol and drug use. This would include getting people signed on as carers, listening to the family and involving them in recovery and protective measures for vulnerable families.	There's very little on how this outcome would be achieved, particularly in rural areas. Trauma informed practice was mentioned for families, and it would be assumed that the HSCP workforce would receive this rollout of training eventually. The focus was statutory services to provide this, though historically mainland to Arran services do not end well.	• Family members are attending appointments with their loved ones. Those who do not have permission experience severe distress as communication to why that have been excluded from updates has not occurred. • Often interviewees did not see themselves as carers, so it should not be assumed that this is part of their conscious identity, meaning this conversation would need to be brought up by health and social care professionals. • Children in the study experience distress or pick up on familial drug/ alcohol use, though not all are affected. Children may present at mental health because of familial substance use. • Referral process to Scottish families should be established. Better links with Turning Point to facilitate family support on Arran.

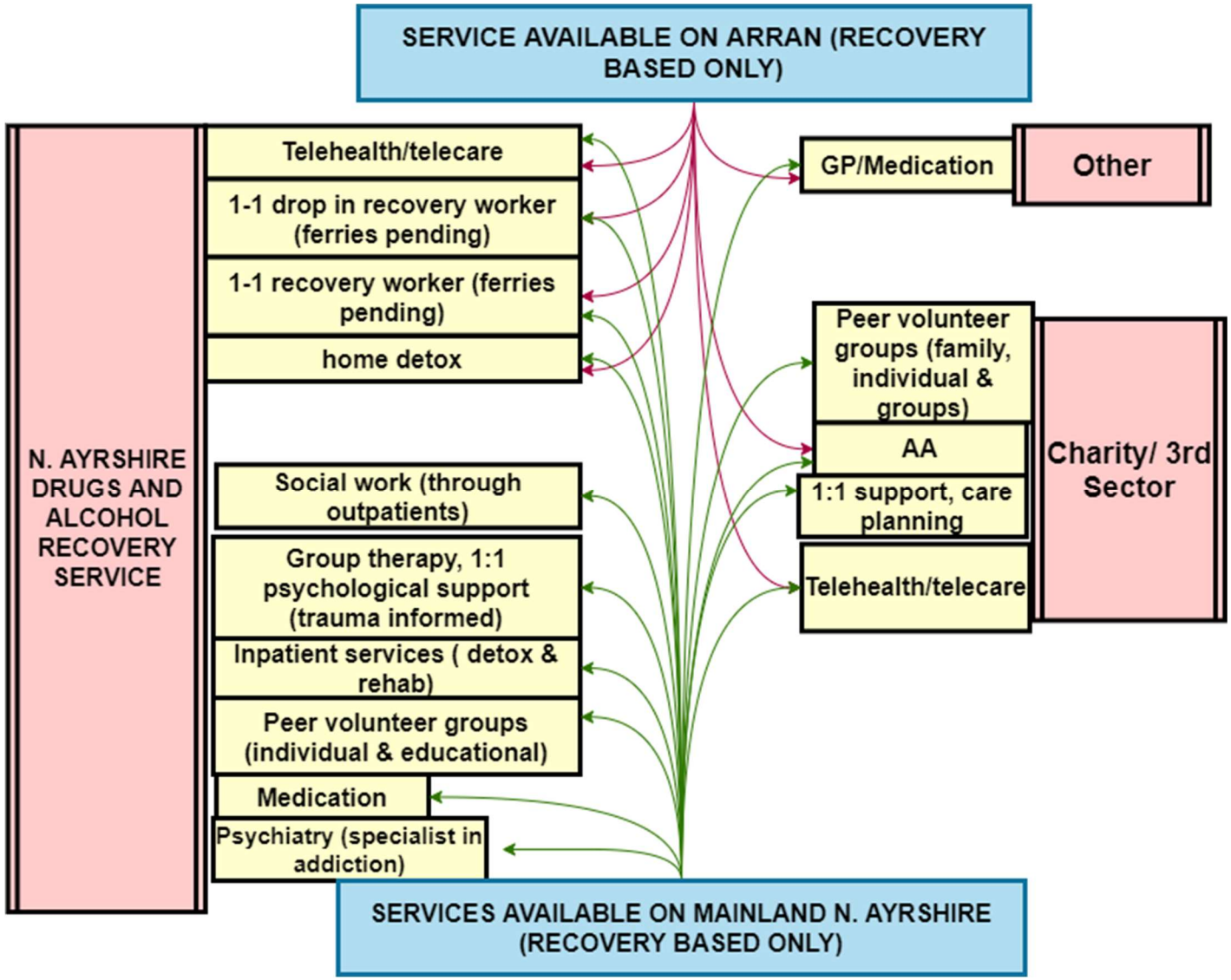
	Work with NHS Boards, Local Authorities and Health and Social Care Partnerships to ensure that there is fair, accessible health and social care for those on islands. Work with our partners to consider a range of options to ensure that adequate mental health care is available, whilst taking into consideration the uniqueness of our island communities.	Boards will need to take islands into consideration for their HSCP. Working with the partners often mean third sector/ community led groups. Could also involve corporate social responsibility for private companies.	There are no charity groups on Arran other than small community groups who work on wellbeing, rather than specific programs for mental health. This is because Arran has a statistically high wellbeing. Proper funding could be obtained but again resource capacity is and remains an issue.	There was zero mention of alcohol or drug issues or recovery in this bill. Most interviewees had some sort of mental health or emotional concern. Cocaine side effects tend to be mental health, and we need to understand this when understanding service development. More involvement with NHS boards to detail strategy for equitable access of care. ADP strategy will need to incorporate islands who have different needs.
National Islands Plan (overall outcomes) *The National Islands Plan aims to join up different policies to create a cohesive Islands strategy.*	An integrated Plan will promote joined-up services based on a cohesive, place-based and holistic approach to policy and will build economic, social and environmental	Difficult to establish whether the integrated plan IS part of the islands bill or it's separate. Essentially it's linking how one area of policy impacts another.	Joined up services in policy are needed in Arran as tourism, housing, HSCP don't talk to each other but rely on each other to succeed. It is particularly acute in housing and recruitment.	The integration of policy should theoretically help us when justifying resource allocation (i.e. lost wages due to ferry cancellation to be diverted to an on island drug/ alcohol counsellor) as this is needed for recruitment, retention, housing, community empowerment and correct infrastructure.

Scottish Government, Agriculture and Rural Delivery Directorate (2019) National Islands Plan.	considerations in an integrated approach to island policy.			A focus on upskilling the current workforce or the younger generation instead of external recruitment may help.
Rural Economy and Connectivity Committee (part of the islands and highlands bill) *This strategy is to decentralise local government and give more control over to the islands.* Parliament.scot/S5_Rural/inquiries/Highlands_and_Islands_Enterprise.pdf	Would the devolution of more power to the islands councils or councils with islands would be potentially advantageous to the governance and sustainability of those areas? Evidence received on Committee visits and in oral evidence also made it clear that a one size fits all approach would not work in relation to the proposed National Islands Plan	Arguing for more control to be handed over to the islands in terms of spending, community development and infrastructure	This is difficult to achieve with the current HSCP in place as we rely on mainland services and money. Whereas island councils who are independent may have a better chance at developing strategy.	There is a disconnect between interviewees who wish to be supported on Arran, and the likelihood of that happening without the correct support in place. Having more control would be similar to decentralising services, but would Arran be better placed at having independent recovery support when expertise are not available?
Stigma in addiction (upcoming)	Looking into how stigma impacts people's interaction	Stigma is incredibly complex. Often in policies and research	Stigma can impact hugely on how a person access treatment.	Stigma was spoken about by the interviewees but incredibly hard to define as a concept. Often if direct

An upcoming policy developed alongside the University of Dundee as a response to their kindness approach to recovery. This emerged from the drug death summit in Saltcoats	with services, society and family. Note: within the rights & recovery policy they mention three types of stigma and this may be used as the theoretical underpinning of their work. *Stigma by association* *Self stigma* *Institutional stigma*	that addiction and stigma go hand in hand but there is often not really a good definition on what stigma is. How would we define stigma in an addiction's context?	Fear of judgement contributes towards health-seeking behaviour. This can be particularly acute on an island with little anonymity. Stigma will impact on anxiety of ferry travel as there is little space for privacy.	examples were not given, people's behaviour of how they responded to other's is a pretty accurate representation of how they face stigma. For example, locking yourself away in your house because you are scared of being seen drunk. However, Community responses to addiction are not pleasant. This could be a good definition of stigma. Maybe we should start asking the community for their attitudes as a measurement of stigma rather than the people it affects?

2. **CHAPTER TWO: Current service provision on Arran for people who need substance/ alcohol support**.

Mapping Services Available to Arran and North Ayrshire residents.


SERVICE AVAILABLE ON ARRAN (RECOVERY BASED ONLY)
N. AYRSHIRE DRUGS AND ALCOHOL RECOVERY SERVICE
Telehealth/telecare
1-1 drop in recovery worker (ferries pending)
1-1 recovery worker (ferries pending)
home detox
Social work (through outpatients)
Group therapy, 1:1 psychological support (trauma informed)
Inpatient services (detox & rehab)
Peer volunteer groups (individual & educational)
Medication
Psychiatry (specialist in addiction)
GP/Medication
Other
Peer volunteer groups (family, individual & groups)
AA
1:1 support, care planning
Telehealth/telecare
Charity/ 3rd Sector
SERVICES AVAILABLE ON MAINLAND N. AYRSHIRE (RECOVERY BASED ONLY)

2. I) The Layout of Arran Health, Social and Third Sector Care

Due to the small population health & social care staff are known as "generalists" rather than specialists, except for mental health (including dementia) and maternity. There are no specialist addiction services or staff living on Arran. There is a dedicated drop in support worker who goes to Arran from NADARS, however the coverage of this drop in clinic is patchy, as there are low referrals to the service, a lack of continuity of staff and a poor ferry service.

Third Sector - Arran

- AA is the only charity on Arran that specialises in alcohol and drug misuse. AA usually only caters to personal use of alcohol but because there is nothing else on Arran they are open to family members and people who are struggling with drug dependency and addiction. AA occurs 4 times a week (it is now on zoom due to COVID) to try and cater to people in different locations with both afternoon and evening times. It is set up and run by a group of dedicated volunteers who live on Arran.
- AIMS advocacy has a dedicated worker on Arran who helps individuals who are classified as eligible for requiring a care service. They are self-referral and well as health and social care professional referrals. They do not have fixed amounts of sessions with individuals and will teach self-advocacy to individuals. As a statutory service, they are funded by North Ayrshire HSCP.
- Mary Davies Trust is a GP referral service that provides 6 sessions of counselling or alternative therapy for residents on Arran. Carers are a priority. The Mary Davies Trust covers the costs of these 6 sessions. The Mary Davies Trust is funded through the rental of a holiday home donated by Mary Davies.

Third Sector- North Ayrshire

Turning Point P.E.A.R service (prevention, early intervention and recovery)
Turning Point North Ayrshire provides drop-in services, psycho-social support and personalised action plans. Turning Point can help set up and facilitate groups for both personal experience and families, with the goal of groups being self-sustaining[39]. Referrals can be made by calling or dropping into a drop in centre, or can be made through healthcare professionals and NADARS. Turning Point is on a 3 year funded contract.

NADARS

North Ayrshire drug and alcohol recovery service is the statutory service for recovery services in North Ayrshire. According to their brochure[40]:
You will meet a wide range of different professionals, including nurses, social workers, addiction workers, support workers, occupational therapists, consultant psychiatrists, GPs and pharmacist prescribers. We will work with you to complete an assessment based on your strengths, goals and wishes. You will be involved in reviewing your recovery care plan: your family will be invited to be part of this process.

Group work programmes to help improve self-confidence and self-esteem
- Support to stop taking drugs and alcohol
- Occupational therapy support
- Social work assessment and support
- Support can include home visits and/or appointments in your locality
- Mental health related support
- Physical and sexual health interventions
- Injecting equipment provision (needle exchange)
- Opiate replacement therapy medication prescribing and recovery support
- Additional parenting support

Referral can be made over phone, through email or in person and can be done either by yourself, a relative or a health and social care worker.

11 Referral numbers to NADARS from Arran.

Referral numbers of distinct clients to NADARS from Arran between 2016-2019 were:
6 drug related referrals
12 alcohol related referrals
£163.72 was spent on ferry travel between 2018-2019, from the NADARS service, which approximately amounts to:
1 return car journey
8 foot passenger journeys, one of which was not accounted for.

This is just an estimate from the researcher's calculations based on the ferry prices of 2018-2019 and the total expenditure of travel. There may have been further ferry travel which was not put through on expenses. With 18 referrals throughout 4 years, around 9 visits a year would appear to be a reasonable amount of visits.

According to the NADARS website, drop in sessions ended from April 2019 for North Ayrshire (http://nahscp.org/addiction-service/), however there is still an occasional drop in service delivered to Arran on Mondays in the early afternoon. This has caused some confusion on Arran to whether there is still a drop in service to refer people onto.

A key worker on Arran responded to the number of referral to NADARS:
My initial response is obviously quite surprised at the low numbers. I think this serves as an indication of low levels of referrals being made to NADARS (both professionals and self-referrals) due to a lack of awareness, inconsistency of service provision (unfortunate that cancelled clinics are not collated) and additional stigma etc… from a strictly financial perspective it certainly doesn't strengthen our case for a dedicated worker!

3. CHAPTER THREE: Recovery Support on Other Scottish Islands:

This section will look at recovery provision support to a selected amount of Scottish islands. When looking at other islands it is important to note that the focus will not just be based on similar population size, but will look at other similarities, such as islands having a similarly high quality of life or high socio-economic status.

3. I) Orkney*:* Population 22,270 [41]
The Orkney Isles in 2018 came out top in the best places to live in the UK[42]. This is the reason why Orkney was used as a case study. All information was gathered from the Orkney ADP website[43] and a phone conversation with the OACAS manager.

Orkney Alcohol Counselling and Advisory Service (now defunct) [44]
OACAS was a counselling and advisory service specifically for residents who had alcohol misuse problems or addictions, "for people of Orkney – and by people of Orkney".
Whilst OACAS was still operating, the manager spoke about the service being available since 1975, starting up by acquiring funding for counsellors already trained on Orkney to train further through Alcohol Focus Scotland – in the promise that the counsellors would provide free counselling until their funding was repaid. The service grew to fund a young person service with a dedicated youth worker specialising in addictions, as well as providing education for those involved in criminal justice.
The OACAS service was funded through lottery, Children in Need, and private Orkney based businesses, until it was completely funded by the Orkney Alcohol and Drug Partnership. It lost its funding in early 2020.
This service was taken over by Relationships Scotland, where the counselling service is more encompassing of other emotional problems but still does have a dedicated substance use counselling service and a paid substance misuse worker who can work with children and young people. This is funded by the Orkney ADP and provides free or donation counselling service.

Orkney Drugs Dog
Funded by the Orkney Drugs & Alcohol Partnership and local business, the Orkney drugs dog works in partnership with police Scotland who use stop/search and intrusive warrant searches. The key is to try and prevent drugs coming onto the island and to prevent distribution, particularly with the post office and the ferry. According to an update on their website [45] on May 24th 2020, 10 packages all containing cannabis had been seized since the start of the coronavirus lockdown on the 23rd March 2020 from the postal service. On another update[45b], between 1st October 2019-31st March 2020 there were a further 13 packages of drugs seized from the air and ferry ports and post office.

As well as this, the Orkney Drugs Dog and their handler do education courses on drug use, the impact of drugs on small communities and general advice and law on drugs

to education services and community gatherings. Part of their funding comes from fundraising activities, and the dog's food is paid for by local businesses.

Orkney Mental Health and Substance Misuse Team
This is a statutory service specifically for people who have a dual diagnosis of mental health and substance use. They are a group of mental health nurses and social work practitioners who have direct access to psychological therapies. Harm reduction, holistic therapies and signposting services are also available, self-referral and GP referral. There is no mention of assertive outreach.

Y-Talk
Youth counselling service
Needle Exchange Service
Fire Safety

AA
There are 5 AA meetings (Pre COVID) in Orkney that were not visible on the ADP.

3. II) Outer Hebrides – Uists, Benbecula and Barra. Population: 6,110[46]

All information was taken from the last available Outer Hebrides ADP[47]. The Outer Hebrides was chosen due to the similar population demographic of the smaller Outer Hebrides islands.

Substance misuse coordinator
Offers Tier 1 and 3, meaning signposting and active listening, to structured care planning and drug assessment within the community with health and social care professionals. In the last report 53 distinct clients were seen by the substance misuse coordinator per annum.

Community education
Offering drug and alcohol impact and addiction education for people aged 25 and under, as well as training youth workers. Community education reached 244 people per annum according to their last report.

Caladh Trust - Road to Recovery Support Group (drop-in service, one-to-one support, etc.)
Alcohol only, supported 25 people per annum.
Caraidean Uibhist (Support Group)
Supported 32 people per annum.

AA
There is 1 AA meeting a week on Barra which was not visible on their ADP

3. III) Argyll & Bute (Bute, Islay, Mull, Tiree, Coll & Jura) Population of Bute: 6,498; Islay: 3,228; Mull: 2,800; Tiree: 653; Coll: 195; Jura: 19648

   All information gathered is from Argyll & Bute ADP49. Argyll & Bute was chosen as an example as they have a similar funding structure to Arran, unlike the Outer Hebrides & Orkney which have their own island councils.

   Argyll & Bute Addiction team: Bute
   "Services include Assessment, Recovery Planning, Harm Reduction, Sexual Health Information, Blood Borne Virus Information and Testing, Opioid Replacement Therapy and Naloxone Training and Supply. Referral is via another professional e.g. GP, Social Worker etc". Bute service is held on the island and not an outreach service.

   Argyll & Bute Addiction team: Outreach
   Dedicated outreach to selected islands from workers who are stationed in port towns of Oban (Mull &Tiree) and Campeltown (Islay)

   Addaction We Are With You
   "We Are With You provide a recovery service across Argyll & Bute. The service is for people and families who need support around their own or someone else's drug or alcohol use. It's a really simple process to access our services. One of our experienced staff will be on hand to speak with you and provide support. They will also arrange to meet you in person in a location that is convenient for you. We offer drop-in Needle Exchange at Ballochyle House Monday-Friday 9-5." Dedicated outreach from stationed workers in Oban to Mull, Coll, Tiree and Smaller isles. Dedicated outreach from stationed workers in Dunoon to Bute. Dedicated Addaction office in Islay.

   AA
   Mull: 1 weekly
   Bute: 3 weekly
   These meetings were not visible on the ADP website.

3. IV) What Does This Tell Us?

   What was noticeable when researching other island's approaches to alcohol and drug services was that it was finding the information was relatively simple, although some of the ADPs were not up to date (for example the Outer Hebrides only went up to 2016 in reporting). Despite this, there was evidence that dedicated specialists who could perform outreach or have a stationed office could demonstrate their reach and effectiveness. The 53 service users a year being seen by a substance misuse worker for a population of 6,110 in the Uists is a good example of how a dedicated worker can draw in higher referral numbers, as well as demonstrating the

value of their work. The thriving third sector in some of these examples, such as the Drug Dog on Orkney, allows the police and the ADP insight into what type of drugs are coming onto the island.

4. CHAPTER FOUR: Steering Group & Key Workers: Initial Themes and Interpretations

The Steering Group originally consisted of the following representatives:
Lived Experience
Third Sector
Social Work
Police
Paramedic
Hospital Management
Nurse (Hospital & Health Visitor)
CPN
Community Link Worker
Youth Work
NADARS
ADP

Additionally there were GPs, GP managers, additional nurses, police and youth workers, North Ayrshire Third Sector and national groups (Scottish Families, SHAAP) who would ask to be updated in the research. They will be called "Key Workers" The steering group spoke about the barriers of accessing treatment for people on Arran needing recovery services. They also mentioned the drink and drug culture on Arran, and communication between services. These were then synthesised in themes, which will be explained through quotations gathered in interviews. Key workers were not included in the theming but helped with gaining additional information. Some of the themes will be analysed and elaborated upon. Communication barriers that came up for key workers and steering group will then be presented.

Themes from the steering group:

Lack of continuity may damage engagement or awareness of services. Interventions are primarily based on the mainland.

Escaping to Arran because it's seen as idyllic and cut off without dealing with historic problems, making people either vulnerable to addiction or more likely to continue addiction.

There isn't that mainland visibility of ingesting alcohol and drugs in public spaces. This helps fuels the assumption that there isn't an issue here. There isn't a visible presence of alcohol and drug support on the island also, although if there was it poses questions of anonymity.

1.To educate in what addiction can look like as Arran has a typically high employment rate and successful professionals, again feeding into the hidden nature of the problems. 2.Educating parents & their children on where to go to when there is a situation arising. High functioning doesn't mean fully functioning.

Historic & cultural significance of alcohol, but building belief of cannabis as a new wonder drug without understanding of harmful side effects is becoming more prevalent. The binary thinking of "drugs are everywhere" vs "drugs are nowhere" is pretty strong. Class plays a part into this, where the quality & expense of D&A legitimizes the amount consumed.

Population is significantly older adult, retired & has a good source of income. Contrast to the working population, often working in hospitality trades & poorly paid to reflect the tourism industry. This will impact on how alcohol and drugs are consumed and their presentation at hospitals, GPs & social services

4. I) Current Provisions on Arran:

"We're a jack of all trades"

"People have to cause substantial harm [to themselves] before help is offered"

"We have capacity to help children whose parents have addiction but we aren't utilising it"

"Alcohol is lumped together with mental health"

"I know someone who has to go to Ardrossan every day [when AA isn't on] because they want help"

"Do they still do drug tests at the school?"

"What about families?"

"Previous groups did little to protect the vulnerable people attending them. The teens also needed permission from their parents"

"We've had to discontinue services when staff leave"

"I often refer to the CPN here. If the CPN is not available, I'll go to the drug & alcohol services"

"People call ahead and ask to stay over the festive period in the hospital to prevent relapse"

"Services are all mainland. It keeps the issues hidden here"

"Services that are set up here from the mainland get abandoned"

"We need [mainland recovery] staff that enjoy working on Arran"

"We rely on a visiting service"

"Staff change at Brodick (drop in). The continuity isn't great"

"The mainland have the third sector"

Current provisions were near universally agreed as lacking for Arran residents. The generalist model for Arran is functional, but the drawbacks were noted to be profound for people with substance use issues. With mental health being a specialist service on Arran, it was a concern that referrals were going to the CPN rather than recovery. Some were reluctant to refer to recovery, as the communication between the two services was not great, and frequent recovery worker changes or ferry cancellations put the steering group off as it was interpreted by some that mainland workers did not want to work on Arran. The group would provide examples of people trying to help residents on their own. Arran GPs have been known to do on the day visits to people who need urgent attention out of hours. Furthermore, a bed in the hospital if not taken by an emergency is usually reserved for people who need a temporary safe space, both steering group and residents who did not wish to be recorded spoke of this bed being used for people with alcohol and drug problems,

particularly over the Christmas period for those who did not want to be around alcohol use in their families.

Services that were set up on the mainland on Arran as a "visiting group" were seen sceptically. It was hard to keep numbers up and would often tail off in the wintertime due to the ferries and would not start back up in the summer. There were historical incidents where the steering group mentioned groups, set up by mainland services, which were not believed to have been properly risk assessed. Not all the groups mentioned were statutory groups, this furthered distrust.
As a result of low referrals and turn outs, knowledge of what services are available, and the referral pathway were limited. The distrust from previous failed attempts of groups made people more reluctant to refer. The community link worker explained a recent experience of trying to refer onto recovery services:

I received a referral *today from a GP Trainee asking me to see a patient for Alcohol Cessation. As this is not part of my remit as Community Link Worker, I contacted Addictions Services at Cunninghame House to speak to NAME and hopefully pass on the referral. The member of staff at HSCP was unable to locate NAME or take the referral information from me, I asked her if she could give me an email address for NAME but this information was refused. During our conversation, I checked the Arran Medical Practices Appointment diary and discovered that NAME was in fact at Brodick Health Centre today, so I called the surgery direct and asked to speak to NAME. I explained the case to her and she agreed that it was an Addictions Service Referral but I would need to fill in a Referral Form for this and she would e-mail said form to me. I haven't yet received the email with the form.*

4. II) Hidden/ Mainland Issue
"Family members don't admit addiction in their family"

"The parents know about their child's drug use"

"It's all OK on Arran. It's safe here"

"A lot of it is in the hospitality industry. But they're not very visible"

"When we worked on the mainland, addiction was visible. Now we see people hurting in their homes instead of hurting on benches"

"Whitey Woods is an unseceret secret…they'll still say it's a mainland issue"

(Against this theme) "The community does recognise repeat offenders and work together so they don't slip through the net"

"Stop pretending there's not an issue!"

"People don't like going over to the mainland. [The assumption is recovery is] A mainland issue"

"Alcohol is part of our culture. That makes it worse. Addiction is hidden. It's a big issue."

"Services being mainland keeps addiction hidden"

What is a difficult balance to strike is to show that there is support available on Arran whilst maintaining that anonymity.

The perception of Arran being a refuge from the issues on the mainland is a common vein running through each interview with the steering group. With the perception of Arran being "safe", some thought there were people using this to fuel denial into the drink or drug cultures on Arran, or that there are people on Arran who may need help that weren't being reached.

4. III) Attitudes & Beliefs:
"Quality red wine [as if it's preventing them from damage]"

"It's either "drugs are everywhere" or "drugs are nowhere" here"

"We all care! That's something we can agree on."

"If you get strict rules, if they (pub/ golf club owners) know that police are coming out and continually looking at the CCTV, it makes them report stuff. It's already had a slight effect already and we get to see the repeat people and then if they realise that that's going to risk their license then they're going to think "actually I don't want those people in my pub" whereas at the moment they're thinking "Ahh, doesn't matter, just gonna keep doing it. If there's a fight on a Friday night it's fine.""

"People drop out of AA a lot because they've been taught they can drink less and don't need to stop."

"Referrals to recovery are rare. Healthcare like to deal with [recovery] "in house""

"I want to educate people on addiction can look like. I was dismissed [by Arran professionals] as an "extreme case". I'm not an extreme case I'm a normal case for alcohol dependency."

"There's a lot of shame we don't talk about"

"Sometimes it's still difficult to maintain patience during alcohol callouts"

"People think we can just "get a drugs dog". We can't. If we get a drugs dog then all of the other islands would want a drugs dog, there's not enough money for every island to have a drugs dog."

"I went to a NA meeting with MAINLAND RESIDENT. It opened my eyes to everything about addiction. It really made me empathise."

"There's minimising of addiction here. Definitely."

"If you don't drink, what's wrong with you?"

Similar to the hidden/mainland issue, the attitudes of people on Arran are spoken about as a minimisation of substance use, alcohol use and addiction. Some of the steering group also reflected on their own perceptions.

Class came up here, with the perception that the type of drink a person consumed "proving" they were not dependant on alcohol. Red wine was a common drink of choice, but gin and whisky also came up a couple of times. The steering group would often talk about this with exasperation or sarcasm.

Complacency from a lack of monitoring in pubs and golf clubs came up, toilet checks or physical fights were not recorded by publicans. A key worker mentioned that some locations were not visited for years to check on their monitoring of drug use or recording of physical violence resulting from alcohol.

FINDING: SOME PUBLICANS ARE NOT MONITORING PHYSICAL VIOLENCE, DRUG DEALING OR USE IN THEIR ESTABLISHMENTS, OR ARE MONITORING IT SPORADICALLY.

RECOMMENDATION A: FREQUENT CHECKS ON TOILET CHECKS, DRUG USE AND VIOLENCE MONITORING WITH ALCOHOL LICENSING. More checks were happening with the police during interviews in 2019, and the quality and frequency of recording has started to improve once publicans were aware they were being monitored more rigorously. This should be continued.

RECOMMENDATION B: SCOPING PUBLICAN'S PERCEPTION OF DRUG USE IN THEIR ESTABLISHMENTS, AND WHETHER THEY NEED SUPPORT POLICING DRUG USE. In rural locations to ban someone from their pub will guarantee a loss of income, and the use of bouncers are inefficient as bouncers will know a good proportion of pub goers. It can make policing drug use and adopting zero tolerance policies harder and therefore easier to ignore drug use. An empathetic approach should be adopted, especially as the fragility of Arran's economy has grown since COVID_19.

FINDING: THE COMMUNTIY ARE AWARE OF ADDICTION ON ARRAN AND EMPLOYERS MAY NEED HELP COMMUNICATING WHEN THEIR EMPLOYEES ARE IN NEED OF SUPPORT.

RECOMMENDATION: THE ARRAN ECONOMIC GROUP SHOULD DEVELOP A PROTOCOL AND COMMUNICATION STRATEGY FOR EMPLOYERS ON ARRAN IF EMPLOYERS ARE UNSURE ON HOW TO HANDLE EMPLOYEES WHO MAY BE STRUGGLING. Employers have come up consistently as being aware of their employees drink/drug use. Whilst some employers have policies in place, these tend to be statutory services who have bigger resources. Employers may not know how to start a conversation with their employees, and either dismiss them without a conversation or ignore their use and potentially endanger themselves and others. As this effects the economy of Arran, the economic group on Arran are in a position of developing protocol for Arran where can: scope the employers understanding of addiction in their company; their ability to have conversations with their employees; their knowledge of recovery services and who to refer to. This would be to supplement national protocol in place for employers.

4. IV) Where do I go?

"When a client discloses [their drink/drug use], where do I go?"

"I'm unsure whether I can use ABI (alcohol brief interventions), if they needed more support I wouldn't know where to go"

"After people detox, what support are they given? Are they just left?"

"Don't know any referral pathways to drug or alcohol services if I'm honest"

"I don't know any current provision except detox and AA"

Only one member of the steering group talked about being trained in brief alcohol interventions. The uncertainty of what was available – rather than the lack of people on Arran needing ABI – was the preventing factor of them performing ABIs.

FINDING: COMMUNICATION BETWEEN ARRAN AND RECOVERY SERVICES IS POOR, REUSLTING IN LOW REFERRALS.

RECOMMENDATION: UTILISE THE ARRAN COMMUNITY LINK WORKER AS A COMMUNICATOR BETWEEN THE RECOVERY AND ARRAN SERVICES. THIS WOULD MEAN BEING INCLUDED IN RECOVERY AND GP MEETINGS.

4. V) Education

"We tried to reach out to parents but almost no one attended"

"We get young people coming in with anxiety over heart palpitations they get from taking drugs the day before. People aren't aware that palpitations are a side effect of certain drugs… serotonin syndrome as well we get that, kids, adults aren't aware of these side effects."

"Parents keep asking me where should they go for their child. They ask what support there is."

4. VI) Transferring Trauma

"It's not just individuals that run to Arran. Families do too."

"People run away from Arran as well."

"People run away to Arran without dealing with their mental health first"

"People run away to the island"

"People run to here because it's seen as idyllic, they don't see the issues underneath"

"There's been suicides. People self-medicate because of the trauma they've seen."

"There was a suicide not so long ago. It's affected the young people here on Arran quite a bit. It was hard."

"The healthcare staff…we slip through the net. We're the helpers, not the helped."

"Parents are scared they'd lose their children if they get help. Support is punitive for family and children."

"Some parents won't turn up to A&E to see their child because they're too drunk themselves"

"Cannabis and Alcohol are both intergenerational"

Three members of the steering group mentioned suicides on Arran, including staff within the healthcare teams themselves.

FINDING: THERE IS A SIGNIFICANT AMOUNT OF TRAUMA ON ARRAN.

RECOMMENDATION A: INCORPORATE PARENTAL ADDICTION INTO YOUTH MENTAL HEALTH & WELLBEING SERVICES. Parental drug and alcohol misuse is recognised as an official Adverse Childhood Experience (ACE), yet often this is not considered when drug and alcohol safety is taught, or when a young person is accessing services for poor mental health. Mental health services that provide resilience and coping strategies will be inefficient on its own if ACEs caused by parental drink and drug use are a significant factor in a young person's life.

RECOMMENDATION B: TRAUMA INFORMED PRACTICE SHOULD BE ROLLED OUT TO FRONTLINE SERVICES ON ARRAN: including education and justice services. This is so people on Arran can understand the behaviour of those who have experienced or are experiencing trauma. Rolling out trauma informed practice is already part of the NHS Ayrshire & Arran agenda, however due to Arran's high levels of health equalities there is a risk of Arran being forgotten. The high rates of suicide on Arran needs to be pushed when attempting to gain trauma informed practice training from NHS NES.

RECOMMENDATION C: TRAUMA BASED COUNSELLING NEEDS TO BE OFFERED TO ARRAN RESIDENTS. Part of the trauma-based counselling should be offered through the Mary Davies Trust for family members who have experienced significant psychological harm due to the experiences of familial substance misuse. This would mean up skilling counsellors in accredited trauma-based theory

4. VII) Additional comments from key workers on Arran:

North Ayrshire Alcohol and Drug Partnership

Key Workers on Arran have spoken about the poor communication between Arran and recovery services and the alcohol and drug partnership. A significant focus of North Ayrshire Alcohol and Drug Partnership is preventing drug deaths, naloxone distribution and training for naloxone use. Whilst Arran staff acknowledge the necessity of this, there is a fear that problems resulting from increasing drug and alcohol use on Arran are being missed. One GP stated that they personally have not used naloxone on Arran, since the issues were around cocaine and alcohol. This mismatch of priorities has been perceived by keyworkers on Arran as not been listened to, furthering the inward tendency to deal with people independently. Because of this, key workers on Arran were not aware of North Ayrshire charities focusing on recovery, such as Turning Point.

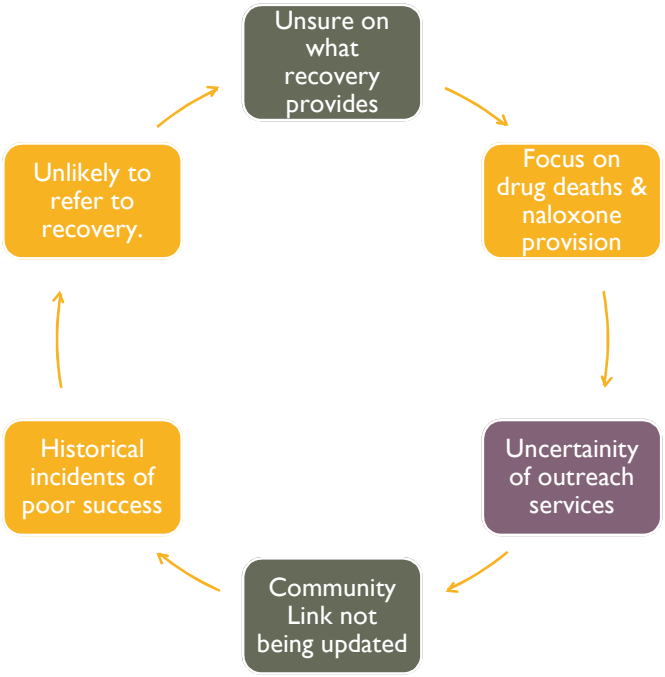
Despite this, the ADP and recovery services do not have well documented data to go on to demonstrate that Arran has issues surrounding drug or alcohol use. The referral numbers to recovery are low, there are no drug deaths in the official definition, and there has not been much communication from Arran key workers to suggest that further investment should be prioritised.

Third Sector

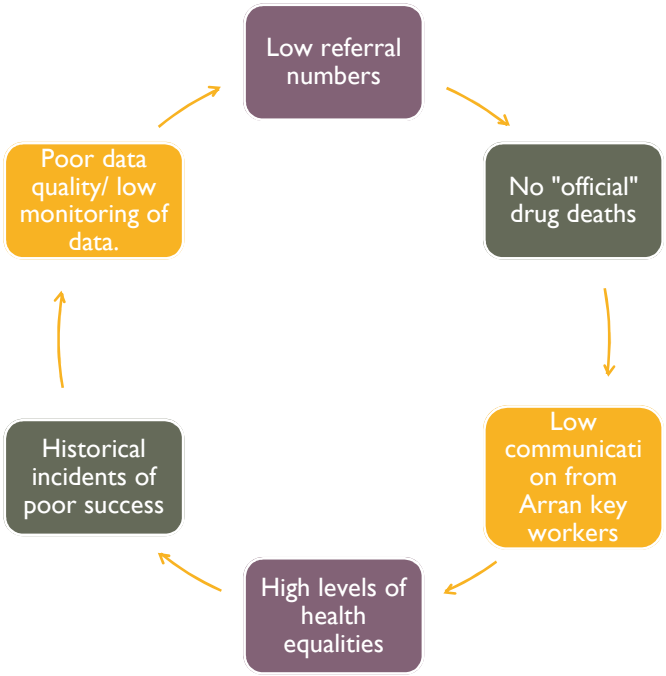
When asked about charities to help people with addictions, key workers would talk about signposting onto national charities for a more educational approach to support. One person mentioned Scottish families. AA was the only unifying group that was mentioned by most key workers, although some were not sure whether AA was still running on Arran. AA group information can be found on the AA website and in the local newspaper. A couple of workers were reluctant to refer to AA as they heard negative stories of people on Arran attending, or that AA was seen as too religious.

Uncertainty of Recovery Services

"I don't really feel that addictions have much to offer. It'd be easy enough for me to say I'll refer you on to addictions, end of story, but I know that's not really going to cut it and you're just going to come back… if someone's coming in at crisis point, I don't know what addictions are gonna do, but then again I might be wrong because I don't know what addictions do. I don't know their, the whole, the armoury of their, what else they can offer? Apart from seeing somebody or monitoring reduction regime, or what else can you do?... with alcohol, opioid, even benzodiazepine addiction I've seen huge work that the addictions team have done with them, whereas cocaine I don't think, I struggle to see how the setup, that same sort of setup would work for cocaine, it has to be more of a visibility thing, at least somebody knows where to go" – Arran Key Worker



Examples of why poor communication may occur between **key workers on Arran** and mainland recovery services/ Alcohol and Drug Partnerships



Examples of why poor communication may occur between **recovery services** and the Alcohol and Drug Partnership and Arran key workers.

5. CHAPTER FIVE: Lived Experience of Drink and Drug Use on Arran.

This chapter will explore the lived experience of those with current or historic alcohol/drug use on Arran, and their families. To understand how to help and provide the current support, it is important to gather a detailed picture of the lived experience. The layout of this chapter will involve explaining the methodology of collecting the experiences, before going into the themes of what was found in the interviews. A mapping exercise scoping other residents on Arran who have dependencies and addictions on Arran is included, as is a tally of what services were used by the participants will also be included. Findings and Recommendations will then be discussed.

It is important to stress that not every participant who spoke of personal use were drug or alcohol dependant, but all had experienced significant harm in some form, whether that was physical, criminal, relational, social or psychological, as a result of drug and or alcohol use whilst living on Arran. It is also important to note that some information is missing to maximise the privacy of the participants, such as age, socioeconomic status, and duration of recovery.

5. I) Method

The part of the study was designed to provide a further understanding of the experiences of living with substance use on Arran. This chapter will go on to illustrate the research procedure, recruitment, design, philosophical positioning, data analysis and ethics.

5. II) Study Design

The methodology was of qualitative design. The study aims to add the lived experience into the substance use narrative, holding as equal importance to the participant's experience as the steering group[50,51]. Whilst ideally the research would have used co-production approaches for substance use, the methodologies as discussed previously are too urban centric and issues around anonymity in co-production are difficult to use on Arran. Therefore, interviews with participants were developed. It is hoped that gaining the experience of living on Arran alongside substance use would provide an are not currently describing. As such, for this context qualitative design was reasoned as a suitable method of research.

Semi-structured interviews were initially used, with questions being formed from the 1-1 meetings with the steering group. However, the difference in experiences between participants in accessing or not accessing services were so wide ranging it was difficult to maintain a semi-structured interview. The number of participants discussing suicide which was not in the original plan also rendered the semi structure approach unviable. As such, an unstructured approach was adopted. The intention of this is to uncover meaning that goes further than the face value data, exploring

the emotions and comprehensions of participant's experiences[52,53], eventually discovering more about the participants than what the participant intentionally reveals about themselves[54].

5. III) Philosophical Position

The research is influenced by social justice positioning towards qualitative enquiry. Social justice theory looks at cultural, political, and social factors that form the individual experience[55]. Social justice tries to view data in the paradigm of "challenging universal truth, scientific neutrality and researcher dispassion" [56].
The research is influenced by critical interpretavism, viewing theory, analysis, and discourse in abstract[55]. Interpretative positions view theory and analysis would not look at direct phrases, or necessarily take the data at face value. This is because in therapeutic theory, when narrative is not spoken about out loud often or at all, the experiences are not as articulated, risking discourse to be confused, minimal, or repetitive[56,57]. Likewise, difficult emotions such as anxiety or guilt are felt very physically[57], and this can hamper how people express their experiences with these emotions[57,58] in context of substance use or accessing services.
This awareness of constructions held individually and societally demonstrates reflexivity needed in qualitative enquiry[55]. This reflexivity was exercised through reflective journaling[60].

5. IV) Participants

Thirteen participants were recruited who described themselves as Arran residents (either through primary or secondary homes) who were either family members of someone with a substance use problem or had personal experience of substance misuse. Participants would usually talk about historic use (between one- five years ago) however five participants had recent or ongoing issues regarding substance use. Participant age range was 22-71.
Twenty-three participants initially came forward with their names and contact details but ten of these dropped out. Some of the ten potential participant gave full interviews without but did not wish to be recorded. Exclusion criteria involved those were not residents on Arran (part time residents were accepted), who were under the age of 18 or who had current severe diagnosed mental health impairment.
One participant who signed a consent form had to be withdrawn from the study following a suicide attempt and their data was not used.

5. V) Recruitment

Recruitment was carried out through three strands. The first method was through meeting with the steering group and asking them to talk to potential participants themselves as they had a good understanding of Arran residents. Eventually this

became more of a snowballing method, and participants came forward after talking to previous participants.
Secondly, participants were recruited through a newspaper campaign. This allowed a further reach of participants who may not have been aware of the research, particularly if they were part time residents. Poster advertisements were put on the notice boards across the island.
Lastly, opportunistic sampling was sought attending AA meetings and talking to people in the community, such as the youth and elderly forums.
Once the researcher had participant contact details, participants were sent a participant information sheet **(Appendix 7,8,9)** were the study and participant expectations were laid out with more detail. Consent forms **(Appendix 10)** were sent via email and were either filled out in person if interviews were conducted face-to-face.
Initially, participants needed to have used the NADARS service in order to qualify. However, people who came forward fulfilling this criterion was low, and so it was decided to also accept people who self-identified as having substance misuse issues or their families but did not receive NADARS support. With most research based around drugs and alcohol, participants are generally recruited tend to be current or historic service users. Interviewing people who have not used services changed the direction of the research into a more exploratory approach.

5. VI) Interview Schedule

Whilst the interview was unstructured, there were themes some of the interviews went through, depending on the experience of the participant. These included:

Checking awareness of what help is available/ where to go
Experiences of services
Accessing support
What participants would want on Arran for their/family recovery
Relationship towards frontline practitioners
Relationship towards family
Relationship towards themselves

Barriers to receiving help
- Practical
- Emotional
- Psychological
- Stigma
- Relational (such as a positive/ negative experience with a GP)

Is the community aware of your/ family drink/drug use?
Is the community aware of a drink/drug culture on Arran (if participants agreed there was a culture of drink/drug use on Arran)?

In contrast to interviewing health and social care professionals, there was a general lack of confidence in whether what people spoke about was "worth" anything and would question whether they knew anything. Conversations when talking about certain groups of people would involve suicide and suicide attempts, which was an unexpected revelation in the research, so a few interviews delved more into this than others. Questions were given to the steering group for feedback and to help minimise bias.

5. VII) Procedure

Once participation was established, there was an email discussion on whether participants preferred to be interviewed via telephone or through face-to-face. Three were done face-to-face at the Arran Community and Voluntary Service, with 2 interviews happening in a portacabin outside the Brodick GP practice, and a further 1 conducted in a participant's home as they had childcare responsibilities and did not drive. This participant was referred through a member of the steering group. Before the interview commenced, the research procedure was reiterated verbally for clarification, with consent forms signed, although some participants signed consent forms electronically.

To capture the Interviews were audio-recorded and lasted approximately between 32 and 75 minutes. Participants were then in discussion with the researcher about the reasons to why the wished to take part and followed through with their experiences of drug and alcohol use on Arran. Participants were thanked verbally and followed up with a further email with debrief information **(Appendix 11,12)**. Participants were able to contact the researcher for follow up, of which several did, whilst others reached out to talk about further developments or bits they missed in their original interview.

5. VIII) Ethics

The researcher included a participant information sheet, consent form detailing the inclusion and exclusion criteria and debrief sheet for the participant. Participants were interviewed about sensitive topics around living with drug and alcohol use, some participants were actively in the early stages of recovery. Referrals were made to other agencies by the researcher including Scottish Families and AIMS advocacy. Participants who were seeing the CPN had the opportunity to talk to them after the interview if they were feeling distress. There were incidents were participants became very emotional or disassociated during the interview. During these incidents they were asked if they were OK to continue or the interview was stopped temporarily. After the interview participants were able to spend as much time as needed to talk further without being recorded.

The interview was dictated by the participant's course rather than the course of the interview schedule to minimise distress[53]. Pseudonyms were created with participants using a baby name generator. Pseudonyms were created to create anonymity, with places, hospital names, and relations of the participant were

removed to protect participant's identity[59]. Due to the small population, even direct quotes can be made as identifiable information. This means that quotations will be generalised to protect identity, with the first two or three letters of the pseudonym used instead[21]. This was done after consultation with participants when seeking feedback of earlier drafts of the research.

Consent forms and audio recordings were kept within the ACVS office, complying with GDPR procedures. Transcripts were encrypted with a password.

5. IX) Data Analysis

Interview transcripts were analysed using Grounded Theory. Grounded theory attempts to look at the data to generate theory, rather than letting theory and previous research guide the data collection and analysis [54,56,61]. This is particularly useful when subject matters such as drug and drink culture on island communities have been scare in research previously[21]. Hearing from the participant's experience gives voice to a population who may have had their narratives silenced or judged due to the cultural, historical and social oppressions on those with lived experience and their families[50], potentially unearthing experiences that might not have been discovered otherwise by the medical professionals[50,51].
Transcriptions were analysed individually, read and re-read multiple occasions alongside listening to audio-recordings. Capturing the overview of the interviews, non-interpretative information was written in the left-hand column of the text alongside reflective notes known as memoing[62,63]. Reflexivity is a pivotal part of grounded theory[62,64] as it can challenge assumptions and biases[60] increasing the validity of the research. As the research is placing the lived experience within the social and cultural contexts, interpretation of the transcripts is vital to the analysis[64], which occurs after initial memoing and reflexivity.

5. X) Rigour.

To increase the quality of the research, four qualitative codes of conduct[65] were adhered to.
Sensitivity to context: Meeting the steering group and talking to medical professionals on Arran helped me was used to guide the interview, however there was plasticity to this schedule due to the unstructured nature of the interviews, allowing for the potential of different or new interpretations.
Commitment to rigour: Memoing allows for exploratory and interpretative analysis, increasing the reflexivity needed to accommodate the political and cultural settings for both researcher and participant[62,63].
Transparency and coherence: clarity was retained throughout by thorough explanation and understanding of the analysis and memoing of the transcripts
Impact and importance: This study is hoped to help medical and social practitioners understand the difficulties facing Arran residents who have problem substance

misuse and their families. Authenticity and evidence is used back up the anecdotal evidence from the steering group and members of the public who say there is a lack of service availability for people who need help.

6. CHAPTER SIX: Results

6. I) Participant's knowledge of alcohol and drug dependency or addiction on Arran.

Participants would speak about other people on Arran with drink or drug problems. This was a mapping exercise to evidence the scope of the issue on Arran. 20 people were mentioned with substantial drug/ alcohol use in Arran (in recovery or otherwise), with a further unidentified number of people in Chloe's and Ben's groups of friends. Chloe's and Ben's groups were aged between early twenties and 30s who consume large amounts of cocaine some of whom on a daily basis, but because they were mentioned as a group and not individually they will not be included in this count. The 20 mentioned do not include the participants with lived experience.

Of the 20 people mentioned:

- **5 were alcohol, 6 were primarily cocaine (almost always taken with substantial alcohol consumption prior), 1 was both marijuana and cocaine, 1 was prescription & unspecified illegal opiate drug and 7 were either unspecified drugs or was asked by the participant to not specify the type of drug.**
- Overwhelmingly male. Despite the majority being female participants, those spoke of others with substantial historical or current issues with alcohol or drugs were much more likely to be male. 15 out of the 20 mentioned were male, 4 were female, and 1 did not specify a gender.
- **3 had parental responsibilities.**
- 6 were noted to have either developed or worsened an existing mental health problem or neurological condition as a result of alcohol or drugs, with people who mentioned drug use more likely to mention a development or worsening of mental health or neurological condition, a further 1 was not mentioned as mental or physical but was said to have "permanent damage" caused by an unspecified drug. 1 was described as suicidal. 2 of these 6 are known to have had mental health support.
- **Only 2 were known to have had addictions support to some extent.**
- Some of the participants mentioned family members of the 20 named individuals**. None of these family members were offered or received support.**
- 1 died because of their alcohol use. A further 2 overdosed but survived.
- **Only 3 were known to be in recovery, the rest are considered as active heavy consumers of substances and/ or alcohol on Arran, with one unknown**

Participant Pseudonym	Residents on Arran known by participant with drug/alcohol dependency or addiction					
Louise	Unidentified M-Alcohol, in recovery					
Kelly	M, drugs	M, drugs	M, drugs	M, cocaine	M, alcohol	F, drugs
Hazel	M, opiates/ prescription drugs, in recovery	M, drugs, in recovery	M, drugs, in recovery			
Joseph & Connie	M, Cannabis & cocaine					
Amy	F, Alcohol					
Chloe	Non specified gender, cocaine					
Ben	M, cocaine	M, cocaine				
Callum	M, cocaine	M, cocaine				
Jennifer	M, alcohol	F, alcohol, died				
Karen	M, alcohol					

Additional Information:

The people mentioned here are NOT speculative cases. Speculative cases where participants mentioned “so-and-so MAY have an issue” etc were mentioned in most interviews but I only included cases were the participant personally knew an individual, or personally knew the family member in an in-depth capacity. Details are removed to keep participant anonymity.

This is not the exhaustive list, and only contains people who are or were heavily using drugs/alcohol or had an addiction, not people who consume less frequently.

6.II) Services used by participants

	Personal experience						Family Members						
	Ben	Karen	Rosemary	Callum	Viola	Jennifer	**Joseph & Connie**	**Louise**	**Kelly**	**Hazel**	**Amy**	**Chloe**	**Total**
GP		x	x	x	x	x	x	x	x	x			**9**
Police		x	x	x		x	X	x	x				**7**
AA		X 1/2	X 1/2	X 1/2	1/2	x1/2		x	1/2				**6**
Hospital (Arran)	x	x	x		x	x			x				**6**
Medication		x	x	1/2		x			x	x			**5.5**
3rd Sector			Z		x		X1/2	Z?	x	x			**5.5**
Hospital (mainland)	x		x			x	X		x				**5**
CPN			x	1/2	x	x	X	1/2					**5**
Other NADARS		x1/2	x	1/2	x	x				x			**5**
Ambulance	x	x	x			x			x				**5**
Inpatient Rehab/ detox			x		x	x		x					**4**
Private Counselling			x1/2			1/2		x	x		1/2		**4**
Detox (home)						x				X			**2**
Social services				x						x			**2**
Psychiatry							X			x			**2**

6. III) KEY TO CHART AND ADDITIONAL INFORMATION
   - "½" indicates that they were offered these services, but they declined for a range of reasons, it is not just a simple "I do not want this service." Declines are multifaceted.
   - "X1/2" indicates that participants initially agreed to a service but did not continue it for a range of reasons.
   - "Z" indicates that they were offered charitable *funding* rather than charity *services*, except for Louise who said she received a carer's grant therefore it's uncertain whether that's and NHS grant or a charity grant. From conversations with GP managers it is likely to be a Mary Davies Trust grant.
   - Purple indicates that a participant used this service alongside their loved one. i.e. they were involved in the criminal justice system as they turned up to court or reported a loved one missing to the police, or they attended hospital where their loved one was an inpatient.
   - Green highlights that a family member mentioned that their loved one used this service but they themselves did not.
   - The "X" in the family/ loved one participant without colour indicate that they have used this service because of having a loved one with drug/alcohol misuse. I.e. going to the GP and getting medication caused by stress or having private counselling.
   - Third sector used or sought were: AIMS advocacy, Mary Davies Trust grant and Penumbra. Only one third sector was used specific to alcohol and drug use (Scottish Families).

6. IV) Reasons for declining or discontinuing services offered:

- No reason specified.
- Felt like the service was inappropriate (i.e. did not feel fully addicted to substances).
- The service was a tele service and they preferred 1-1
- Nobody turned up to the groups apart from them, so they stopped going.
- Ferries were cancelled and took it as a sign that society is working against them.
- Support worker would change frequently or not show up due to ferries and participants stopped engaging.
- Medication offered felt was too extreme.
- Did not believe their issues were severe enough to warrant CPN and felt the CPN's time was better spent on other people.
- Was too scared to go seek help
- Knew the professional personally and was embarrassing for them.
- Had ongoing mental health illness that prevented them from attending.
- Attending a meeting was very daunting and did not want to go alone.

6. V) What does this mean?

- Arran residents were much more likely to attend an Arran resource (AA) than mainland services. Amy had heard of AA and used the opportunity of the interview to ask how to access AA for her loved one. The high turnout to AA suggests that people on Arran want treatment and want support, which AA can provide, but there is no alternative on Arran if it is unsuccessful.
- Families are likely to be visible and present during loved one's crisis and will attend appointments to help their loved one. The loved ones were not asked if they were needed support during these meetings with health and social care professionals.
- Family members were attending separate appointments independently of their loved one because of extreme psychological stress and caring responsibilities. Hazel and Kelly did not trust GPs on Arran because of her negative experiences, making her less likely to reach out again.
- Participants in this sample were more likely to meet criminal justice, medication, and hospitalisation than they were statutory recovery services. This is a small sample, but due to the low referral numbers to recovery service on Arran these results would be expected.
- Most services offered were accepted, again suggesting that Arran residents want treatment and support.

RECOMMENDATION: HEALTH AND SOCIAL STAFF TO INVESTIGATE AND RECORD SERVICE REJECTION. Service rejection was not asked about but was very important in understanding the psycho/social barriers on Arran. Collating this information will help recovery services gain a better picture of service provision and ways to improve access. Service rejection information should not be based on a pre-existing tick box of reasons, as the research suggested participant's reasoning was often complex and multifaceted.

6. VI) Results: Themes from interviews

Four themes emerged from the interviews, which were then categorised into subthemes.

Main themes	**Where do I go?**	**Arran Community**	**Observations from Participants**	**Experiences of Services and Professionals**
Subthemes	*I don't know – can you help?*	*Denial*	*Suicide/ mental illness*	*Positive Experiences*
	Help to understand	*Everyone Knows*	*Complex relations*	*Negative Experiences (professionals)*
	There's nothing here – no support	*Normality of use (Access)*		*Negative Experiences (services)*

6. VII) Theme One: "Where do I go?"

I still want to talk about my alcohol problems because when I have really bad anxiety and stress, where would I go? - Jennifer

"Where do I go" encompasses participants not sure on what services are available, what they were entitled to, and using the opportunity of research to ask what support was available.

6. VII.I) I don't know – can you help?

Most participants – whether they experience recovery services or not – did not know where to go for help. Those with no experience of services or family members were the least likely to know what was available (CH: 220-226; JO: 312-314) and would wonder out loud whose responsibility it was to help people struggling with substance use (CA: 225-228), whilst others would guess (BE: 198-199). For those who used recovery services previously, ongoing support was

uncertain (KA: 203-204). Others were able to say that if they were struggling again, they would go to their doctor

Not knowing what services were available could be distressing, particularly if there was an emergency. An emergency for participants with lived experience caused a substantial increase of negative emotions, alongside a strong perception that they were not coping with these emotions. For family members, the emergency was just after a relapse for their loved one.

I've tried to contact CPN but he's not accessible by phone. Email I guess and you can leave a message but it's not the same as having somebody... you don't want to feel like you're annoying people. I don't know what the solution to that would be. *VIOLA starts crying* - VIOLA

"I don't know- can you help?" was also used as an opportunity to ask the researcher about how to access services. This was done either during the interview or afterwards.

***You were asking me what services would be available for her erm you know maybe you could tell me what services are…I mean to be honest I don't know, are you able to give me any advice on where I should go on where I can get help.* – AMY**

FINDING: PARTICIPANTS AND ARRAN STAFF WERE UNAWARE WHERE TO GO FOR HELP. PARTICIPANTS WERE OFTEN LEFT TO THEIR OWN DEVICES IN FINDING OUT WHAT SUPPORT WAS AVAILABLE.

RECOMMENDATION: THERE NEEDS TO BE A DEDICATED WORKER ON ARRAN/ DEDICATED OUTREACH ON ARRAN

A dedicated outreach would be more proactive and go beyond a drop-in session but would link in with the community link worker and other members of public service on Arran. This outreach will keep staff up to date to what is available, what developments are happening within the ADP, and any progressions with new charities (this could also be done through the community link worker). The dedicated worker would ideally be the contact for people on Arran who may need help and who is present on the island. The dedicated worker can also collect and monitor evidence of drink and drug prevalence, its harms, and can document the effectiveness of their services. This would mean Arran would have a similar standing in producing quality evidence as other Scottish islands as evidenced previously. With higher quality longitudinal evidence comes better opportunities for long term charity funding, larger statutory investment or funding for testing pilots. The position may only need to be part time.

6. VII.II) I don't know – need help to understand

"He was on Valium and gabapentin. They prescribed him the gabapentin the same time [as methadone]…why? Why? …I questioned the doctor saying "well why would you give someone who has addiction issues a drug that's like, severely addictive? And then carry on giving it to him?" – Hazel

And what about families? What do we get? Are we just meant to tough it out? – Kelly

I don't know – need help to understand was when questions arose in the interview that had previously been unanswered. They were often rhetorical, as the participants were aware they were not going to get answers from the interview, but used the interview as an opportunity to get across what they wanted to ask healthcare and social professionals (KA: 278-280). Medication offered was not taken by some as it was not explained to them in enough detail about side effects (CA:392-394). In the case of Hazel, she was angry that her loved one was prescribed valium and gabapentin with methadone, but despite her loved one eventually giving consent for information to be shared with her, she was never updated. It left her to try and find information on her own with using the internet as a method of seeking understanding (HA: 98-99; 315-316). A lot of Hazel's interview revolved around her asking rhetorical questions to why she was not informed about certain aspects of her loved one's care.

"I gave him (loved one) a call and said "phone them (recovery services & social services) and tell them you give them your consent because I'm only hearing your side of it. I want to hear their side." And eventually he did but they ant kept in touch with me.

INTERVIEWER: They've not kept in contact?

HAZEL: Not unless I contact them but why should I? Why should I be doing that? … Why should I have to be chasing them to see whether he's lying to me?

Needing help was also more complex than understanding the actions of health and social care professionals. Some wanted to understand themselves and their own behaviour and actions. With Louise, she felt she needed a support system where she could contact other family members of Arran. This was important for her, as sometimes she was unsure on whether how she reacted to her loved one was appropriate, or whether it was "ok" to feel a certain way towards them.

FINDING 13: FAMILY MEMBERS ARE OFTEN EXCLUDED IN THE DECISION MAKING OF THEIR LOVED ONE, OR ARE NOT UPDATED

RECOMMENDATION: BE HONEST WITH THE FAMILY MEMBER IF THEY DO NOT HAVE PERMISSION TO BE UPDATED AND OFFER SUPPORT FOR THIS. This can have profound consequences in any future healthcare engagement. An honest conversation with people involved in the loved one's care should be facilitated, with the opportunity to refer the family member to additional services and recommend professional support for themselves would benefit people in this situation.

RECOMMENDATION) Ask family who have permission to be included in the care and turn up to joint appointments about their needs and priorities are. Asking about their childcare and work responsibilities as well as any other personal circumstances such as disability would also allow family members to perform their caring responsibilities to the best of their ability with less psychological burden. They may need to make an independent appointment, and this should be facilitated.

6. VI.III) There's nothing here – no support

> ***It's the stepping forward and saying "I have a drink problem" as soon as I started going round and saying "yeah I have a drink problem", I felt such a relief. Did it help me with the drinking? No, because there was nobody here to help me. - Jennifer***

This was separate from "I don't know" what support is available; this was a firm answer that there was zero support for the participant (KA: 421-429; J&C: 265-267; 340). Most – but not all – were aware of AA on Arran. There were participants who had negative experiences of AA (Rosemary), or did not believe it was the right fit for them (Karen, Callum, Jennifer). Viola and Kelly were either offered AA or knew of its existence but were too scared to go on their own (VI: 131-132; KE: 392-393).

People who spoke about rehabilitation spoke of it very highly (Viola, Jennifer), or neutrally (Rosemary) but it was often contrasted with the "nothing" on Arran.

> ***But it [rehabilitation] was great. It was structure. I had lessons every day. I had purpose. That's what I had when I had my children, I had purpose. And for six weeks it was great, and then I came back here and it was shit. There's nothing, there's no go back to Arran and you can go do this and that, there's nobody. – Jennifer***

Rosemary had a positive experience with the support she received and expressed gratitude to the support that was unique to Arran, mainly the amount of time staff can spend on people and how soon they can be seen:

> **Rosemary:** ***if it wasn't for Arran, having the doctors checking up on you and the chance to just be able to walk into the hospital I would've not had done that on***

the mainland, at all. You know, I was given that chance. I feel like I was protected here. So there is a negative aspect of being here, but personally for me and I can see this not being everyone's experience but personally for me I felt protected…I would've have been given the same amount of chances. This was pointed out to me as well by addiction services on the mainland. That just wouldn't have happened. And I was grateful for that.

FINDING: WHEN TREATMENT HAS GONE WELL, ARRAN PROVIDES A VERY SAFE AND CARING ENVIRONMENT FOR PEOPLE. INPATIENT REHABILITATION HAS BEEN PRAISED FOR ITS CARE AND EXPERTISE.

RECOMMENDATION: REFERRALS, EMPATHY, EXPERTISE, WELFARE CHECKS AND AVAILABILITY WERE THE BEST INDICATORS OF GOOD CARE AND SHOULD BE ENCOURAGED. The fact that there were two participants who experienced very good quality care on Arran demonstrates that good quality care for this population is doable despite the limited resources.

6. VI.IV) Support I would like

Discussing support allowed participants to talk about what help they would prefer on Arran, if not for them than others on Arran who were experiencing similar issues. This differed slightly depending on whether they were people with lived experience and family members. Due to the length of these quotes this will be put in the appendix (Appendix 13).

FINDING: PARTICIPANTS KNEW ABOUT PROBLEMS BUT STRUGGLED TO FIND CONCRETE SOLUTIONS

RECOMMENDATION: INVOLVE SERVICE USERS AND FAMILY MEMBERS IN SERVICE DEVELOPMENT AS PART OF THEIR RECOVERY. It's important to understand that people who have very difficult experience cannot always articulate solutions straight away, often needing time and multiple engagements. Participants also felt like their opinion was of "low value" and this further hampered their ability to provide articulate solutions. Persistence and high involvement in service development as part of their recovery could build up self confidence, engagement and trust between themselves and services, and it would evidence that their experiences and opinions are valid.

6. VII) Theme Two: Arran Community

6. VII.I) Denial

It was almost laughed off on (by the community), seen as a silly boy type thing – Family member

Denial about alcohol or drug consumption was a frequent subject. Familial and friend denial came up the most, where loved ones and friends knew about substance and alcohol use but was downplayed or ignored (RO: 267-269; JO:215-219). The denial in this instance wasn't explored thoroughly in the interviews, but participants were frustrated that this denial existed as it stopped them being taken seriously, or their suffering to be legitimised (RO: 269-273). This denial also kept some participants ignorant to the real extent of their family member's substance use, which manifested in self-blame- they were angry that they were unable to help sooner. Witnessing denial of drink or drug use in other Arran residents was common (KA: 210-212; RO: 278-279; CH: 203-205; JE: 197-199; CA: 389-391; BE: 52; KE: 416-417).

Community denial occurred when Arran residents were aware of individuals or groups of people who were consuming large and frequent amounts of substances or alcohol, but downplayed or ignored that this was happening, or denied that this amounted to an "issue" on Arran. This was best described by Chloe:
People don't want this perfect little bubble of Arran to be tarnished I mean it's like, on the FACEBOOK FORUM there's a picture of someone dropping litter and you're thinking "well we've got bigger problems to deal with here haven't we than someone dropping a packet of crisps". That's how perfect they think Arran is and needs to be, "what's happening to Arran nowadays there's so much litter." And that's your concern? The amount of litter is your concern. But I know for a fact these people know about cocaine, and it's like, why aren't you putting that on facebook?

Callum gives a lived experience example of open drug use being tolerated in certain Arran establishments:

You've been to LOCATION? It's a shit hole. I don't know why people go there. I've been there for a few fights, bloody nose. Why would you go there? For drugs. You go there for drugs. I've been in the toilets snorting cocaine and the owners come in and go "how you doing CALLUM?" and he walked out. Now how disrespectful was that of me to be snorting cocaine in their pub. But he's cool with it, so I'm going to keep going there because he's cool with it. I think folk need to tighten up a bit.

6. VII.II) "Everyone Knows"

Despite the denial, people who had lived experience of substance use would state that "everybody" on Arran knew that they were drinking and/or using drugs (JE: 73; KE: 417; CH: 52-54; BE: 330). People with lived experience were more likely to talk about the community "knowing" than family members, who were

more likely to talk about their isolation and not knowing other people on Arran with drink or drug concerns.
Everyone knows would either be a criticism of the lack of privacy on Arran, or a criticism to Arran residents themselves, as some who spoke of "everyone knowing" would complain that those who knew did nothing, who were then contributing towards a community denial of drink/ drug culture on the island.

6.VII.III) Normality of Use

Members of the steering group would talk about cocaine use being discussed openly in pubs and golf clubs, and residents of Arran would speak of witnessing cocaine use in daylight hours in public by other Arran residents.

The easy access of alcohol (KE: 17; RO: 223-225) and drugs (CA: 131-135; JO: 188-197) helps with facilitating the normality of drink and drugs on Arran.

Participants would talk about the "normality" of drug use or talk about the amount of people who take cocaine (CA: 304-307; BE: 72-73; KE: 57-59; JO: 181-184) whereas alcohol use was seen as "everyone" does it and was more associated with the culture on Arran or societally (RO: 181-187; KA: 210-212; JE: 339-340; VI: 108-115).

Cocaine would occur when alcohol had been drunk (BE: 15; CH: 22-23) unless a dependency had formed. Dependency was seen when cocaine was taken outside of parties or weekends, such as at work (CA: 345-348) or in pubs during dinner on a weekday (CH: 4-9). The normality of cocaine is so prevalent that Chloe stated that any get togethers at her house would be strictly cocaine free.

CHLOE: I don't go to house parties, ever. I can guarantee that's what would be happening. Unless it was a party at my house. I can have a policy, control.

INTERVIEWER: Do people respect that?

CHLOE: I would say so, as far as I'm aware, I am very strict on that. Everybody knows who come knows I don't, and I know people who do come do take drugs but as soon as someone walks into my door I always say to them "I have a no drugs policy in this house, you all know that."

6. VIII) Theme Three: Observations from Participants

6. VIII.I) Suicide and suicide attempts

Out of the thirteen participants with lived experience, six spoke about suicide on Arran to some extent: suicide attempts were mentioned by two participants, ideation mentioned by one and three further participants mentioned suicide on

Arran. Suicide was usually described consequently on mental illness, exasperated by drink or drug use. Ideation was based more on feeling unworthy of living, or that they did not care whether they were alive or not. Some of the suicides on Arran were believed to be caused by a drink or drug addiction. A few suicides on Arran occurred around five to nine years ago, and their funerals were described by one participant like "attending a college assembly", referencing at how young people were.

At least 3 hangings, we knew each one of them they had all been taking drugs prior to the suicides. It was tragic attending a funeral with attendees comparable to a college assembly.

Chloe elaborated that the group of young people – who would now be in their late 20s and 30s- were vulnerable to developing cocaine dependency partially because of the trauma that can come from multiple suicides. The increase of alcohol and drug use as a result of suicide or death was mentioned by other residents who did not wish to be interviewed.

CHLOE: A lot of the suicides have been drug related but a lot of the young deaths haven't been drugs they have been freak accidents and things, and that age group I think is massive for it's like an escape. And they haven't ever gotten out of that escape, and I don't think in that age there's enough support on the island, that age group, kind of like 30s, they've kind of had the worst, they've had a lot of, it's just kind of followed, I know one guy who has lost so many people and I just look at the group around her and I'm not really surprised they've gone to that.

6. VIII.II) Mental Health & Illness

PTSD, depression, anxiety, and other mental illnesses were mentioned by participants. As mentioned in the methods, there were participants who experienced distress during the interviews.

Ben's interview discussed more of the culture of drink and drugs on Arran, where he mentioned cocaine and alcohol were negatively affecting some Arran resident´s mental health, such as developing psychosis and paranoia. In his interview, he mentioned three separate people on Arran with current substantial damage caused by alcohol and drugs.

BEN: I mean like he'll sit in his house on like, weeknights sit up for days getting himself in hundreds of debt eh, and then er, dunno he just sort of lost his mind really.

One of the boys gets really paranoid er. A few people actually er… he gets paranoid he drives about when he's been taken Charlie and then he gets dead paranoid and is looking in his mirrors all the time and that the police are there and he starts going on about that he can't park somewhere and "you can't park somewhere else because they'll get you."

Jennifer spoke about becoming a counsellor by proxy for people on Arran with issues around substance use, despite her own emotional wellbeing being fragile. She felt obligated to provide help since there was a gap in support (JE: 201-209). Viola also wished to have more psychological support (VI: 119-121), whilst Rosemary and Karen wanted to explore deeper meaning of their alcohol use that went outside of her relationship with alcohol (RO: 88-93; KA: 273-278).

Anger, guilt and despair were frequent emotions described. Family members – who were often not included as part of the recovery process – wouldn't describe themselves as suffering from a mental illness, but would talk about acutely stressful events, often watching events unfold whilst feeling helpless to the situation.

6. VIII.III) Complex relations

Family members would discuss trust in their interviews (KE: 175-178; LO: 105-107; HA: 136-139). Trust was broken at some point in most family conversations, and whilst some relationships were able to build trust back, others were not. Brothers and sisters were noted to be affected by their sibling's substance use (CA: 369-373), increasing the likelihood of their own substance use as a way of coping or dealing with traumatic incidents related to drug or drink use within the family.

FAMILY MEMBER: It's had a massive impact on his sister, of which I feel really guilty about. Because she ended up being "where's NAME what's he up to? What's he doing?" so she contacted me all the time… Makes you wonder what you've done wrong.

INTERVIEWER: Is that something you think about?

FAMILY MEMBER: Yeah I do. Always. All the time.

Young children (under five years) were picking up on their parent's behaviour whilst under the influence (HA: 148-152). All of this had a severe impact on the family members who would discuss ongoing issues with trust, self doubt, self blame and anxiety. The impact of loving someone with problem substance use was difficult to explain, often using singular words such as "tiring" and "hopeless", but a couple were able to describe the experience for them.

HAZEL: I wouldn't wish this on my worst enemy, it's like watching somebody die slowly. And dragging you down with them. It's not nice. I wouldn't wish it on anybody. That's it really.

Family members would talk about their "naivety" or "stupidity" to their loved one's problems (LO: 102-104; JO: 378-380; HA: 93-95), that they often took out on themselves. They were willing to help, and would express frustration that they were limited in their capacity to lessen the suffering for their loved ones:

It's sadness really. We're not ashamed. I'm just, I'm just irritated and I'm irritated with myself and I may or may not had changed anything, but at least I could have had some input.

Some of the participants with lived experiences had unpleasant or unhelpful responses from their relatives, (KA: 253-60; RO:267-272). Others who had more supportive relatives acknowledged the harms of alcohol and drugs (BE: 217-18,249-255).

To ignore your family being upset for a glass of wine or a line of cocaine. It takes a lot of willpower to say "fuck you mum I'm gone" you know what I'm saying?

Physical and psychosomatic symptoms caused by extreme psychological stress were also noted by family members (KE: 182-185).

FINDING 12: FAMILY MEMBERS ARE OFTEN CARERS AND NEED SUPPORT

RECOMMENDATION: FAMILY MEMBERS ARE TO BE OFFERED SUPPORT INDEPEDENTLY
Family members on Arran are looking after those with alcohol and drug dependency or addiction are not seen as carers, and were not offered support they had the legal right to. Family members should be signposted to the appropriate charities and recovery services and be offered the opportunity to be seen independently from their loved one.

6. IX) Theme Four: Experiences of services.

6. IX.I) Positive Experiences.

The variety of positive experiences with services and professionals varied greatly. Louise, who had a good experience with most services she contacted, was able to talk about how she was listened to and how she was able to get the best support for herself and her loved one relatively easily compared to some of the other participants (LO: 180-188). Positive experiences were more limited in their vocabulary and were more descriptive in nature, with a good service or person described as "brilliant" or "fantastic" without much elaboration, with the

exception of Rosemary as mentioned previously (RO: 165-174) and Callum. Callum spoke highly of the police on Arran:

The police said to me one day "you need to stop this" and I said "why" and she said "because you're going to die one day and I don't want to be the person who taps on your mother's door one day telling her you passed away." I will remember that for the rest of my life…but at the time I thought "what a daft cow what does she know?" She's a police officer she knows what she's talking about but at the time I was "ok whatever babe."

The police also referred him to recovery services, which he didn't use but was grateful for. Positive experiences were often framed when a professional referred them to an appropriate service or listened to them. Positive experiences were also more likely to be referred to when professionals on Arran "checked in" on the participants after a crisis, whether that's a relapse or an emergency hospital admission (JO:123-125; Louise in emails). The CPN on Arran was spoken about highly (VI: 279; JE: 98-100) as well as always being "busy" (CA: 153-155; JO: 298-304) and participants were worried about burdening the CPN as they were seen as a good resource on Arran but viewed as overworked (JO: 125).

JENNIFER: My CPN was also my alcohol counsellor was also my friend but he's only one person! He can't stretch to all these different angles. Not that he's ever said that. But he sees that.

This view was the case even when the participant did not see them, but they were aware they existed. The OT on Arran was also positively spoken of (JO: 131-132).

Scottish Families (KE: 158-169) and AIMS advocacy (VI: 98-99) was spoken of positively, as well as counselling services on Arran (LO: 183-187; RO:82; KE: 199-200). AA was viewed as useful and a necessity on Arran by some, although this view was not shared by all.

6. IX.II) Negative experiences – professionals.

Whilst GPs were seen overall as "good people", with Louise and Rosemary having particularly kind experiences with their GPs, GPs on Arran were mainly viewed negatively. This was not -for the most part- down to individuals but rather realising that GPs were not knowledgeable enough about alcohol or drug dependence or were aware of the services available for people. Their experiences with GPs who were believed to have limited knowledge shook their confidence in how other services would be able to help them, making them more reluctant to come forward again should a relapse occur. A lack of knowledge in the medical profession would manifest in participants not feeling listened to or

given medication such as antidepressants and Antabuse when participants felt they needed more intensive support such as counselling, social care support or support groups.

Some participants had very distressing incidents with their GPs. These incidents stayed with them years after it occurred and still had difficulty recalling it during the interview. Two family members personally blamed the healthcare on Arran for making their situation worse and it affected how they communicated with frontline services. Karen had difficulties to refer herself to other services due to a medical condition but took multiple appointments to try and get a successful referral.

Due to the length of the quotes about this issue these will be put in the appendix (Appendix 14)

FINDING : GPs AND PARTICIPANTS WERE AWARE OF THE LACK OF EXPERTISE ON DRUG AND ALCOHOL DEPEDANCY AND ADDICTION, INCLUDING THE AFFECT OF DRUG WITHDRAWAL ON MENTAL HEALTH.

RECOMMENDATION: GPs ON ARRAN NEED FURTHER TRAINING OF ADDICTION AND DEPENDECY, COCAINE AND ALCOHOL, AND AVAILABLE LOCAL SERVICES TO SIGNPOST ONTO. GPs NEED A NAMED CONTACT IN RECOVERY TO CONTACT SHOULD THEY HAVE ANY QUESTIONS.

GPs are rarely referring to the recovery services and are on the whole unaware of third sector agencies for North Ayrshire that work in recovery. GPs are also admitting to low levels of understanding in addiction behavior, meaning they struggle to engage empathetically despite their best intentions. Training should be sensitive to the cultures on Arran and information on relevant referral agencies needs to be circulated to GPs.

There was a lack of or no follow up after major, life changing incidents for some. Participants left hospital suffering with temporary yet disabling injuries due to harms related to substance use with no awareness of whether these injuries were permanent, putting immense strain on their loved ones who were unaware on how long they needed to take time off work or how to care for their family member, uncertain of the permanency of acquired injuries.

FINDING: PARTICIPANTS WERE OFTEN LEFT ON THEIR OWN DURING CRISIS PERIODS:

RECOMMENDATION: DISTRESS BRIEF INTERVENTION SHOULD BE CONSIDERED AS A POSSIBLE TREATMENT ON ARRAN
Often Distress Brief Interventions are done through charities, but with the greater investment in mental health care for Scottish Islands this may be an ideal time to apply for funding to train or upskill residents.

RECOMMENDATION: A WELFARE CHECK SHOULD BE CONDUCTED BY ARRAN STAFF, WITH APPROPRIATE SIGNPOSTING.
There were two incidents were participants reached out to the researcher during a personal crisis as there was nothing immediately available to them or they did not know where to go. What made a difference in their experiences of care was whether participants received a welfare check shortly after their crisis. These were informal checks, with staff who were involved in their care during the crisis point turning up at their house or calling to check in with them. Checks should also be carried out if resident's care is transferred to the mainland. When checks were not carried out, this increased participant's loneliness and resentment towards services. In turn, this became distrust and made some participants unlikely to ask for help.

Other negative experiences of professionals were around feeling too "textbook" in their approach (VI: 43-48), were not dealing with mental health alongside the drug issue (or vice versa); (RO: 321-323; HA: 59-61; JO: 237-240), professionals cancelling last minute due to ferry cancellations (AM: 27-29) and that support workers would frequently change. The changing of support workers again affected a participant's self-worth and consequently their engagement.

JENNIFER: For someone with addiction it's important to have the same person you see all the time, and not keep getting flung around with somebody else. It's very difficult. One, it's very anxious…I was ok with you Heather actually because I spoken to you on the phone a few times but when it's just for the first time you know. Oh "so-and-so isn't here today please see whatsit." Nahh. That's a downer. That automatically makes you feel awkward and not comfortable.

6. IX.III) Negative experiences – services.

For those who knew of services and had tried to access them, the availability of a service was the most common complaint. The buses (KA: 144-147; JO: 78-80) or the ferry was a barrier (JO: 81; KE 78-80; AM: 33-35).

VIOLA: I discovered the joys of being able to use alcohol as a crutch, allowed me to get on the bus, go on the boat...

INTERVIEWER: Is it difficult to get onto the boat to get onto the mainland now?

VIOLA: Not with a drink in me! But then I'm trying not to drink. Up until I was going to rehab you'd be lucky if I left the island once a year.

If a support worker found it difficult to have a continuous presence on Arran, residents also found it difficult to maintain their appointments. There was a worry that if you bumped into someone on the ferry who asked you where you were going – or saw you getting off the train at Stevenson – that they knew you were going to recovery services (JE: 274-275). This put people off travelling. The lack of privacy scared some, who would delay going on in fear of being seen, spoken about, or talked to during times of acute suffering (KE:107-109)

Due to the comorbidity of anxiety, mental health, and substance use in the participant population, getting on the ferry was a genuine challenge. When a ferry was cancelled, this was taken as a personal rejection and a sign that they were not worthy enough to have help. It was not uncommon for people to think about dropping out of recovery after a ferry cancelled to prevent them from being "rejected" by recovery services for failing to attend an appointment.

FINDING: THE FERRY IS A SERIOUS BARRIER IN ACCESSING SERVICES AND THERE NEEDS TO BE SUBSTANTIAL LONG TERM RETHINKING TO ADDRESS THIS.

RECOMMENDATION: THERE NEEDS TO BE A BACK UP WHEN THE FERRY IS OFF LIMITS AND THERE NEEDS TO BE MORE INVESTMENT INTO HAVING SUPPORT PROVIDED ON ARRAN.

SHORT TERM: When the ferries are cancelled patients should be called immediately and offered telehealth/ video call. If they reject this, this does not mean they are rejecting the service and should be offered understanding to the frustration of having their face-to-face appointment cancelled at short notice. Switching over to telehealth/ehealth for all service users in North Ayrshire may help reduce the disparity of care provision.

MEDIUM TERM: A volunteer network on Arran, managed by the dedicated outreach worker or third sector, where a trained volunteer calls on the service user personally once they are made aware that the ferry has been cancelled so they are not alone. Volunteers can also go with the people attending mainland appointments on the ferry to ease any anxiety.

LONG TERM: Young people and people on the island who wish to continue their professional development should have affordable access to training in alcohol and drug use, counselling and mental health. This is so Arran can have trained professionals that are not needed to be externally recruited and do not need to be housed. Talking to members of the youth foundation, those who showed a genuine interest in mental health as a career felt stifled due to the limited training opportunities on Arran and would need to leave the island to train. Having trained professionals from Arran limits the necessity to rely on the ferry.

7. CHAPTER SEVEN: SUMMARY

7. I) Similarities to previous research:

The findings of feeling either not supported at all or not being able to access the correct support have been felt in others living in remote areas in Scotland trying to access mental health help[62]. Likewise, the lack of understanding that being mentally unwell can occur in naturally pleasant environments like Arran[15] or that those with addiction can hold down employment have been evidenced previously[22]. There is a prevalence of mental health investment in rural environments, due to in part to the increasing evidence base of isolation and loneliness research and greater political involvement in mental health. The findings in research in rural addiction is few and far between6. Stallwaitz (2004) documented a similar island and class culture on the Shetland Isles; particularly of drug use and addiction presentation. Unfortunately, there is little more modern research to contribute towards the findings of this study.

7. II) The Case of Funding a Dedicated Arran Worker

In terms of what the participants wanted, most spoke of having expertise on Arran, having someone on Arran who has capacity and is an expert in addiction was needed. This study hopefully provided the case that Arran has significant enough issues around drug and alcohol harms to warrant a part time dedicated worker for Arran that was expanded outside the realms of a drop in. Other islands with similar affluence, population size and funding structures provide some sort of dedicated worker, with some providing this on the islands themselves. Mapping who participants knew on Arran with issues around addiction further evidenced the scale of harms caused by alcohol and drugs on Arran that is not being addressed. With a dedicated worker, Arran has a chance to collect more evidence, and has the chance to heal from the trauma it is gained over the years as its residents receive a better opportunity to get help.

However, this is hard when housing on Arran is in such a scarce supply, and when the expertise would roughly start on a NHS Band 5 salary (£25,100 as of 2020) or even less on a charity wage, and with the average house price costing 22% higher on Arran than the rest of North Ayrshire[2], it would be difficult to house workers with this salary range on Arran. Creative, self-reliant solutions to housing are needed on Arran to stabilise the workforce. In the meantime, a dedicated recovery worker who spends a set time working for Arran that is linked in with the Arran community link worker is a compromise. Setting up self-reliant groups on Arran that are based around social support would also be beneficial.

7. III) The Positives of Arran

This study has admittedly focused on the negatives of service supply and experiences on Arran, but for two participants they experienced incredibly supportive care. Having medical staff readily available is a huge benefit on Arran most mainland services do not have. It demonstrates that good quality care is available, and it does work. This is good, because it demonstrates the issues are not around capacity, but are more cultural.
In terms of statutory recovery services, participants did not have negatives for inpatient services. Individual workers in outpatient services were caring.
Being cared for is the fundamental vein throughout this report.

7. IV) Further Study Opportunities:

- The impact of suicide or suicide attempts in rural communities.
- The representation of addiction dependant on geography and class.
- Community Denial as a prevention mechanism to coming forward for help
- Cocaine user perceptions of mainstream recovery services

7. V) Limitations of the study:

Whilst this was an indepth exploratory study, there are limitations.

- Ethical approval was not able to be approved as the host of the research did not have the appropriate business insurance needed. This means collection of other data the NHS had access to was unavailable. The researcher cares a lot about participant mental wellbeing and took good care to minimise distress during the data collection period.
- Data collection involves qualitative data collection. This is not a limitation, but in terms of NHS standards of evidence-based practice, qualitative data in low down on the scale of "data quality"[16]. Quantitative data would be a lot harder to obtain on Arran. There is an argument that qualitative data is "anecdotal evidence" however most rural research is founded on anecdotal research[15] as they do not have the resources urban centres have, as discussed previously.
- Participants and the steering group primarily focused on young people and drug culture. This was partially because they were aware of the increased drug use and worried about its consequences. However, it meant that older adults were not prioritised, despite Arran having a primarily older adult population. The other reason for the focus on younger generations was due to the suicides on Arran that were primarily committed by younger people. This has an unexpected impact on the study direction as suicide was not discussed in the original set up on the research but ended up being the focus for many people who spoke. This includes people who were not recorded.

Unfortunately, it means older adults were not focused as much as needed to balance the demographics, despite having a good age range of interviewees.
- The original strategy hoped to gain in the original outcomes were not able to be reached as there was a limited dataset available to scope and begin.
- Most participants were female, despite males being the most likely to be affected by drink and drugs. This means outreach is likely to capture female family members before being able to reach male users. This again is not a bad thing, but will take persistence, finance, and resources before people with lived experience that the study did not capture were brought forward.

7. VII) What this Study Contributes:

- An indepth understanding of the experiences of people on Arran who have had harms because of drugs, alcohol or both.
- An understanding of the gaps and barriers in care provision, and recommendations to remedy these.
- A better understanding of how political, societal and class systems impact on addiction presentation on Arran.
- Evidence that families are struggling but are also likely to reach out given the opportunity to receive help.
- An evidence base to the scale of a drink and drug culture on Arran.
- The start of a chance to talk about some of the problems Arran residents are facing, and some unique local issues that are contributing towards the drink and drug culture.
- A chance to start fixing these, collectively.

Your Drink. Your Drugs. Our Problem.

Towards a biopsychosocial model of understanding and treatment

	Diagnosis	Treatment	Barriers
Biological	Liver hardening; blood tests; drug and alcohol testing; other (brain imagining, ECG etc for damage)	Medication OST Detox	Invasive procedures; Painful withdrawal; Side effects; Fear of diagnosis; Unpleasant medical experiences (medical procedures is an ACE).
Psychological	CPN; GP; Psychiatry; psychologist	Therapy and counselling by experts Specialisms in trauma Family therapy; Art therapy; Rehabilitation; Medication; Spiritual Care (i.e AA)	Denial; Fear of judgement, shame & guilt; Comorbid mental illness; Previous cancelled appointments; Previous poor experiences of HCP;
Social/ Political	Friend and Family support; Urging from friendly Health & Social care professionals; Referrals through 3rd party	Social support (group, family, peer, volunteer, assertive) Service Development Involvement; Social work; Family involvement; Educational resources on what addiction is	Service Accessibility; No privacy on the ferry; Community Denial; Lack of investment; Invisibility of trauma; Too ill to travel; Cost and time off travelling & overnight stay; Low knowledge of cocaine addiction; Low knowledge of available services; Low referrals; Low data accuracy

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PARADISE EXPLORED

Appendix

Heather Still
Corra Funded Project

Contents: **Page**

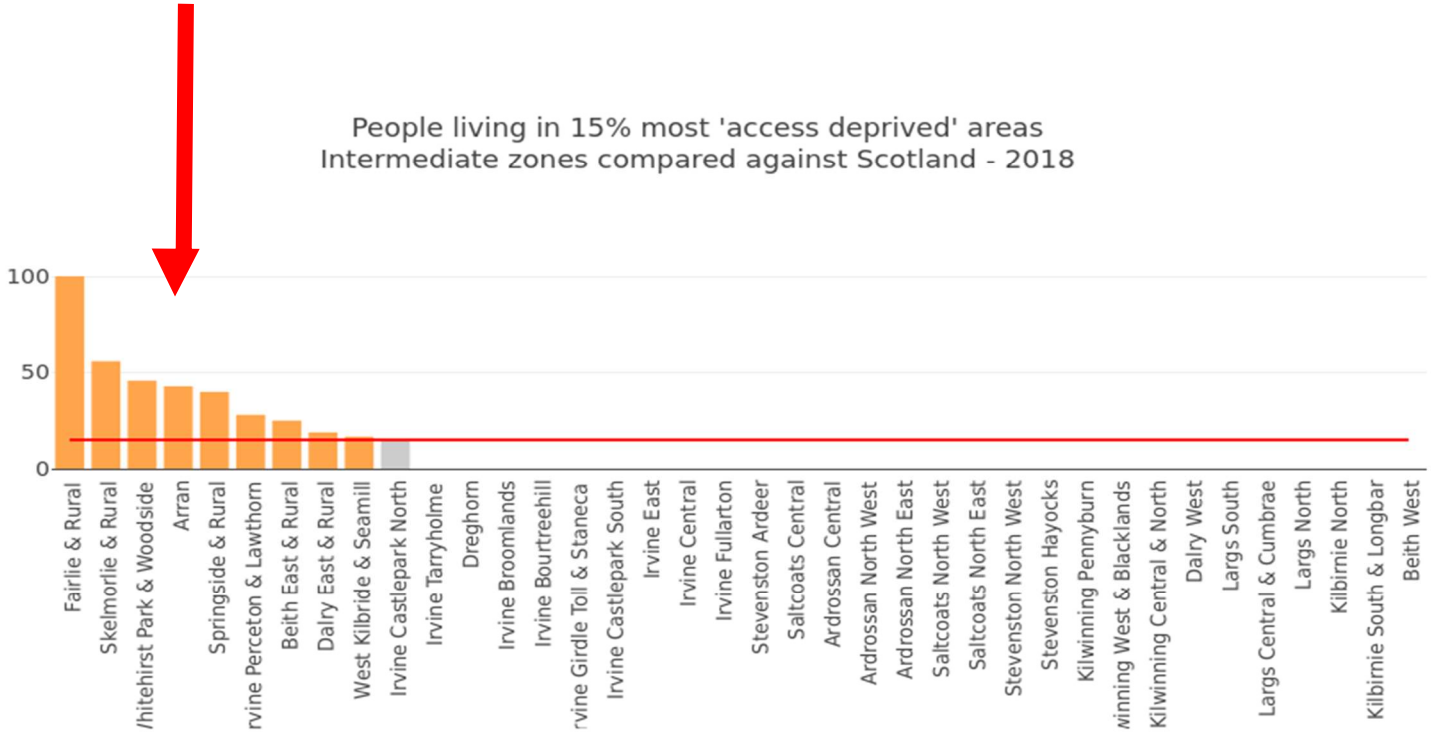
APPENDIX 1: ACORN postcode analysis

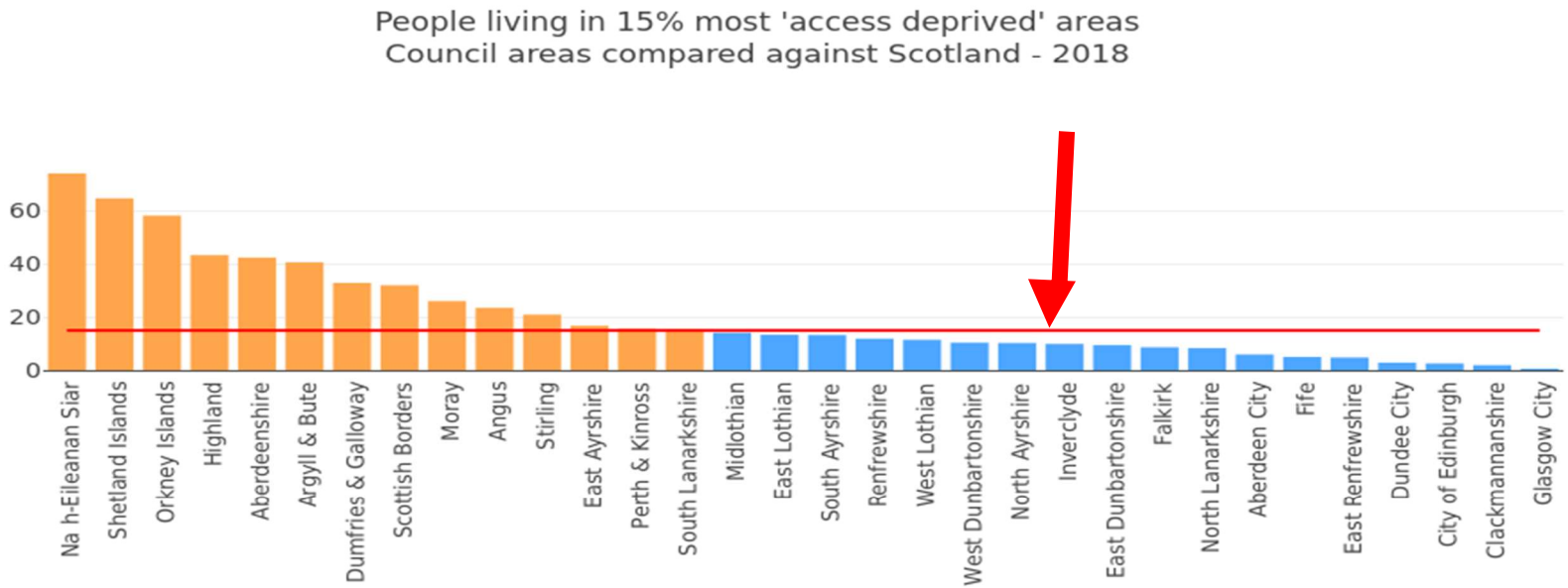
The acorn structure

6 categories. 18 groups. 62 types.

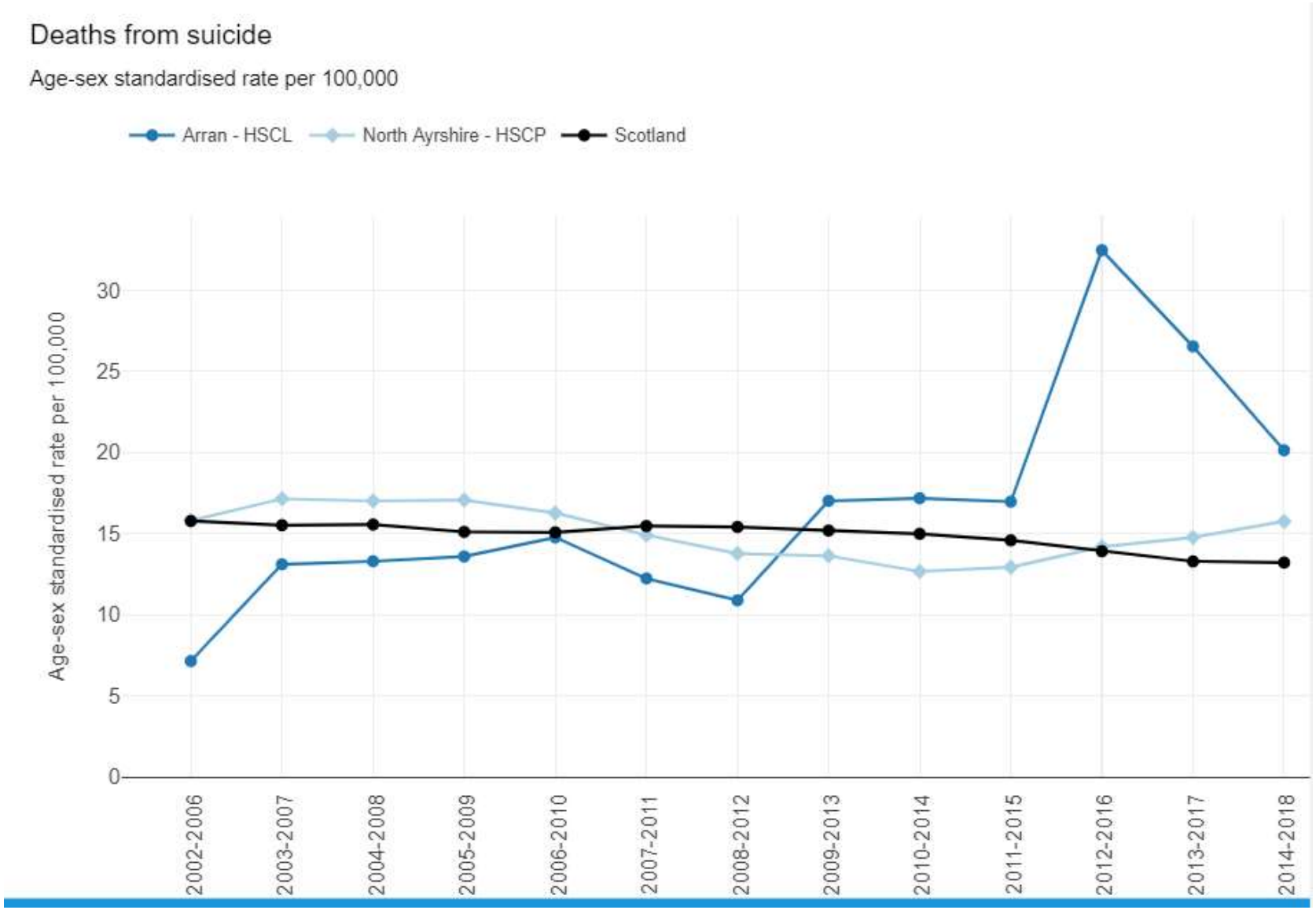
1 AFFLUENT ACHIEVERS		**Types**
A	Lavish Lifestyles	1 Exclusive enclaves 2 Metropolitan money 3 Large house luxury
B	Executive Wealth	4 Asset rich families 5 Wealthy countryside commuters 6 Financially comfortable families 7 Affluent professionals 8 Prosperous suburban families 9 Well-off edge of towners
C	Mature Money	10 Better-off villagers 11 Settled suburbia, older people 12 Retired and empty nesters 13 Upmarket downsizers
2 RISING PROSPERITY		**Types**
D	City Sophisticates	14 Townhouse cosmopolitans 15 Younger professionals in smaller flats 16 Metropolitan professionals 17 Socialising young renters
E	Career Climbers	18 Career driven young families 19 First time buyers in small, modern homes 20 Mixed metropolitan areas
3 COMFORTABLE COMMUNITIES		**Types**
F	Countryside Communities	21 Farms and cottages 22 Larger families in rural areas 23 Owner occupiers in small towns and villages
G	Successful Suburbs	24 Comfortably-off families in modern housing 25 Larger family homes, multi-ethnic areas 26 Semi-professional families, owner occupied neighbourhoods
H	Steady Neighbourhoods	27 Suburban semis, conventional attitudes 28 Owner occupied terraces, average income 29 Established suburbs, older families
I	Comfortable Seniors	30 Older people, neat and tidy neighbourhoods 31 Elderly singles in purpose-built accommodation
J	Starting Out	32 Educated families in terraces, young children 33 Smaller houses and starter homes
4 FINANCIALLY STRETCHED		**Types**
K	Student Life	34 Student flats and halls of residence 35 Term-time terraces 36 Educated young people in flats and tenements
L	Modest Means	37 Low cost flats in suburban areas 38 Semi-skilled workers in traditional neighbourhoods 39 Fading owner occupied terraces 40 High occupancy terraces, many Asian families
M	Striving Families	41 Labouring semi-rural estates 42 Struggling young families in post-war terraces 43 Families in right-to-buy estates 44 Post-war estates, limited means
N	Poorer Pensioners	45 Pensioners in social housing, semis and terraces 46 Elderly people in social rented flats 47 Low income older people in smaller semis 48 Pensioners and singles in social rented flats
5 URBAN ADVERSITY		**Types**
O	Young Hardship	49 Young families in low cost private flats 50 Struggling younger people in mixed tenure 51 Young people in small, low cost terraces
P	Struggling Estates	52 Poorer families, many children, terraced housing 53 Low income terraces 54 Multi-ethnic, purpose-built estates 55 Deprived and ethnically diverse in flats 56 Low income large families in social rented semis
Q	Difficult Circumstances	57 Social rented flats, families and single parents 58 Singles and young families, some receiving benefits 59 Deprived areas and high-rise flats
6 NOT PRIVATE HOUSEHOLDS		**Types**
		60 Active communal population 61 Inactive communal population 62 Without resident population

APPENDIX 2: Figures for access deprivation: Arran and North Ayrshire

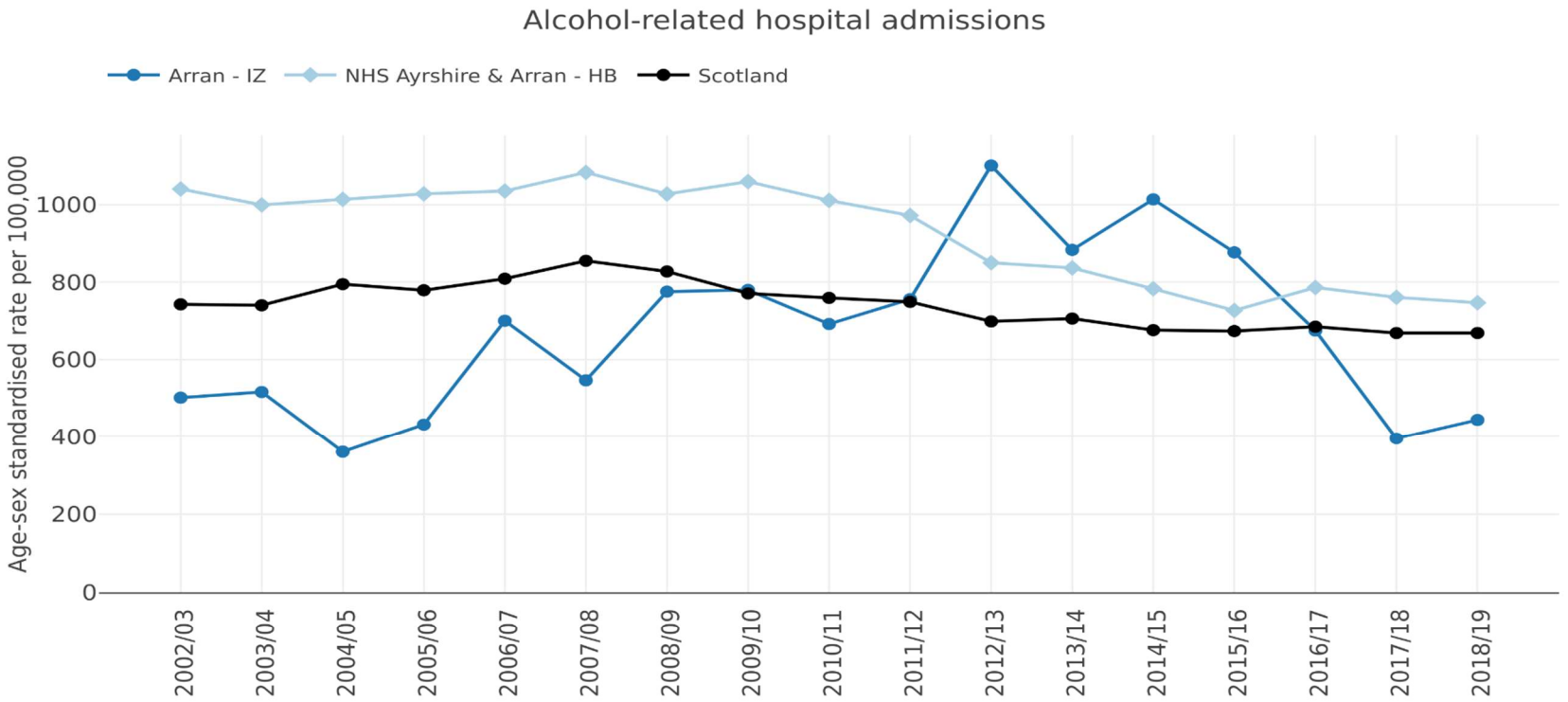



People living in 15% most 'access deprived' areas
Council areas compared against Scotland - 2018
60
40
20
0
Na h-Eileanan Siar
Shetland Islands
Orkney Islands
Highland
Aberdeenshire
Argyll & Bute
Dumfries & Galloway
Scottish Borders
Moray
Angus
Stirling
East Ayrshire
Perth & Kinross
South Lanarkshire
Midlothian
East Lothian
South Ayrshire
Renfrewshire
West Lothian
West Dunbartonshire
North Ayrshire
Inverclyde
East Dunbartonshire
Falkirk
North Lanarkshire
Aberdeen City
Fife
East Renfrewshire
Dundee City
City of Edinburgh
Clackmannanshire
Glasgow City

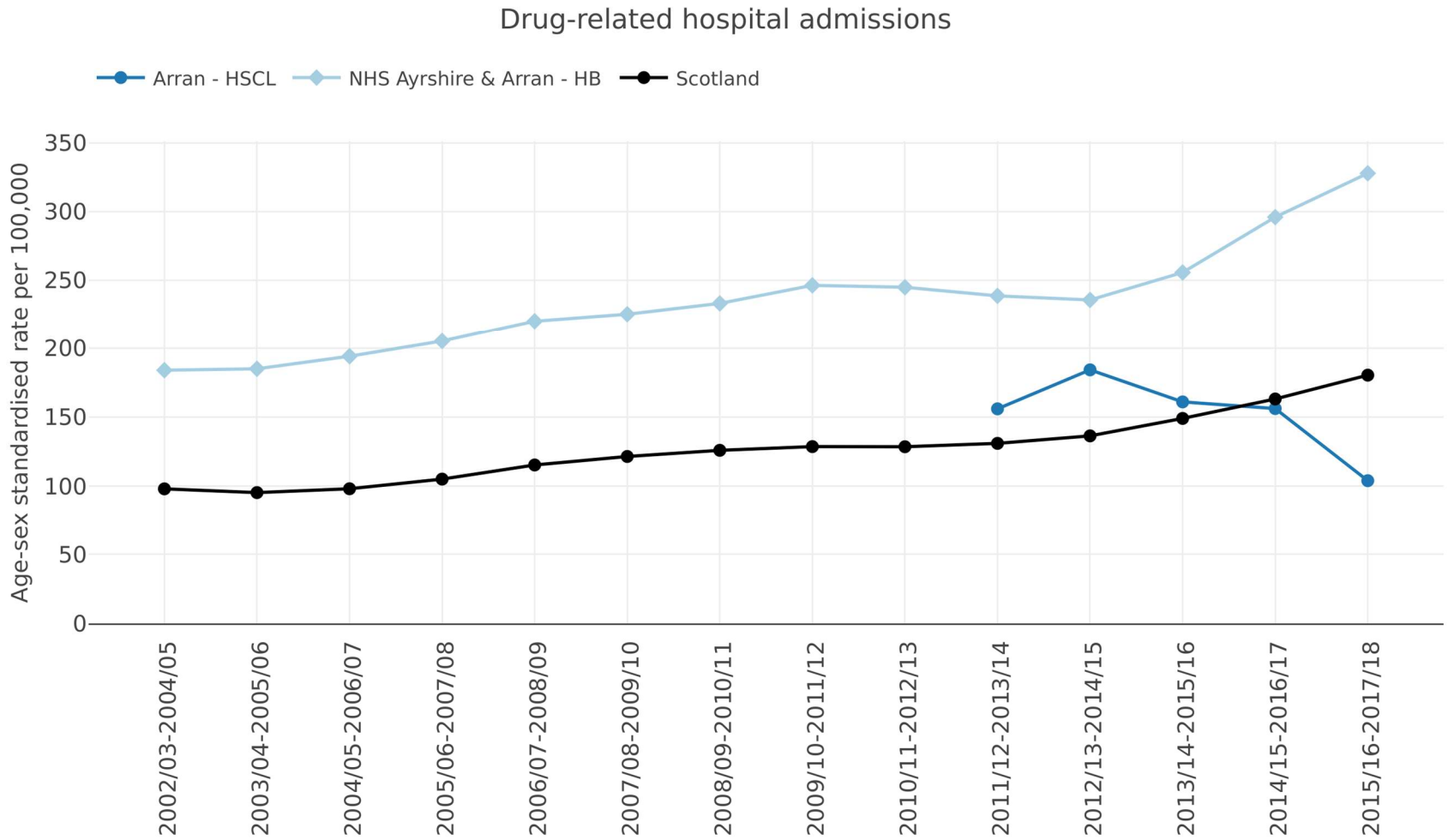
APPENDIX 3: Deaths from suicide: 2002-2018



APPENDIX 4: Alcohol related hospital admissions 2002-2018



APPENDIX 5: Drug related hospital admissions 2002-2018



APPENDIX 6: FOI REQUEST RESPONSE:

Dear Ms Still,

REQUEST FOR INFORMATION FREEDOM OF INFORMATION (SCOTLAND) ACT 2002

Thank you for your request for the provision of the following information. I am requesting the following information under the Freedom of Information Act 2020 from either North Ayrshire Council or NHS Ayrshire & Arran, in relation to North Ayrshire Drugs & Alcohol Recovery Service:

- The TOTAL expenditure on overnight accommodation for NADARS staff on the Isle of Arran between 02/06/2018 – 03/06/2019.
- The TOTAL amount of expenses for NADARS staff paid whilst they were working on the Isle of Arran between 02/06/2018 – 03/06/2019
- The TOTAL expenditure of ferry fees (including foot passengers, cyclists and car) for NADARS staff travelling to and from the Isle of Arran 02/06/2018 – 03/06/2019.
- The TOTAL number of days NADARS staff could not access the Isle of Arran due to ferry disruption between 02/06/18 – 03/06/2019
- The TOTAL number of days NADARS staff could not access Ardrossan harbour from the Isle of Arran due to ferry disruption between 02/06/2018 – 03/06/2019

Response:

1. The TOTAL expenditure on overnight accommodation for NADARS staff on the Isle of Arran between 02/06/2018 – 03/06/2019. NIL
2. The TOTAL amount of expenses for NADARS staff paid whilst they were working on the Isle of Arran between 02/06/2018 – 03/06/2019 £36.00
3. The TOTAL expenditure of ferry fees (including foot passengers, cyclists and car) for NADARS staff travelling to and from the Isle of Arran 02/06/2018 – 03/06/2019. £163.70
4. The TOTAL number of days NADARS staff could not access the Isle of Arran due to ferry disruption between 02/06/18 – 03/06/2019. NHS Ayrshire & Arran do not record this information.*
5. The TOTAL number of days NADARS staff could not access Ardrossan harbour from the Isle of Arran due to ferry disruption between 02/06/2018 – 03/06/2019. NHS Ayrshire & Arran do not record this information.*

As we do not hold this information it is classed as an exclusion under section 17 (1) of the Freedom of Information (Scotland) Act 2002. I trust this response is helpful. However, under the Freedom of Information (Scotland) Act 2002 if you are dissatisfied with our response you are entitled to request a review. A request for a review must be made in writing to Mrs Jillian Neilson, Head of Information Governance, NHS Ayrshire & Arran, 14 Lister Street, University Hospital Crosshouse, Kilmarnock, KA2 0BB or email InformationGovernance@aapct.scot.nhs.uk, no later than 40 working days from 30 June

2020. You must provide your full name, an address for correspondence, details of your original request and say why you would like a review.
If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal appeal to the Scottish Information Commissioner at www.itspublicknowledge.info/Appeal Please do not hesitate to contact me should you require any further advice or assistance.

Yours sincerely,

Tara Palmer
Freedom of Information Officer Information Governance

NHS Ayrshire & Arran
14 Lister Street,
University Hospital Crosshouse
Kilmarnock, KA2 0BE

APPENDIX 7: INFORMATION SHEET (LIVED EXPERIENCE):
Reviewing current alcohol and drug service provision on the Isle of Arran: Personal experiences of problem drug and alcohol use.

Name of researcher: Heather Still, Arran Community and Voluntary Service.

You are invited to take part in a research study that is reviewing the current service provision of alcohol and drug services provided for the Isle of Arran population. Part of this research involves exploring the experiences of people who have been directly affected by problem alcohol and drug use, this includes either service users themselves or their family/ close friends. You do not need to have direct experience with alcohol and drug services.

Why are we doing this research?
The research project has three overall aims. This study will look at the *first* aim:

- There is an improved understanding of the experiences of people living with problem alcohol and drug misuse.
- There is an improved communication and information sharing across services.
- There is an improved understanding of current model and scoping for potential alternatives.

It is thought that a thorough understanding of personal experience of drugs, alcohol and services contacted (if any) could provide a better knowledge of current provision which in turn would help look into new ways of working to improve how alcohol and drug services are accessed and delivered. *Service user experiences and engagement is a unique and vital set of expertise that we are currently underusing in alcohol and drug service development, and this study will attempt to readdress this.*

Why have I been invited?
You have been invited either because you have either direct personal experience of problem alcohol/drug use (including prescription drugs) or you are a family member of someone experiencing problem alcohol/ drug use. You do not need to have direct experience with drug and alcohol services to take part, since this study is also exploring barriers in accessing care.

Do I have to take part?
No. Participation is entirely voluntary.

What will happen if I take part?
You will asked to sign a consent form and then an interview date will be arranged at your convenience. The interview will be placed in a private room, and the interview will be recorded. It should not last more than an hour.

What will I have to do?
You will be asked questions about your experiences with drug and alcohol, as well as

your experience of services, if you have had any. Questions will involve any barriers you've experienced in accessing care, the emotional impact of alcohol and drug use, and what you believe would help improve recovery. The interview will be semi-structured, which means there is a set list of questions but the researcher may ask other questions that are relevant to your own personal experience.

What are the possible risks of taking part?
Whilst risks are minimal, talking about experiences relating to alcohol and drugs may be distressing. Whilst there will be some exploration with your alcohol and drug experiences, it will be related to any experiences you have had to alcohol and drug services, if any. You do not have to answer any questions and the interview will be terminated if distress occurs. A full debrief will be conducted after every interview.

What are the benefits of this study?
It is hoped that collecting your experiences and expertise would help inform where improvements need to be made and then recommendations put in place. Whilst there may be no direct benefit to you personally immediately, these findings will go on to help improve services that you may or may not use in the future, and may positively benefit others struggling with alcohol or drugs. From previous experience in interviewing participants for research, participants often feel quite positive and empowered from having their experiences heard and believed.

Can I withdraw?
Yes, you are free to withdraw at any point. All data you would have provided would be deleted and you will not be included in the study.

What about confidentiality?
Your name will be anonymised in the study and report. Any recording device used for the interview will be kept in a locked secure unit only accessible to the researcher. All computer devices used to analyse the interview are password protected. Your data will be deleted once the report has been published. Everything you say will be kept confidential, except in exceptional circumstances where what you say may pose an immediate threat to yourself or others.

Are there any exclusions?
Due to the limitations of aftercare those with severe mental health concerns cannot take part in this study. You also need to be a resident in the Isle of Arran and be aged 18 or over.

Questions or concerns.
If you have any questions or concerns please contact the researcher. If you have formal complaints about the study, please contact Elizabeth Watson at revewatson@btinternet.com, who is independent from the study.

Who is organising and funding this research?
Arran Community and Voluntary Service is hosting the researcher and research project, with input from a steering group of health, social and third sector leads on Arran. The study is funded by the Corra Foundation, as part of the substance misuse challenge fund.

Researcher contact information:

Heather Still. heather.still@arrancvs.org.uk. 01770 600611. The supervisor is Vicki Yuill vicki.yuill@arrancvs.org.uk. Vicki is line managing the project but does not have access to any participant data to retain anonymity.

APPENDIX 8: INFORMATION SHEET (FAMILY):
Reviewing current alcohol and drug service provision on the Isle of Arran: Personal experiences of drug and alcohol use within the family.

You are invited to take part in a research study that is reviewing the current service provision of alcohol and drug services provided for the Isle of Arran population. Part of this research involves exploring the experiences of people who have been directly affected by alcohol and drug use, this includes either individuals themselves or their family/ close friends. You do not need to have direct experience with alcohol and drug services, nor have a known addiction.

Why are we doing this research?
The research project has three overall aims. This study will look at the *first* aim:

- There is an improved understanding of the experiences of people living with problem alcohol and drug misuse.
- There is an improved communication and information sharing across services.
- There is an improved understanding of current model and scoping for potential alternatives.

It is thought that a thorough listening to the personal experiences of having a family member with alcohol or drug addiction, as well as any alcohol and services contacted you may/may not have contacted, it could provide a better understanding of family experiences with addiction on Arran and of current provision which in turn would help look into new ways of working to improve how alcohol and drug services are accessed and delivered. *Personal experiences and engagement is a unique and vital set of expertise that we are currently underusing in alcohol and drug service development, and this study will attempt to readdress this.*

Why have I been invited?
You have been invited either because you have either direct personal experience of alcohol/drug use (including prescription drugs) or you are a family member of someone experiencing problem alcohol/ drug use. You also do not need to have direct experience with drug and alcohol services to take part, since this study is also exploring barriers in accessing care.

Do I have to take part?
No. Participation is entirely voluntary.

What will happen if I take part?
You will asked to sign a consent form and an interview date will be arranged at your convenience. You can choose to sign the consent form electronically or before the interview in person. The interview will be placed in a private room, and the interview will be recorded. It should not last more than an hour.

What will I have to do?
You will be asked questions about your experiences of drug and alcohol in your family, as well as your experience of services, if you have had any. Questions will involve any barriers you've experienced in accessing care, the emotional and physical impact of alcohol and drug use, and what you believe are the main issues around alcohol/drug use are on Arran. The interview will be semi-structured, which means there is a set list of questions but the researcher may ask other questions that are relevant to your own personal experience.

What are the possible risks of taking part?
Whilst risks are minimal, talking about experiences relating to your family member/s may be distressing. Whilst there will be some exploration with your alcohol and drug experiences, the interview has no focus on traumatic experiences unless you choose to talk about them and are comfortable in doing so. You do not have to answer any questions and the interview will be terminated if distress occurs. A full debrief will be conducted after every interview.

What are the benefits of this study?
It is hoped that collecting your experiences and expertise would help inform where improvements need to be made and then recommendations put in place. Whilst there may be no direct benefit to you personally immediately, these findings will go on to help improve our understanding on the prevalence of drug and alcohol use in Arran, to help improve services that you may or may not use in the future, and may positively benefit others family members struggling with alcohol or drugs. From previous experience in interviewing participants for research, participants often feel quite positive and empowered from having their experiences heard and believed without judgement.

Can I withdraw?
Yes, you are free to withdraw at any point. All information you have provided would be deleted and you will not be included in the study.

What about confidentiality?
Your name will be anonymised in the study and report. Any recording device used for the interview will be kept in a locked secure unit only accessible to the researcher. All computer devices used to analyse the interview are password protected. Your data will be deleted once the report has been published. Your interview will be analysed by the researcher, who may use direct quotes in the research. If you mention names, places, dates, jobs etc, all of this will be removed, and your name will not be used. Direct quotes will only be used if they have no way of being traced back to your own personal experience. Everything you say will be kept confidential, except in rare circumstances where what you say may pose an immediate threat to yourself or others.

Are there any exclusions?
Due to the limitations of aftercare those with severe mental health concerns cannot

take part in this study. You also need to be a resident in the Isle of Arran and be aged 18 or over.

Questions or concerns.
If you have any questions or concerns please contact the researcher. If you have formal complaints about the study, please contact Elizabeth Watson at revewatson@btinternet.com, who is independent from the study.

Who is organising and funding this research?
Arran Community and Voluntary Service is hosting the researcher and research project, with input from a steering group of health, social and third sector leads on Arran. The study is funded by the Corra Foundation, as part of the substance misuse challenge fund.

Researcher contact information:
Heather Still. heather.still@arrancvs.org.uk. 01770 600611. The supervisor is Vicki Yuill vicki.yuill@arrancvs.org.uk. Vicki is line managing the project but does not have access to any participant data to retain anonymity.

APPENDIX 9: INFORMATION SHEET (PROFESSIONALS):
Reviewing current alcohol and drug service provision on the Isle of Arran: Professional experiences of drug and alcohol use.

You are invited to take part in a research study that is reviewing the current service provision of alcohol and drug services provided for the Isle of Arran population. Part of this research involves exploring the experiences of people who have been directly affected by alcohol and drug use. If you are handed this information sheet you are a member of the community with professional capacity where the people you serve may be using drugs/ drink. You do not need to have direct experience with alcohol and drug services, nor have a known addiction.

Why are we doing this research?
The research project has three overall aims. This study will look at the *first* aim:

- There is an improved understanding of the experiences of people living with problem alcohol and drug misuse.
- There is an improved communication and information sharing across services.
- There is an improved understanding of current model and scoping for potential alternatives.

It is thought that a thorough understanding of how professionals come into contact with drug or drink use and services contacted (if any) could provide a better knowledge of current provision which in turn would help look into new ways of working to improve how alcohol and drug services are accessed and delivered. *Professional experiences a unique and vital set of expertise that are particularly useful in areas of research where people may feel ashamed or embarrassed to come forward, or fear punishment.*

Why have I been invited?
You have been invited either because you have either direct professional experience of alcohol/drug use (including prescription drugs). You may not have alcohol/drug problems yourself, but you may be witness to a culture or community that involves drug use or heavy alcohol use, or you may be witness to members of your community developing addictions. You also do not need to have direct experience with drug and alcohol services to take part, since this study is also exploring barriers in accessing care.

Do I have to take part?
No. Participation is entirely voluntary.

What will happen if I take part?
You will asked to sign a consent form and an interview date will be arranged at your convenience. You can choose to sign the consent form electronically or before the interview in person. The interview will be placed in a private room, and the interview will be recorded. It should not last more than half an hour, but make room for about an hour for debrief.

What will I have to do?
You will be asked questions about your experiences with drug and alcohol, from what you've witnessed or heard, as well as your experience of services if you have had any. Questions will involve the emotional and physical impact of alcohol and drug use, and what you believe are the main issues around alcohol/drug use are on Arran. The interview will be semi-structured, which means there is a set list of questions but the researcher may ask other questions that are relevant to your own personal experience.

What are the possible risks of taking part?
Whilst risks are minimal, talking about experiences relating to alcohol and drugs may be distressing. Whilst there will be exploration with second hand alcohol and drug experiences, the interview has no focus on traumatic experiences that you may have from looking after others in your care. You do not have to answer any questions and the interview will be terminated if distress occurs. A full debrief will be conducted after every interview.

What are the benefits of this study?
It is hoped that collecting your experiences and expertise would help inform where improvements need to be made and then recommendations put in place. Whilst there may be no direct benefit to you personally immediately, these findings will go on to help improve our understanding on the prevalence of drug and alcohol use in Arran, to help improve services that you may or may not use in the future, and may positively benefit others struggling with alcohol or drugs. From previous experience in interviewing participants for research, professional participants often feel positive about their experiences being heard without judgement.

Can I withdraw?
Yes, you are free to withdraw at any point. All data you would have provided would be deleted and you will not be included in the study.

What about confidentiality?
Your name will be anonymised, during the analysis and all professionals will be referred to a "key informant". Any recording device used for the interview will be kept in a locked secure unit only accessible to the researcher. All computer devices used to analyse the interview are password protected. Your data will be deleted once the report has been published. Your interview will be analysed by the researcher, who may use direct quotes in the research. If you mention names, places, dates, jobs etc, all of this will be removed, and your name will not be used. Direct quotes will only be used if they have no way of being traced back to your own personal experience.

Are there any exclusions?
Due to the limitations of aftercare those with severe mental health concerns cannot take part in this study. You also need to be a resident in the Isle of Arran and be aged 18 or over.

Questions or concerns.
If you have any questions or concerns please contact the researcher. If you have formal complaints about the study, please contact Elizabeth Watson at revewatson@btinternet.com, who is independent from the study.

Who is organising and funding this research?
Arran Community and Voluntary Service is hosting the researcher and research project, with input from a steering group of health, social and third sector leads on Arran. The study is funded by the Corra Foundation, as part of the substance misuse challenge fund.

Researcher contact information:
Heather Still. heather.still@arrancvs.org.uk. 01770 600611. The supervisor is Vicki Yuill vicki.yuill@arrancvs.org.uk. Vicki is line managing the project but does not have access to any participant data to retain anonymity.

APPENDIX 10: CONSENT FORM:

CONSENT FORM

Reviewing current drug and alcohol service provision on the Isle of Arran: Professional experiences of problem drug and alcohol use.

Please answer the following questions to the best of your knowledge

DO YOU CONFIRM THAT YOU:

ARE A RESIDENT OF ARRAN ☐

ARE AGED 18 OR OVER ☐

ARE NOT DIAGNOSED WITH A SEVERE MENTAL HEALTH CONDITION. ☐

I hereby fully and freely consent to my participation in this study

I understand the nature and purpose of the procedures involved in this study. These have been communicated to me and I have had the opportunity to ask questions.

I understand and acknowledge that the investigation is designed to promote the understanding of drug and alcohol experiences in the Isle of Arran.

I understand the data I provide will be **anonymous**. No link will be made between my name or other identifying information and my study data.

I understand that the ACVS will destroy my data after the final report has been published.

Participant's signature: _____ Date: _____

Name in BLOCK Letters: _____

APPENDIX 11: DEBRIEF (LIVED EXPERIENCE):
Debriefing Information

Thank you for taking part in this project that has been trying to understand the experiences of those living with addiction. Your contribution is much appreciated.
We realise that talking through your experiences can be distressing. Below is a list of organisations that may contain information useful to you.

Alcoholics Anonymous

Alcoholics Anonymous holds four weekly meetings on the island, in Lamlash, Brodick and Whiting Bay. AA on Arran are open meetings, meaning that they are open to ALL who may or may not have an alcohol problem. AA is concerned solely with the personal recovery and continued sobriety of individual alcoholics who turn to the Fellowship for help. AA is free to use but donations of £2 each meeting is encouraged.

Meetings are held in the following areas every week:
Brodick: Tuesdays at 1400, Church of Scotland Hall KA27 8NS.
Brodick: Sundays at 1700, Brodick Church Hall, Knowe Road, KA27 8BY.
Lamlash: Wednesdays at 1930, Church Hall, KA27 8LL
Whiting Bay: Fridays 1900 at Whiting Bay Hall, Shore Road, KA27 8PR.

North Ayrshire Drug and Alcohol Recovery Service

North Ayrshire Drug and Alcohol Recovery Service (NADARS) offers confidential support and advice to anyone affected by drug and alcohol addiction. Anyone can refer, yourself, a family member or a health/social care professional.

You may be offered the opportunity to attend a confidential drop-in session (near where you live) to discuss your addiction.
We will meet with you to complete an assessment. We will work with you to assess your strengths, goals and wishes: we will create your recovery care plan. Your family will be invited to be part of this process.

The plan will help us to support you towards goals and promote your recovery. You will be supported by different professionals covering a wide range of disciplines, including: addiction workers, consultant psychiatrists, GPs, nurses, occupational therapists, pharmacy prescribers, social workers, support workers.

Phone Number : 01294 476000
Website : http://www.nahscp.org/addiction-service/?repeat=w3tc
Address : Caley Court Resource Centre Moorpark Road West Stevenston
Post Code : KA20 3HU

Turning Point Scotland has recently been awarded the services for Ayrshire and Arran for drug and alcohol support and are accepting referrals, however I am unable to provide you with information with what they cover yet. If you would like I will keep you updated

of any further information I find.

Thank you again for participating. If you would like to speak to us about the project, please get in touch. I look forward to hearing from you.

Heather Still: Email – [heather.still@arrancvs.org.uk] Phone – [01770 600611]
When calling the office please use your pseudonym (fake name) if you wish to remain anonymous as the administration will usually answer the phone, or just ask to speak to "Heather".

APPENDIX 12, DEBRIEF (FAMILY):
Debriefing Information

Thank you for taking part in this project that has been trying to understand the experiences of those living with addiction. Your contribution is much appreciated.

We realise that talking through your experiences can be distressing. Below is a list of organisations that may contain information useful to you.

Scottish Families Affected by Alcohol and Drugs (SFAD)

Scottish Families Affected by Alcohol and Drugs is a national charity which supports anyone concerned about someone else's alcohol or drug use in Scotland. They give information and advice to many people and help them with confidence, communication, general wellbeing, and they link them into local support. They also help people recognise and understand the importance of looking after themselves.

They have a helpline service you can call: 08080 10 10 11.

When: Monday – Friday between 9am and 11pm and they run an out-of-hours weekend service where if you leave a message someone will get back to you within 48 hours.

What the helpline does: Call our helpline if you are worried about someone else's alcohol or drug use. This can be your partner/parent/child/friend or anyone you care about. We will be able to give information on local services and recommend support for both yourself and the person you care for.

Scottish Families also provide Telehealth for the family member. You can request telehealth through their website:
www.sfad.org.uk > Support Services > Family Support groups and Telehealth > Telehealth > Request Telehealth.

What does telehealth do?: SFAD offer listening and emotional support and use the evidence-based programme CRAFT (Community Reinforcement and Family Training). More information about their training and CRAFT is available on their website. There is also a webchat service available on the website.

North Ayrshire Carers

An adult carer is 18 years or older. They take responsibility for the care of relatives or friends who need help because of an illness, drug or alcohol misuse, disability or the effects of age. It is important that carers have a say on the type of caring they are comfortable with providing. North Ayrshire provide the opportunity to fill out an adult carer plan which will document your needs and wishes for yourself. There is also a carer's centre which helps with information on any carers issues e.g. benefits, respite and transport, contact with other carers, advocacy, 1:1 support, relaxation in the form of alternative therapies.
The Arran locality is: Shore Road, Lamlash, Arran KA27 8JY Phone: 01770 600742

Turning Point Scotland has recently been awarded the services for Ayrshire and Arran for drug and alcohol support, however I am unable to provide you with information with

what they cover yet. If you would like I will keep you updated of any further information I find.

Thank you again for participating. If you would like to speak to us about the project, please get in touch.

Heather Still: Email – [heather.still@arrancvs.org.uk] Phone – 01770 600611

When calling the office please use your pseudonym if you wish to remain anonymous as the administration will usually answer the phone.

Vicki Yuill: Email – [vicki.yuill@arrancvs.org.uk] Line Manager

Our address is: Park Terrace, Lamlash, Isle of Arran, KA27 8NB

Your data will be used to form an understanding of the experiences of alcohol and drugs on Arran and will only be for research purposes. Transcripts and completed questionnaires will be kept securely in a locked cabinet in the ACVS office. Any recordings of interviews and all questionnaires will be destroyed once the data is analysed in accordance to the charity's data protection policy. If you have any concerns related to your participation in this study please direct them to the Elizabeth Warren, revewatson@btinternet.com

APPENDIX 13: SUPPORT FOR PARTICIPANTS ON ARRAN:
Below are some of the suggestions either put forward by participants or interpreted from the data:

SOCIAL SUPPORT NETWORK FOR FAMILY MEMBERS TO BE ESTABLISHED ON ARRAN
Family members were very isolated, and they were more likely to believe that their family were the "only one" on Arran that were suffering from addiction or dependency. Knowing that they are others on the island with similar experiences would help the isolation family members can feel as well as being able to support others. Family members spoke of their willingness to help others in a similar situation and this should be utilised. If the support network is not a virtual one, then the network should be maintained by people on Arran, as historically groups that have come from the mainland have been unsuccessful. AA is successful in part of the dedication local residents put into its maintenance.

VOLUNTEER OUTREACH (ASSERTIVE, GROUP, SOCIAL) TO BE OFFERED ON ARRAN FOR THOSE WITH LIVED EXPERIENCE
People with lived experience expressed loneliness on Arran and asked for support that wasn't necessarily around reducing alcohol or drug use but a shared experience in dependence and addiction was asked for.

AN ALCOHOL AND DRUG FREE SAFE SPACE FOR PEOPLE ON ARRAN WHO ARE IN RECOVERY OR FOR THOSE WHO ARE SIGNIFICANTLY IMPACTED BY DRUG/ALCOHOL USE
Cafes on Arran are seasonal, and going to the pub is not an alternative for a significant proportion of people. Cafes on Arran are also applying for alcohol licenses due to their financial losses from COVID. Keeping in mind that some are unable to drive due to previous DUIs or accidents, accessing other people's houses may also be hard. During winter in particular it is difficult to go somewhere on Arran that is alcohol and drug free. Participants who turn up to hospital and the GP for peace and quiet on Arran indicates a lack of safe space.

To have a calming, warm safe space that is anonymous, with access to tea/coffee/ washing up facilitates would give people a chance to escape chaotic households, and the space could facilitate informal get togethers. The safe space would also have contact information for emergencies or to signpost to other services. Heatherlodge in Brodick, Arran, have a similar successful set up for counselling and alternative medicine, as does the Youth Foundation in Lamlash. This model could be used and adapted on a smaller scale for people affected by drugs and alcohol and their families.

These suggestions have also been found in SHAAPs recent publication on alcohol use and service access in rural Scotland.

Diarmond, J. (2020). Rural Matters: Understanding alcohol use in rural Scotland. *Scottish Health Action on Alcohol Problems. https://www.shaap.org.uk/downloads/reports-and-briefings/278-rural-matters.html*

APPENDIX 14: NEGATIVE EXPERIENCES FROM GPs (EXPERTISE, KNOWLEDGE, DISMISSIVE)

I don't know how good the GPs are on this subject.

I don't want him to be telepathic but it was so obvious I was in such a bad state.

They're general practitioners they have a bit of hindsight and things but their expertise isn't alcohol.

I think doctors here need to be a bit more experienced in it, I don't think any of them are.

Doctor's aren't stupid but this one was stupid and he's ruined all our lives, that's the way I see it.

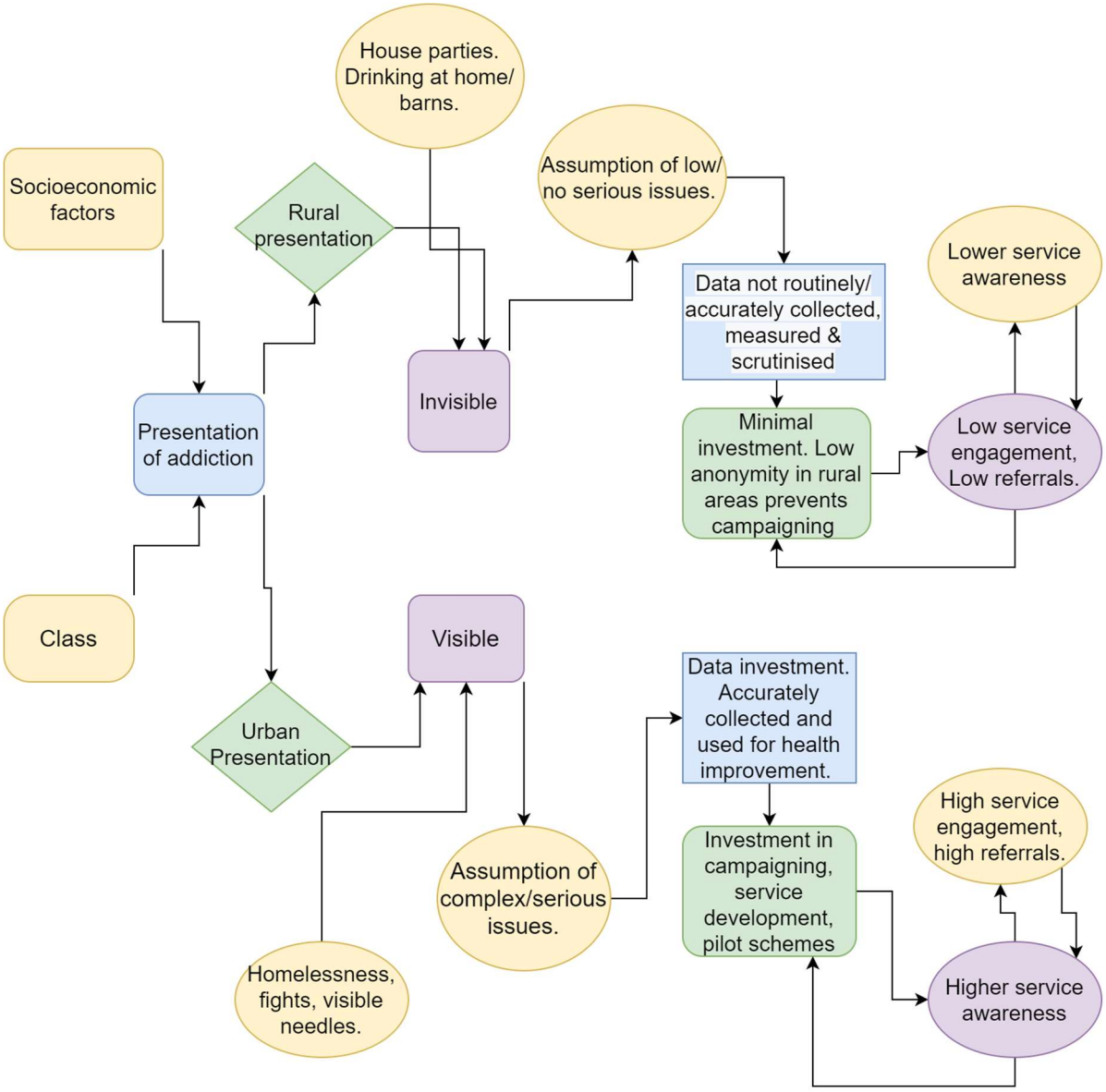
He (GP) is to blame but the other doctors that continued the prescription I said "look I know GP is to blame for this but you guys (OTHER GPs) are also to blame for this, you kept gave him access to this drug and just kept giving it to him…why?

I went to the doctors. I went to the doctors about this around February time and I was getting really bad pains in my arms, I couldn't move them and when I did I was getting really bad shooting pains down my arms I do wonder whether it was a psychosomatic thing, could be, I had tension in my shoulders, so when I saw him, I started to initially talk about my arms and then I just broke down and starting telling him about my son. And he told me to do some stretches. He told me to do some stretches because that's what the animals in LOCATION do and was telling me about his holiday in LOCATION he just came back from. And I left the GPs in a far far worse state than I walked in. That just total lack of, because I found it really hard to talk about it anyway for then to hear that.

I went to the doctor a few months ago and she you know, I was saying something to her and she was saying "oh what do you do with yourself" and that's difficult.

I was so angry with everybody. There were lots of things going on that week, the anger was rising rising rising and then *explosion sound* that was it don't want anything just leave me alone don't want to talk. But how do you express that to other people? And express that to the GPs? Because you end up going slightly intoxicated to the GP and what do they do? They call the police and then the ambulance are called. And then you know you can't go to the doctor for help…I just didn't want to be in the house anymore. I just wanted to go to the GP for quiet. I had enough. So they just called the police and took me home.

APPENDIX 15: The Socio-Political- Historical Influences of Rural Underinvestment and its implications in Research, Policy & Practice



Historical context: A rural environment during the pre-industrial revolution eras were seen as retrogressive and associated with poverty. Nowadays we are nostalgic, admire nature, deem it as untainted and contributes to rural lifestyles as an "idyllic perception" and often as a hideaway for urban holidaymakers.
Conversely, an urban environment pre and early industrial revolution was seen as progressive as the British romanticised future orientated thinking (i.e. the enlightenment). As the poverty of mass urban living became more obvious, urban living began to be seen as dirty. Nowadays we continue to view urban areas as unhealthy (environmentally, stressful, lonely).

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North Ayrshire
Community Planning Partnership

CPP Senior Officers Group

Date: **21 January 2021**

Subject: **Children's Services Strategic Partnership Update**

Purpose: **To update the CPP Senior Officers Group on developments in relation to the Children's Services Strategic Partnership**

1. Background

1.1. The Children's Services Strategic Partnership (CSSP) is responsible for delivering against the Community Planning Partnership theme of "A Thriving North Ayrshire – Children and Young People" and working towards our ambition to ensure children have the best start in life and for North Ayrshire to be the best place in Scotland to grow up.

1.2. The CSSP provides a strategic lead in the delivery and monitoring of Children's Services Planning.

1.3. The CSSP meets quarterly and is currently chaired by the Executive Director (Communities and Education) and includes representatives from:

- North Ayrshire Council
- NHS Ayrshire and Arran
- North Ayrshire Health and Social Care Partnership
- Police Scotland
- Scottish Children's Reporters Administration
- Children's Panel
- Third Sector, and
- Scottish Fire and Rescue Service

1.4. In October 2020, a new Children's Services Plan 2020-23 was approved by Cabinet and the Integration Joint Board. The reports reflect a strong focus on Children's Services and the impact of Covid-19. This approach has received positive feedback from Scottish Government.

1.5. The process of Children's Services Planning has been reviewed and streamlined during 2019/20. Diagram 1 below provides a clear visual representation of the key elements of Children's Services Planning. This links the Children's Services Plan, Children's Rights Report and the Child Poverty Action Plan and Report into one suite of planning documents and ensures a co-ordinated and strategic approach.

Diagram 1: Children's Services Planning Dashboard

1.4. The Children's Services Plan 2020-23 builds on the progress made since the previous Children's Services Plan 2016-20. The Children's Services Plan priorities are:

- Children and young people's rights and views are respected and listened to
- Act early to improve what happens next
- Make things fairer and better
- Support mental health
- Help children and young people to be active and healthy

1.5. Public authorities (including all local authorities and health boards) are required to report on the steps they have taken to secure better or further effect of the requirements of the United Nations Convention on the Rights of the Child (UNCRC). This section of the Act came into force on 1 April 2017 with the first reports required in 2020. A decision was taken to link our Children's Rights Report with our Children's Services Plan to ensure children's rights remain at the heart of everything we do.

2. Key Points

2.1. To align with the new Children's Services Plan 2020-23, the format of the CSSP meetings have been revised. Each meeting will now focus on a Priority of the Children's services Plan for in depth discussion and challenge.

2.2. The governance for the Child Poverty Action Plan has also been agreed to sit with the CSSP. A key theme from the Child Poverty Action Plan will be discussed at each meeting of the CSSP.

2.3. The CSSP has agreed that there will be stronger Elected Member engagement and Councillor Bell (Portfolio Holder for Education) and Councillor Foster (Portfolio Holder for Health and Social Care and lead Member for Poverty) will be invited to future meetings to support this.

2.4. The Sub-groups that previously reported to the CSSP will no longer be required to report to each meeting. Groups can provide information when appropriate or bring items to the CSSP for approval or input.

2.5. A new Children's Services Executive Group has been created which brings together Heads of Service from Communities and the Health and Social Care Partnership. The group is chaired by the Executive Director (Communities and Education). The purpose of this internal group is to take forward operational decisions and link to the Transformation agenda, Renewal Strategy and the Budget. This group will link to the CSSP.

2.6. The Children's Services Executive Group has agreed that six workstreams will be set up, each chaired by a Senior Manager from Communities or Health and Social Care Partnership. The workstream groups will take forward specific pieces of work and report progress to the Children's Services Executive Group. The workstreams have been agreed as:

- Children and Young People Community Mental Health and Wellbeing Supports and Services Framework
- Review and evaluation of Named Person Service
- Planning for transition to adult services
- External Residential Placements
- Multi-agency and Locality Working
- The Promise (informing our response to the National Independent Care Review)

2.7. The Children's Services Executive Group and the CSSP have agreed that due to the Covid-19 pandemic it will no longer be appropriate to carry out the ChildrenCount pupil survey that was due to be undertaken by the Dartington Service Design Lab in April 2020. Dartington have agreed to scope a different proposal to best use their expertise to inform the CSSP's response to The Promise. Dartington will work with The Promise workstream that has been set up to provide a response to The Promise recommendations and take forward actions identified.

3. Proposals

3.1. The CPP Senior Officers Group is asked to note the refreshed direction of the Children's Services Strategic Partnership to align to the new Children's Services Plan 2020-23 and the Child Poverty Action Plan 2019-20.

Lauren Cameron
Policy Officer (Children's Services)

North Ayrshire
Community Planning Partnership

North Ayrshire Local Outcomes Improvement Plan 2017 - 2022

CPP Structure

CPP Board

CPP Senior Officers Group

Community Engagement Network

Economic Development and Regeneration Board

Safer North Ayrshire Partnership

Health and Social Care Partnership

Children's Services Strategic Partnership

Arran Locality Partnership

Garnock Valley Locality Partnership

Irvine Locality Partnership

Kilwinning Locality Partnership

North Coast Locality Partnership

Three Towns Locality Partnership

Overarching themes:

Strengthening local communities

Prevention

Tackling inequalities

Fair For All

North Ayrshire CPP pledges to tackle the root causes of Child Poverty and mitigate its impact to create a better life for local people.

Priority:

Our ambition:

A Working North Ayrshire

To have created the most improved economy in Scotland by 2026

A Safer North Ayrshire

North Ayrshire is a safer place to live, residents feel safer and communities are empowered.

A Healthier North Ayrshire

All people who live in North Ayrshire are able to have a safe, healthy and active life.

A Thriving North Ayrshire

We want you to have the best start in life and for North Ayrshire to be the best place in Scotland to grow up.

CPP SOG Decision Tracker 2021

Strategic Priority	Jan-21	Mar-21	Apr-21	Jun-21	Aug-21	Oct-21	Nov-21	To be scheduled
Working NA								Ayrshire Growth Deal, Community Wealth Building
Healthier NA	Arran Alcohol and Drugs Study, Community Food System, Integrated Joint Board minutes	Alcohol and Drugs Partnership update, Integrated Joint Board minutes, Young Peoples' Suicide Taskforce	Integrated Joint Board minutes, Community Health and Wellbeing	Integrated Joint Board minutes	Integrated Joint Board minutes	Integrated Joint Board minutes	Integrated Joint Board minutes	Caring for Ayrshire, HSCP Strategic Plan
Thriving NA	Childrens Services Strategic Partnership update	Cost of the School Day		Childrens Services Strategic Partnership update			Childrens Service Strategic Partnership Update	Child Poverty Action Plan
Safer NA	Draft Local Police Plan, Community Justice Ayrshire	Performance reports as per Police and Fire and Rescue Committee, Safer North Ayrshire Partnership update		Performance reports as per Police and Fire and Rescue Committee, Community Justice Ayrshire		Safer North Ayrshire Partnership update		
Locality Partnerships	Locality Partnership minutes		Locality Partnership minutes		Locality Partnership minutes		Locality Partnership minutes	Locality priorities and profiles refresh
Fair for All		Review update, FFA Advisory Panel minutes				FFA Advisory Panel minutes		
LOIP	LOIP on a page	LOIP on a page, Q3 LOIP Performance Report	LOIP on a page	LOIP on a page, Q4 LOIP Performance Report	LOIP on a page, Draft LOIP Annual Report, Q1 LOIP Performance Report, LOIP 2022	LOIP on a page	LOIP on a page, Q2 LOIP Performance Report	
Communites	Events support for community organisations	CPP Social media						Peoples Panel, Community Engagement Centre of Excellence
Learning and Development	Inviting additional attendees to CPP SOG	CPP Learning and Development Plan						
Governance	Minutes of Dec CPP Board	Risk Register	Annual review of terms of reference, membership and appraisal, Minutes of March CPP Board		Minutes of June CPP Board	CPP Planning, Minutes of Sept CPP Board		
Key Strategic Developments		Partner updates		Partner updates		Partner updates		
Information circulated outwith meeting	Inspiring Scotland Link-Up report, Vice Chair of CPP SOG, Call for agenda items, Community Justice Ayrshire options paper							