Breaking Barriers: Access to Drug & Alcohol Treatment & Support Services in Rural Devon

Devon Communities Together

March 2025

Devon Communities Together

helping communities help themselves

Public Health Devon

Front cover image: Dietmar Rabich / Wikimedia Commons / "Ilfracombe (Devon, UK), Capstone Hill -- 2013 -- 1801" / CC BY-SA 4.

Contents

1. Executive Summary

Devon Communities Together (DCT) was commissioned by Devon Public Health in April 2024 to take a community-led approach to research into barriers in accessing drug and alcohol treatment and support services in rural and coastal towns in Devon. The localities of Ilfracombe, Okehampton, Dartmouth and Dawlish were identified for particular study.

The specification for the commission was:

- Take a community-led research approach to bring together a range of stakeholders to review and evaluate a range of interventions.

- Determine what barriers the target populations have in accessing the drug and alcohol treatment services in Devon and identify a series of actions designed to break down identified barriers at a local level.

- Assess the digital accessibility of the available substance misuse treatment services (website, digital tools, communication methods) to determine if they are useful to the target population.

- Draw together and integrate the findings of other relevant work that may provide further insight into local issues.

- Work with stakeholders to develop new ways of working between agencies to address rural health inequalities with a specific focus on the challenges and barriers faced by people with alcohol or other drug dependency, or in recovery, living in rural areas.

The research methodology was co-designed by statutory and VCSE (voluntary, community and social enterprise) agencies and consisted of:

a) focus groups hosted in community venues

b) 1:1 interviews with those with lived experience of substance misuse, agencies providing treatment, community groups providing support and service commissioners

c) a review of the interviews by a panel to identify emerging themes from the research d) desk review of current theories in respect of treatments for substance misuse and examples of models of delivery from outside Devon.

The importance of the research is emphasised by the statistics of deaths from drug poisoning, which have shown an increase in Devon 2018 – 2023 (source Office for National Statistics UK).

	https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/drugmisusedeathsbylocalauthority		Deaths	Deaths	Deaths
			2021-23	2020-2022	2018-2020
SOUTH WEST			1,429	1,358	1,363
	Bath and North East Somerset		41	38	48
	Bournemouth, Christchurch and Poole		148	119	114
	Bristol, City of		163	150	151
	Cornwall		184	157	151
	Dorset		88	90	80
	Isles of Scilly		0	0	0
	North Somerset		44	38	38
	Plymouth		99	116	118
	Somerset		134	130	134
	South Gloucestershire		33	30	31
	Swindon		37	44	43
	Torbay		47	52	57
	Wiltshire		73	69	74
	Devon		201	185	176
		East Devon	30	27	24
		Exeter	57	48	49
		Mid Devon	14	12	14
		North Devon	31	25	18
		South Hams	18	23	17
		Teignbridge	20	22	22
		Torridge	14	12	15
		West Devon	17	16	17

Table 1: Source: Office for National Statistics ons.gov.uk

DCT has provided Commissioners with 3 interim research progress reports. This final report summarises the findings from the focus groups and interviews, the desk review of treatment theories and examples of delivery from elsewhere. Finally, the report makes recommendations for changes to systems and processes.

2. Key Findings

Service Gaps

Many individuals face difficulties accessing necessary services in rural Devon due to closures of local pharmacies, move to 'hub and satellite' service for rural Devon, poor digital infrastructure, and challenges in cross-boundary service registration (e.g., HALO system). Rurality exacerbates these issues, with transport barriers, digital literacy issues, and fragmented services further isolating people in need.

Co-occurring Issues

Alcohol or other drug dependency is rarely the sole challenge; it often intersects with homelessness, mental health issues, unemployment, and lack of social support. This interconnectedness suggests a need for integrated services that address multiple aspects of an individual's life.

Stigma and Eligibility Criteria

High thresholds for accessing some mental health support services, such as requiring sobriety, coupled with stigma, prevent many individuals from seeking support, especially in rural areas where lack of density in population means that people with issues are more readily identifiable. This reflects the need for more flexible and non-judgmental service offerings.

Community-Based Models Show Promise

Focusing on community-driven solutions and multi-agency collaboration presents a promising framework for addressing alcohol or other drug dependency in rural Devon. Local community groups providing vital support do not currently feature in the planning or funding of treatment and support

services. Integrating services around the needs of individuals in a specific rural or coastal location can reduce inefficiencies, streamline access, and ensure more cohesive care.

Models of delivery from elsewhere have demonstrated success in providing stable housing and resources for long-term recovery. By linking stable accommodation, and opportunities for activities within the community, with alcohol or other drug treatment services, individuals are better positioned for sustained recovery, and these principles need to be embedded in local service delivery. Discussions in focus groups highlighted the lack of temporary and social housing in rural Devon, however.

Benefits of community-based integrated support

The **interviews**, capturing stories from people with lived experience, professionals, and volunteers, have highlighted a pressing need for community-based, integrated support in both rural and coastal areas of Devon. Stories underscored the value of trusted local figures and venues in offering support and the importance of meeting basic needs before expecting recovery progress. The interviews and focus groups reaffirmed the efficacy of non-judgmental spaces and grassroots involvement in fostering recovery.

Innovative Medical Solutions

New treatments, such as long-acting buprenorphine injections, provide promising alternatives to daily methadone and can reduce dependency on pharmacies, lower the risk of infection, and improve stability. This may address some of the fallout from the closure of community pharmacies in rural areas. However, cost and implementation challenges would need to be addressed.

Establish and Sustain Community-Based Hubs

The findings from the focus groups, the interviews, the Panel discussion and the exploration of models and theories from outside Devon have demonstrated the potential benefits of establishing community-led hubs across rural and coastal Devon, ensuring these hubs are embedded in local communities. This will facilitate integrated, non-judgmental services that address the complex needs of individuals facing alcohol or other drug dependency, including stable housing, mental health support, and social integration.

Service Coordination and Access

The need to Improve coordination and communication loops between agencies was highlighted in many of the interviews. It has also shown the

lack of connection between community groups providing 'front line' support – e.g. drop ins, food and listening and agencies providing treatment. There would be benefits of greater collaboration between sectors and agencies in bringing these community groups into the commissioning process. Also highlighted was the need to resolve issues with the HALO system, particularly the increasing emphasis on data recording, 'over time more and things we need to record get added, but nothing ever gets taken off'. Ensuring cross-boundary service access and expanding electronic prescribing to streamline access to medication-assisted treatments would make it easier for people in rural and coastal areas to get the support they need without bureaucratic barriers.

Adopt a Harm Reduction Approach

Foster a cultural shift toward harm reduction, drawing on successful international models such as Denmark's drug consumption rooms, which would require central government to change legislation for this to come into effect. By reducing stigma and offering harm reduction services alongside treatment, agencies can create a more supportive environment for individuals seeking help with alcohol or other drug dependency.

Address Digital and Literacy Barriers

While online services are valuable for prevention, the report highlights that they are less effective for treatment, especially in rural areas, such as Okehampton and Ilfracombe, with limited internet access and digital literacy. Whilst the benefits of online services address some of the issues of rural geography and constrained funding, interviews and focus groups demonstrate that in-person support is essential for treatment. Commissioners should ensure that both digital and face-to-face services are available to overcome barriers of digital exclusion in rural areas.

Long-Term Funding for Local Initiatives

Providing secure, long-term funding (e.g. 3 years) to ensure the sustainability of community-based initiatives and support local operators will empower communities in rural and coastal areas to deliver effective services that are tailored to local needs, while also ensuring stability for individuals in recovery.

3. Methodology

a) Co-design meeting

Following best practice, it was agreed that the methodology for the research would be co-designed by stakeholders in the drug and alcohol treatment and support process. A co-design meeting was held in Ilfracombe in September 2024, consisting of:

- those with lived experience of alcohol or other drug dependency
- treatment and support services
- GPs
- a community group host already providing support.

The session was facilitated by a facilitator with expertise in drug and alcohol services. The co-design group decided on a methodology of a series of focus group meetings in the local areas identified, plus 1:1 interviews to identify individual experiences.

b) Focus Groups

These were promoted via the Devon Communities Together and substance misuse treatment websites with an online flyer.

Fig 1: Focus Group Promotional Flyer

In practice most people attending the focus groups were recruited through personal contact by DCT, from a database compiled to include 73 contact names in agencies and groups active in providing treatment and support services in rural and coastal Devon. Some agencies, and almost exclusively all those contacted with lived experience of alcohol or other drug dependency, preferred a 1:1 interview to attendance at a focus group. Reasons given for this included:

- feelings of stigma (those with lived experience)
- lack of trust in group confidentiality (those with lived experience)
- workload or part time employment (agency staff could not commit to 1.5 hours focus group in addition to other heavy work commitments).

Focus Groups were held in the following local areas, each session in a community venue.

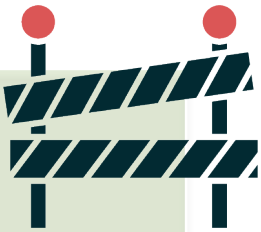
- Ilfracombe – Belle's Place
- Okehampton – Ockment Centre
- Dawlish – The Strand Community Centre

In Dartmouth, attendance by DCT researchers at a drop-in session at Dartmouth Community Café, where hot food was being served, gave rise to several 1:1 interviews with people with lived experience as well as interviews with staff and volunteers from treatment and support agencies and community groups. There was little support for attendance in addition at a focus group, so one was not held in Dartmouth.

In Okehampton, there was attendance at the focus group from Town and District Councillors, and the local well-being community café community interest company (CIC). The Dawlish Library service manager attended the Dawlish focus group.

Notes of each of the focus group meetings have been made available to Devon Public Health as part of 3 interim or 'Phase' reports that have been submitted by DCT as the research as progressed.

Summary of barriers to recovery identified in each town:



Ilfracombe

- Rise in street homelessness has risen due to Airbnb and Section 21 eviction Poor quality housing makes recovery challenges more acute
- 'Dry' supported housing where residents cannot drink or take drugs, so alcohol or other drug dependency issues very visible in the town – in playgrounds and other areas, contributing to poor reputation of Ilfracombe e.g. 'Scagfracombe'
- Lack of activities for those in recovery to engage in
- Hours that Belle's Place is open is restricted due to lack of funding
- Lack of integration between services means that those needing treatment or support 'bounce between agencies' (quote from GP in Ilfracombe)
- Treatment agencies will not see client unless they are abstinent and not using or drinking, i.e. culture of linear treatment path, rather than more realistic using/drinking occasionally but otherwise stable.

Okehampton

- Due to a cut in real terms funding to the community specialist drug and alcohol treatment service contract the experience/level of community engagement was reported to have suffered – now many in Okehampton and surrounding rural villages have to travel to Exeter to get support – 'hub and satellite' services do not work where rural transport is an issue
- Changes in provision reflect budget constraints – commissioners know that 'assertive outreach' would be best practice, but Public Health funding is linked to national deprivation stats whereby Devon is seen as prosperous and issues around rurality are not recognised
- Okehampton is seen from outside as a safe rural place (compared to Exeter) so people living with alcohol or other drug dependency travel to Okehampton to live. But lack of available social housing and other support services means rise in homelessness and rough sleeping, tent sleeping, street drinking/drug taking
- Waiting lists for treatment without other support e.g. activities and drop in facilities mean that people slip back into alcohol or other drug dependency while awaiting assessment
- Some clients/patients/community groups e.g. Library, Wellness Cafe and GP unaware of referral process – can people be referred or do they have to self-refer?
- Community group volunteers providing 'handholding in the system' e.g. Wellness Cafe, should be invited (but are not) to agency meetings. When they are invited, e.g. this focus group, they are not paid to attend so have to balance core activities – e.g. supporting people in the cafe with attending a meeting.

Dawlish

- Issue of staff turnover and filling posts in treatment services mean that consistent relationships with clients, community groups and other agencies is not sustained. New induction processes for staff being trialled may help.
- Access to services is often brokered by community groups e.g. community cafe, Foodbank, but these groups are not formally recognised as part of the treatment/recovery process
- How to get agency staff, who already have a heavy workload, to attend community venues – e.g. drop in cafes – on a regular basis

- Helpful that Recovery Navigators hold fortnightly support sessions in Dawlish (Strand Cafe room on first floor). Transport is an issue still, for clients needing to travel to Newton Abbot for assessment appointments. Rural transport may not run at a time to enable clients to meet fixed appointment times or to collect medication – need for more flexible drop-in services
- Travel vouchers are offered for probation appointments but not routinely by other agencies where fixed time appointments outside the local area are the norm
- Wider business community i.e. outside social enterprises, charity shops and foodbank, is not engaged in services or support – how to reduce stigma
- Drug landscape in rural areas is changing – now away from opioids and more synthetic drugs – Ketamine and Spice
- Lack of activities for people in recovery to take part in – noted that Waythrough's 'Flourish In Nature' project was funded outside the commissioning process.

Dartmouth (no focus group held. Key barriers specific to Dartmouth identified in interviews with agency staff, community volunteers and people with lived experience).

- Need far outstrips provision. Dartmouth has 11 bed hostel but this does not cover the housing need or needs for support and treatment
- Complex issues –not just drugs and alcohol, it's food, housing, mental health too
- Difficult to get health agencies to commit to come to community venue to offer advice and support – community support may organise for someone needing help to turn up on a particular day at a particular time, but then the agency cancels due to workload or other priorities – need for outreach policies within agencies working in rural and coastal areas and expectation of outreach within the commissioning process to enable consistent attendance
- Transport is key issue – affordability, but also availability, especially for people living in villages where there is poor or no public transport
- Lack of private space in community venue, so agency staff such as Recovery Navigators have to go for a walk with clients to talk
- Competition in community groups locally for funds e.g. warm space grants this winter and last winter. Community volunteers spend lots of time in

applying for grants that could be better spent in providing services, so very difficult to plan provision longer than the grant time span

- Monday and Friday drop-in service at a trusted space such as community hub where hot food, advice and companionship is offered and where agencies can come to meet clients – by appointment and in drop in – is the best way to offer whole person support.

c) 'Most Significant Change' (MSC) 1:1 Interviews

These were also chosen by the Co-Design group as part of the research methodology.

The MSC interview process involves participants sharing personal stories of change collected and interpreted.

The provisional wording of the domain of change chosen by the Co-Design group *was:*

> ***"What change (in the past 2 years) have you experienced in the support provided for people using drug and alcohol treatment and recovery services?"***
>
> This could be a personal revelation/moment of clarity, an organizational change or service provided – or other. This first question was extended, over the interview process to include ***"Why has it changed" and "Why is that change important?"***.

For the MSC process, the interviews, or 'stories' are then filtered through various stakeholders in a Panel until the stories that represent the most significant or important changes in rural areas are selected by the Panel. These selected stories are the ones that best represent the types of issues and outcomes that the research identified.

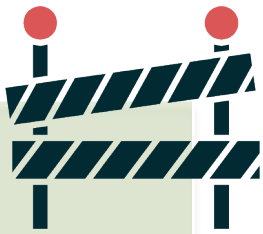
DCT carried out 22 1:1 interviews/stories using this MSC methodology – 16 with people with lived experience of alcohol or other drug dependency and 8 with staff of agencies. All the 4 local rural and coastal areas – Ilfracombe, Okehampton, Dartmouth and Dawlish were covered. The 22 stories were then sent to the Panel for study, before discussion in a Panel meeting in February 2025. The 5 members of

the Panel included someone with lived experience, someone from the commissioning agency and two people from community groups. The Senior Commissioner of Devon Public Health, whilst being unable to attend the Panel meeting, also studied a 'story pack' of the 22 stories and gave his views to be added to the Panel's discussion.

d) Examples of Successful Models of Treatment and Support outside Devon

This was undertaken as a desk review process. See Section 6.

4. Key Barriers to Accessing Services - Identified in 3 Focus Groups and 22 Interviews



Lack of collaboration between agencies

Drug and alcohol issues are often complex and involve several agencies e.g. mental and physical health, housing, pharmacy, police - collaboration is difficult when services are under pressure.

Work pressures

All focus groups agency attendees highlighted work pressures and the hefty amount of administration necessary to evidence activity against targets. Although Police staff were invited to each of the focus groups and to give 1:1 interviews, in practice this only proved possible in a 1:1 interview in Dartmouth. Example: social prescribers and other treatment and support services linked to GP surgeries are heavily over-subscribed and with long waiting lists.

Poor Retention of agency staff

Projects providing support to those who misuse drugs and alcohol are often annual or short-term funded- so difficult to know what services are operating where, or whether they are still operating. Staff 'churn' makes it difficult to sustain relationships with individuals or groups in local areas. Example: staff from Together/Waythrough providing services in Okehampton did not know of the existence of the Well-Being Café which is a hub and drop-in centre for people who

are homeless or rough sleeping as well as those with mental health, or alcohol or other drug dependency issues.

Lack of co-ordination between service providers

There is a need for greater integration of information and support and feedback to other NHS treatment services e.g. GPs on client progress. It is the perceived wisdom that treatment services prefer clients to self-refer to show motivation, but they lose confidence and momentum with long waiting lists or no response to messages left on answerphone.

Lack of funding for place-based low-level support in community spaces - e.g. warm space/drop in

This was mentioned at each of the focus group sessions. Community groups providing informal, inclusive, drop in or well-being services such as a community café (food being the initial draw) feel that their contribution is ignored, or not valued, as it is not considered to be part of the treatment and support commissioning process. They have to rely on short term and project funding which takes lots of time and effort to source through fundraising.

Transport Difficulties

Lack of bus services or other transport to bring people needing help to attend appointments and group sessions – vouchers needed. Example: Only Probation services and Housing services routinely give out vouchers for clients to attend appointments.

Lack of 'drop-in for information' services

All focus groups highlighted that people may not be able to access online information due to poor broadband connectivity, poor mobile signal or not being organised enough to attend timed appointments. Need for more flexible drop-in arrangements in trusted spaces where people can have access to accurate information about services available locally – or as local as they can be given the move to 'hub and satellite' treatment services in rural Devon. Examples: Dawlish Library service has no information currently about how to refer enquirers (those with alcohol or other drug dependency issues or their families) to local treatment services. GP in Okehampton described a lack of general publicity about prescription medication abuse.

Literacy, including Digital Literacy

Seen as a barrier to accessing online support. It was noted at the Dawlish focus

group that online information may be effective for prevention and general information – as long as it is kept up to date and local as well as national services are highlighted. It may be less effective as a method of accessing treatment.

Community pharmacies under pressure, closing or changing opening times
Clients unable to keep to the agreements with pharmacies about when to pick up medication. During periods of austerity community pharmacies witness an increase in shoplifting.

5. Online Resources and Support

As part of the commission specification, DCT was asked to assess the digital accessibility of the available substance misuse treatment services (website, digital tools, communication methods) to determine if they are useful to the target population.

Offering alcohol or other drug treatment support online has several advantages and disadvantages.

Pros:

- **Accessibility**: Online support allows individuals to access help from anywhere, making it easier for people in rural or underserved areas to get the help they need.
- **Convenience**: People can receive support at any time, fitting sessions into their schedule, which can be especially important for those with busy lives or conflicting responsibilities.
- **Anonymity**: Many individuals may feel more comfortable discussing their struggles with alcohol or other drug dependency online due to the perceived anonymity, which could encourage more people to seek help who might otherwise avoid in-person treatment.
- **Reduced stigma**: Some people may feel ashamed or embarrassed to seek face-to-face help. Online platforms can provide a less intimidating environment, reducing the social stigma associated with alcohol or other drug dependency.

- **Cost-effective**: Online services can be less expensive than traditional in-person treatments, both for the provider and the person seeking help. This can increase the affordability and availability of online services.

- **Flexibility in format**: Online alcohol or other drug dependency support can take many forms, including one-on-one therapy, group counselling, forums, or self-help resources, offering multiple ways to receive support.

- **Continuous access to resources**: Online platforms can provide ongoing access to educational resources, coping strategies, and support groups, helping individuals to maintain progress in their recovery.

Cons:

- **Limited personal connection**: Some individuals may miss the face-to-face interaction and personal connection that in-person therapy or group support offers, which can be essential for building trust and emotional rapport.

- **Technical barriers**: Accessing online support requires a reliable internet connection and familiarity with technology (digital literacy), which could be a barrier for some individuals.

- **Lack of immediate crisis intervention**: Online platforms may not be equipped to handle emergencies or severe crises, such as overdose situations, which can be managed more effectively in a traditional in-person setting.

- **Confidentiality risks**: While online platforms often have security measures in place, there's always a potential risk of privacy breaches or hacking, especially if users are not vigilant about securing their personal information.

- **Limited support for physical symptoms**: Alcohol or other drug dependency recovery may involve physical symptoms or withdrawal, which may require medical attention that cannot be provided online.

- **Less accountability**: The anonymity of online services might reduce the sense of responsibility or accountability for individuals who might not take their recovery as seriously as they would in a face-to-face setting.

- **Potential for superficial engagement**: Online support can sometimes feel less immersive or comprehensive, leading to users engaging less deeply with the process than they might in person, possibly hindering their recovery progress.

- ✗ **Out of date or confusing information**. For example, is it 'Together' as many still call the service, or 'Waythrough' as it now is, following merger? It is easy to become confused – both in searching for information and as an information provider – e.g. GP or Library service, as described in the focus groups and 1:1 interviews.

- ✗ **Information is restricted to treatment or counselling services** – it provides no information on, and is not integrated with, community-based services such as community cafés or voluntary/community or social enterprises which may be able to offer support and social interaction.

Online support for alcohol or other drug dependency can provide significant convenience and accessibility for some users and it is a cheaper way of providing information and some support in rural areas in Devon. But it may lack some of the personalised care, sense of being part of a community and immediate assistance offered through traditional, in-person therapy. The effectiveness depends on the individual's needs and preferences, as well as the structure and quality of the online support platform and how it integrates with other information and support services.

The discussions in the rural and coastal area focus groups and interviews for this research in Devon highlighted particularly the importance of social interaction, group activities in the local community and in-person support as well as difficulties in accessing information about local services due to problems with literacy or digital literacy. Agencies where people may go for online information highlighted the difficulties of keeping information current and up to date.

6. Most Significant Change – Results of MSC Panel Discussion Feb 2025

As part of the Most Significant Change (MSC) process, the panel reviewed the 22 collected interviews (stories) to identify key themes and selected 3 stories that best illustrated the challenges and successes in supporting people with alcohol or other drug dependency in rural Devon. The chosen stories were those that resonated most strongly with the panel and encapsulated the core barriers, solutions, and community responses discussed.

The panel chose 3 stories that exemplified key themes from the MSC stories pack they had studied:

A ‘pen picture’ of the 3 representative stories selected by the Panel:

Story 1. A mother in her 80s supporting her middle-aged son through his long-term alcohol or other drug dependency, highlighting the strain on families and the lack of structured support for carers.

> ***“In many respects there has been no change for her. Her son feels he ruins other people’s lives… She doesn’t feel as if she needs support in doing what she does. It is just what you do as a parent.”***

Story 2. Showcasing the power of grassroots, community-led support models. ***"We want people who come with humility not a lanyard."*** The importance of providing a space where people feel safe and supported, reducing stigma and improving engagement with services.

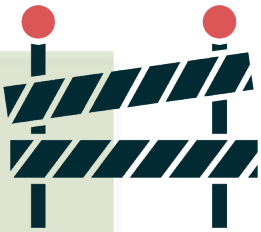
Story 3. A homeless person with alcohol or other drug dependency who managed to access support through the kindness of individuals, underlining the importance of small acts of assistance from individuals in overcoming structural and barriers.

> ***“It wouldn’t have happened without the support and kindness of 2 people – first the worker in the supermarket, who knew he was shoplifting and gave him food, then signposted him to the food bank where another person helped him register as street homeless so he could get food and go into the system.”***

The key themes chosen by the panel from the MSC stories can be summarised as:

- **The impact of alcohol or other drug dependency on family and significant others**
- **the vital role of community-led support**
- **the challenges of navigating services**
- **the importance of informal networks in helping people access structured assistance – if they have the correct, up to date information.**

In the panel discussion that followed story selection and themes, other key issues were highlighted that, in the panel's view, need to be addressed:



Transport Barriers: Rurality, lack of transport links and transport costs make accessing treatment and support difficult; solutions such as travel vouchers could help.

Lack of Coordination between agencies: People often struggle to find the right support due to fragmented service networks.

Changing Drug Trends: An increase in synthetic drugs, accessed often online requires more adaptive treatment pathways.

Community-Led Solutions: Non-judgmental spaces should be supported in rural and coastal areas, like community hubs and cafés, where food and other services are available to create new social links, reduce stigma and build trust.

Support Gaps for Men 20-65: This group often falls outside traditional support structures, especially in rural areas where stigma and lack of confidentiality may be more of an issue and so these men are reluctant to come forward for treatment.

Workforce Stability: High staff turnover and workload in treatment agencies prevents meaningful long-term engagement.

Panel Recommendations

The panel considered actions that could be taken *without additional funding* and recommended the following:

- **Peer-to-Peer Support:** Encouraging people with lived experience of alcohol or other drug dependency to volunteer as a stage in their recovery, supporting activities around well-being
- **Sustaining the Community Hub/Café Model:** finding smart, low-cost ways within commissioning processes to support community spaces that already serve as informal service hubs, particularly those that offer drop-in models where people can get support pending assessment for treatment services.
- **Engaging the Wider Community:** encouraging businesses and organisations e.g. libraries, well-being cafes, community centres, to be aware of available online and in-person support so they can direct people in need.

The panel concluded that focusing on **community-driven support models and better coordination between services** would make the biggest impact in tackling alcohol or other drug dependency in rural and coastal Devon.

7. Theories and Treatment Delivery Models outside Devon

The specification of the commission required DCT to research alcohol or other drug dependency recovery theories and models from outside Devon.

When examining barriers to accessing alcohol or other drug treatment services in rural Devon, various theoretical frameworks and delivery models can provide valuable insights into the issue. Desk research into these frameworks highlighted relevant aspects of Recovery Capital, Housing First Theory, Total Place Theory, Community Reinforcement Approach, and comparative attitudes towards alcohol or other drug dependency in Denmark and Sweden and Asset Based Community Development as an approach to developing resilient and sustainable communities, more able to support individuals in their recovery journeys.

Recovery Capital

This theory, widely used in Canada, refers to the internal and external resources that individuals can draw on to support their recovery from alcohol or other drug dependency. This theory suggests that access to 'recovery capital', such as social support, stable housing, financial resources, and community connections, can greatly enhance the chances of successful recovery.

As shown above in the 'Key Barriers to Accessing Services' section, in rural Devon the lack of access to these resources presents a significant barrier to individuals seeking treatment. Limited social support networks, isolation due to geographical remoteness, and fewer opportunities for employment or training may hinder individuals from accessing or sustaining recovery services. Research indicates that a community-centred approach, leveraging local assets to build recovery capital, can be crucial in overcoming these barriers.

Community Reinforcement Approach (CRA)

A key component of Recovery Capital is the **Community Reinforcement Approach (CRA)**, which focuses on using positive reinforcement to promote sobriety and build a fulfilling life. CRA involves strengthening relationships, improving vocational

skills, and increasing participation in community activities. In rural areas like Devon, where social isolation and limited community engagement can be barriers, CRA can be particularly beneficial. This approach helps individuals rebuild social networks and engage in meaningful activities that promote long-term recovery. By focusing on reinforcing positive behaviours and enhancing the individual's community connections, CRA can support people in recovery by building both their personal and recovery capital, addressing one of the key limitations in rural settings. The importance of these social networks and meaningful activities to individuals in the recovery journey was highlighted again and again in the focus groups and interviews in the DCT research.

Housing First

Housing First is a theory that prioritises providing stable, permanent housing to individuals with substance use disorders before addressing other issues, such as employment or treatment. This approach has been shown to be effective in improving outcomes for people with chronic homelessness and alcohol or other drug dependency in UK, Ireland and in Finland.

The most basic principle of Housing First is that housing is a human right and should be the starting point of supporting a person to recover from other issues such as poor mental health or physical health. Under Housing First there is no requirement for the homeless person to be 'housing ready' or have addressed their alcohol or other drug dependency before moving to a permanent home. Health and alcohol or other drug dependency problems are addressed after housing has been secured and intensive, open-ended support is provided to help the person maintain their tenancy

In rural areas like Devon, the lack of affordable social housing and limited access to specialist alcohol or other drug treatment services may exacerbate the difficulties people face in achieving recovery. One model In North Devon, the Freedom Centre combines the Housing First approach with an integrated multi-agency support service through their Day Centre. Housing First could be a promising strategy for other rural areas of Devon, but the absence of adequate social housing infrastructure presents a challenge. Implementing Housing First principles would require collaboration between local authorities and alcohol or other drug treatment services to ensure that housing availability aligns with recovery needs.

Total Place Theory

Total Place Theory focuses on the integration of services across a geographic area, promoting a holistic, place-based approach to addressing social problems. In rural Devon, fragmented service delivery and the hub and satellite model can exacerbate

the challenges faced by individuals seeking help for alcohol or other drug dependency. By adopting a Total Place approach, services for alcohol or other drug dependency could be better coordinated, ensuring that they are accessible, responsive, and tailored to local needs. This theory emphasises that integrated service delivery encompassing health, social care, and community support, could help reduce the barriers caused by fragmented service provision in rural communities.

The Total Place initiative, piloted in the UK, focuses on a 'whole area' approach to public services, aiming to identify and eliminate overlaps and inefficiencies by fostering collaboration among local agencies. This model has been applied to various social issues, including substance misuse, by integrating services around the needs of individuals and communities. While not universally adopted, its principles have influenced the development of community-based support structures across the country and in Scandinavia. It could be argued that Ilfracombe's Belle's Place is an example of Total Place in Devon.

A comparative study of **Denmark and Sweden** treatment models reveals differences in the attitudes towards alcohol or other drug dependency and recovery. Denmark's more harm-reduction-focused approach contrasts with Sweden's abstinence-based model. Denmark's pragmatic stance on alcohol or other drug dependency, focusing on reducing the negative consequences rather than insisting on total abstinence, has led to greater access to services and a more supportive environment for individuals struggling with alcohol or other drug dependency. In contrast, Sweden's stricter policies may contribute to stigmatization and less access to recovery services.

Understanding these differences can inform the development of services in rural Devon, particularly regarding how attitudes towards alcohol or other drug dependency shape access to and the effectiveness of support services as well as enhancing or lessening a culture of shame, blame or stigmatisation.

Asset Based Community Development

Fig 3: ABCD poster Bristol City Council

Asset Based Community Development (ABCD) is an approach to sustainable community-driven development. It builds on the assets that are found in the community and mobilises people, institutions, businesses and associations to come together to realise their strengths and build on the assets they discover and the connections they make whilst mapping their assets that makes the community, and the individuals within it, stronger.

The ABCD approach has been widely discussed and utilised as a way of developing individual and community resilience by building connecttions.

References for the above approaches:

1. https://www.sigmundsoftware.com/blog/what-is-recovery-capital/
2. https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-024-01035-5
3. https://www.cih.org/media/xkifc4kx/cih0220-pdf-bhousing-firstrv13112017-final.pdf
4. https://www.nurturedevelopment.org/asset-based-community-development

Combining Total Place Theory and Asset-Based Community Development (ABCD) Theory could be a **powerful approach** to community development, supporting those on the recovery journey from substance abuse and connecting them back into the community.

Benefits of Combining Approaches

 **Holistic Approach**

- Total Place focuses on service integration and efficiency, which can streamline how public services are delivered.
- ABCD emphasizes utilizing community assets and fostering self-reliance, which empowers local residents.
- Combining these can create a comprehensive strategy that ensures efficient service delivery while also harnessing and building on community strengths.

 **Increased Community Engagement**

- ABCD's focus on community assets and local participation ensures that residents are actively involved in shaping their future.
- Total Place can benefit from this engagement by aligning service delivery more closely with community needs and priorities, making services more relevant and effective.

 **Resource Optimisation**

- Total Place looks at optimising resources across services.
- When combined with ABCD, communities can better identify and mobilise local resources (such as skills, networks, and facilities), leading to a more efficient use of both formal and informal resources.

 **Enhanced Sustainability**

- ABCD builds community capacity and resilience, which can lead to sustainable, long-term development.
- Total Place's efficiency focus ensures that these sustainable efforts are supported by well-coordinated services, making them more resilient to changes in funding or policy.

 **Improved Outcomes**

- The integration of Total Place and ABCD models can lead to improved social outcomes as services are better coordinated to meet individual needs - and communities are more engaged and empowered to address their own challenges.

Implementation Considerations

- **Balancing Top-Down and Bottom-Up Approaches:** Ensure that the top-down efficiency of Total Place complements the bottom-up empowerment of ABCD without undermining the community's initiative.

- **Collaboration:** Strong collaborative frameworks between public service providers and community groups are essential to make this integration work.
- **Adaptability:** Both Total Place and ABCD theories need to be adapt to the specific context of each community, considering its unique challenges and strengths.

By blending the efficiency of Total Place with the empowerment of ABCD, communities can create a more integrated and inclusive development process that is both effective in developing recovery capital and sustainable in terms of personal and community development.

5. Recommendations

These recommendations aim to provide commissioners in Devon Public Health with actionable steps to improve access to alcohol or other drug treatment, fostering a more inclusive and effective service delivery model that aligns with the principles of Total Place, Housing First, Recovery Capital, and ABCD.

Formalise the 'Total Place with ABCD' model on a 'pilot, test and learn' basis

Expand and secure funding (3 years) for **community hubs** in areas like Ilfracombe (Belle's Place and Dartmouth (these are most mature and established), focusing on local ownership and integrating the key community 'owner' group into the commissioning process. Integrate Asset-Based Community Development (ABCD), and services (housing, mental health, debt, primary health, employment, alcohol or other drug treatment).

Hub Expansion: Develop new hubs in Okehampton and Dawlish to enhance access and create a network of local, trusted, non-judgmental spaces for individuals to seek support.

All these hubs should integrate Total Place, Housing First, Recovery Capital and ABCD principles, ensuring stable accommodation and long-term recovery community-led resources.

The above projects should be supported on a 'test and learn' basis so that the lessons learned in each locality could be evaluated and shared with other community hubs.

Focus on Community Leadership

Local individuals, trained and supported, should lead the hubs to build trust and engage with people from the community. These hubs should foster peer support networks and offer essential services, such as food, healthcare, and social engagement.

Improve Service Coordination and Access

HALO System and Cross-Boundary Services: resolve the technical issues with the HALO system and expand electronic prescribing (4)(5) to facilitate better access to medication-assisted treatments. This will ensure that people in rural Devon can access necessary treatments without undue bureaucratic barriers.

Enable Greater Integration of Services

Services should be more integrated, reflecting the interconnectivity of alcohol or other drug dependency with other social issues (housing, mental health). Encourage agencies to work together to create coordinated pathways to recovery that meet multiple needs simultaneously.

Promote Harm Reduction and Housing First Approaches

Following successful international models like Denmark's drug consumption rooms (this would require central government to change legislation for this to come into effect) and Sweden's harm reduction strategies, commissioners should encourage policies that reduce stigma and focus on practical harm reduction. This approach will create a safer environment for individuals to engage with services and seek

support. Aim to secure funding and policies to offer stable accommodation first, creating a foundation for recovery. Housing should not be conditional on sobriety; instead, it should be a part of an integrated recovery model that prioritizes a safe living environment.

Address Digital and Literacy Exclusion

While online services are valuable for prevention, the report highlights that they are less effective for treatment, especially in rural areas with limited internet access and digital literacy. Increasing face-to-face support and building digital literacy through local hubs and outreach programs will help bridge the gap. Online information should be consistent and kept current. Key community hubs e.g. libraries where people living with alcohol or other drug dependency and/or families may go for support should have training and support to ensure that the information they give out on their websites is current.

Make Long-Term Investment in Recovery Capital and Sustainability of Support Networks

Invest in the broader Recovery Capital infrastructure, including social, human, and financial capital. Support individuals through structured activities, community groups, and employment opportunities. This approach recognizes that recovery is a long-term process supported by the community, and it requires sustained effort and resources.

By integrating these models and focusing on community-based solutions, the report points to a more effective, flexible, and compassionate system for people with alcohol or other drug dependency in rural Devon. These recommendations should empower commissioners to make decisions that prioritise long-term recovery, local community engagement, and holistic support for those in need.

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