



REPORT TO: HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 17 DECEMBER 2019

REPORT ON: DUNDEE DRUGS COMMISSION REPORT – RESPONDING TO DRUG USE WITH KINDNESS, COMPASSION AND HOPE

REPORT BY: CHIEF OFFICER

REPORT NO: DIJB55-2019

1.0 PURPOSE OF REPORT

1.1 To inform the Integration Joint Board of the response to the recommendations presented by the Dundee Drugs Commission and present the action plan developed to support the progress for change.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

- 2.1 Notes the contents of the Dundee Drugs Commission Report – Responding to Drug Use with Kindness, Compassion and Hope – as attached at Appendix 1.
- 2.2 Notes the specific areas for improvement for the Dundee Health and Social Care Partnership as detailed in Paragraph 4.1.5.
- 2.3 Notes the attached action plan developed by the Dundee Alcohol and Drugs Partnership to address the recommendations in response to the Dundee Drugs Commission Report as attached at Appendix 2.

3.0 FINANCIAL IMPLICATIONS

3.1 The response to the Dundee Drugs Commission Report will be funded from current resources available to the Dundee Community Planning Partnership, the Dundee Alcohol and Drug Partnership and the Dundee Health and Social Care Partnership. This includes additional funding from the Scottish Government to support Alcohol and Drug Partnerships.

4.0 MAIN TEXT

4.1 Background

4.1.1 The Dundee Alcohol & Drugs Partnership (ADP) were concerned regarding the level of deaths within the city as a result of substance use. This was further highlighted by the increasing public interest and media coverage in relation to issues associated primarily with the impact of drug misuse and the response of services in Dundee. These included public concerns regarding disturbing images of the impact of drug use on individuals, families and communities; access to and experience of treatment and support services and the continuing rise of drug related deaths.

4.1.2 The Independent Drugs Commission (the Commission) was established in April 2018 by the Dundee Community Planning Partnership in order to:

- To consider the nature, extent and impact of drug misuse and drug deaths in Dundee;
- To identify and investigate the key causes and consequences of drug misuse and drug deaths for individuals and their families along with policy and practical measures to address these;

- To seek the views and involvement of all relevant local stakeholders including individuals with lived experience;
- To assess the effectiveness of the strategic planning and delivery of services co-ordinated by the Dundee ADP and across community planning partners;
- To consider evidence of what has worked elsewhere, including approaches to achieve prevention and recovery;
- To prepare a report for the Dundee ADP and its partners on additional priorities for practical and achievable action to tackle and reduce substance misuse and drug deaths in the city.

4.1.3 The Commission used a range of methods to gather evidence, information and views, including the views of those with lived experience and their families. It considered evidence of what works elsewhere to respond to drug use and drugs deaths, including prevention and recovery approaches. Overall, the Commission focused on four main themes:

- Leadership and Governance
- Drugs Deaths
- Treatment & support
- Mental Health

4.1.4 The Dundee Drugs Commission Report – *Responding to Drug Use with Kindness, Compassion and Hope* was published in August 2019. The report was published in three parts and presents 16 recommendations focusing on issues relating to leadership, stigma, treatment and support, drug related deaths, the protection of children and young people and mental health. The recommendations are presented under three headings, including:

- Culture and systems;
- A holistic system model – including integrated Primary Care Provision;
- Causes and effects of drug use.

A copy of the report is attached at Appendix 1.

4.1.5 The Commission made a number of observations and recommendations relating directly to the services delivered through the Dundee Health and Social Care Partnership:

- Dundee should develop a shared care model and ensure general practice is part of the whole-system approach;
- There should be more choice in the available services, including residential rehabilitation;
- Dundee should develop a new Community Pharmacy model;
- There should be full integration of mental health and substance misuse services.
- There should be the adoption of a gendered approach to all the improvement work and ensure that the specific needs of women affected by drug use are considered and addressed.
- Integrated substance use services should be delivered as part of a whole-system approach;
- There should be improved retention in services (including ‘no unplanned discharges’) and more outreach work;
- There should be a system for same-day prescribing of opioid replacement therapies.

4.2 Response to the Dundee Drugs Commission Report

4.2.1 The Dundee Partnership accepted the report from the Commission and is committed to implementing the recommendations. Responding to the Commission’s report, Chief Officers and Elected Members expressed a commitment to progress whole-system improvements, including better leadership and better engagement with all those affected by drug use, and specific actions to bring about a culture change. There was recognition that significant improvements will take time but that every opportunity for early and quick gains will be embraced. There was also a commitment to change the governance structure of the ADP to increase scrutiny and accountability.

4.2.2 To provide an opportunity for discussion about the recommendations from the Commission and to consult on an early draft plan, a Dundee Community Forum Conference (the Forum) was held on the 23rd October 2019. 132 delegates attended the Forum, including community representatives, individuals with lived experience and family members, staff from a range of statutory and third sector services, Elected Members and members of the Commission. Presentations on the day from Commission members highlighting some key issues, including:

- The need for Dundee to address stigma and language issues;
- The increase in the availability of Gabapentin and Pregabalin;
- Links to poverty and mental health;
- The need for meaningful involvement of those with lived experience; and
- The need to develop an 'open door' access to services.

4.3 Developing a Multi-agency Action Plan for Change

4.3.1 To improve the effectiveness of the work of the ADP, Simon Little, Independent ADP Chair has conducted a governance review of the ADP. The revised governance structure of the ADP will take a leading role in developing, progressing and monitoring the actions for change. To effect the change the following has been implemented:

- Membership of the ADP has been strengthened, including additional representatives from Primary Care and Community Pharmacies;
- ADP membership will now include members with lived experience, including a carer;
- An ADP Implementation Group has been set up to replace the current Alcohol and Drug Strategic Planning Group. The implementation Group will be chaired jointly by Diane McCulloch, Head of Health and Community Care, Dundee Health and Social Care Partnership and Eric Knox, Chief Executive, Dundee Voluntary and Volunteer Action;
- Five workgroups will deliver the strategic actions and lead on the specific elements of the development and progress of the plan for change. The work-streams include the Drug Death Action Plan, Whole System of Care, Children and Families, Prevention and the Resilient Communities. The work-stream leads will be members of the Implementation Group, which in turn will report to the ADP.

4.3.2 A draft action plan was developed which set out the actions to be taken to implement the recommendations contained within the Commission report; this has now been approved by the Dundee Partnership. The actions will be managed through the five work streams and will support the implementation of the wider strategic work of the ADP. The action plan is attached at Appendix 2.

4.3.3 The Dundee Partnership will provide an overall responsibility for reviewing the progress of the plan, and other elements of the partnership will take a role in progressing the actions.

4.4 Progress to date

4.4.1 The ADP and the Dundee Partnership are committed to focus on a number of key areas, and have commenced work to meet the recommendations including:

- Improving the response to all non-fatal overdoses in Dundee to ensure contact is made within 72 hours with all known individuals that have experienced a non-fatal overdose. Multi agency work is already underway to develop, test and embed this new approach;
- Increase the assertive outreach – including a test of change through the Integrated Substance Misuse Service to follow up on people who disengage;
- Progressing with options for same-day prescribing the substance misuse services; moving to deliver services from different localities within Dundee and to increase the prescribing capacity;
- Dundee has volunteered to be an early adopter of the Scottish Government pilot to develop a joint mental health and substance misuse approach.

5.0 POLICY IMPLICATIONS

5.1 This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	The Drugs Commission Report set out 16 recommendations to support people who use substances and to support the reduction of the number of people who die as a result of substance use. The changes described within the report will require significant cultural change and a wholesale redesign of the models of service delivery. There is a risk that without sufficient levels of financial and other resources, the pace of change required will not be met.
Risk Category	Financial, social
Inherent Risk Level	Likelihood 4 x Impact 5 = 20
Mitigating Actions (including timescales and resources)	The implementation of the action plan developed will be closely monitored through the ADP. The strategic commissioning of future services and the redesign programme will developed in line with the commission recommendations Resources to support the change programme will be developed in line with available resources.
Residual Risk Level	Likelihood 3 x Impact 5 = 15
Planned Risk Level	Likelihood 2 x Impact 5 = 10
Approval recommendation	Approve the report.

7.0 CONSULTATIONS

7.1 The Chief Officer, Executive Director of Corporate Services (Dundee City Council), Interim Director of Finance of NHS Tayside and the Clerk were consulted in the preparation of this report.

8.0 DIRECTIONS

8.1 The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working)(Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	Direction to:	
	1. No Direction Required	X
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

9.0 BACKGROUND PAPERS

9.1 None.

David W Lynch
Chief Officer

DATE: 17 December 2019

Vered Hopkins
Lead Officer, Protecting People

Diane McCulloch
Head of Health and Community Care

Simon Little
Independent Chair, Dundee Alcohol and Drugs Partnership

2019

Responding to Drug Use with Kindness, Compassion and Hope

A report from the Dundee Drugs Commission

PART ONE – THE REPORT

Presented to the Dundee Partnership

**FOR FURTHER INFORMATION
PLEASE CONTACT**

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COMMISSION MEMBERS

Dr Robert Peat (Chair, Former Director of Inspection, Care Inspectorate and former Depute Chief Executive and Director of Social Work and Health with Angus Council)

Prof Alex Baldacchino (Consultant Addiction Psychiatrist, Fife)

Sharon Brand (Recovery Dundee)

Dr Andrew Fraser (Director of Public Health Science, NHS Health Scotland)

Prof Eilish Gilvarry (Consultant Addiction Psychiatrist, Newcastle)

John Goldie (Former Head of Addictions, Glasgow Addiction Service)

Cllr Kevin Keenan (Leader of the Labour Group on Dundee City Council)

Eric Knox (CEO, Volunteer Dundee)

Dave Liddell (CEO, Scottish Drugs Forum)

Jean Logan (Associate Director of Pharmacy, NHS Forth Valley)

Cllr Ken Lynn (Vice Chair, Dundee Health and Social Care Integration Joint Board)

Suzie Mertes (Superintendent, Police Scotland)

Justina Murray (CEO, Scottish Families Affected by Alcohol and Drugs)

Prof Niamh Nic Daeid (Director of the Leverhulme Research Centre for Forensic Science, University of Dundee)

John Owens (Independent Chair of Argyll & Bute ADP)

Dr Tessa Parkes (Research Director, Salvation Army Centre for Addiction Services and Research, University of Stirling)

Hazel Robertson (Head of Services for Children, Young People and Families, Perth & Kinross Council)

Jardine Simpson (CEO, Scottish Recovery Consortium) and his predecessor (**Kuladharini**)

Pat Tyrie (Family Member)

Maureen Walker (Family Member and member of the Lifeline Group)

COMMISSION FACILITATOR AND LEAD CONTACT FOR REPORT

Andy Perkins Director (Figure 8 Consultancy) – c/o The Signpost Centre, Lothian Crescent, Dundee, DD4 0HU. ✉ andyperkins@f8c.co.uk 🌐 www.f8c.co.uk

FIGURE 8 RESEARCH AND SUPPORT TEAM MEMBERS

Kevin Gardiner (Research Assistant)

Trevor McCarthy (Associate Consultant)

Jennifer Turnbull (Business Administrator and Commission Secretary – until January 2019)

COMMISSION STEERING GROUP

The Chair of the Commission (Robert Peat) and the Commission Facilitator (Andy Perkins) were assisted by a small steering group (below), who provided guidance and support. This group met on six occasions. The Commission are grateful for the advice and support they provided.

Peter Allan (Community Planning Manager, Dundee City Council)	Vered Hopkins (Protecting People Lead Officer, Dundee Protecting People Team)
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NOTE: Simon Little was a member of the Drugs Commission until January 2019 when he resigned his position to take up the role of independent Chair for the Dundee Alcohol and Drugs Partnership.

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Reports

This Part 1 report is the main report of the Dundee Drugs Commission. There are two accompanying (Appendix) reports which contain all the supporting evidence collected over the course of the Commission in a set of 22 Appendices:

- Part 2 – Supporting Evidence – Background (contains Appendices I – IX)
- Part 3 – Supporting Evidence – Fieldwork (contains Appendices X – XXII)

Disclaimer

This report contains the views of members of the Dundee Drugs Commission who also took into account data, intelligence, evidence and views from invited participants and experts as well as over a thousand people who have responded to the Commission's calls for evidence. The members do not speak on behalf of any organisation but rather express their own conclusions following evidence from these and many other sources. The report is not intended to reflect the entire breadth of the discussions that have taken place over the last year but, instead, is a distillation of the many and varied contributions that have been made.

It is not the intention of this report to cast aspersions on any individual, but rather to help identify where systems and services are not working as they should in order to help identify realistic and workable solutions. Any identifying information about individuals has been removed to protect anonymity and confidentiality. Permission was sought from all individuals who contributed evidence to the Commission on the basis that responses would be anonymised.

For details of the Commission members (see **Appendix I** in the **Part 2 – Supporting Evidence – Background** report), as well as those who attended and contributed to the discussions (see **Appendices XI, XIII-XXII** in the **Part 3 – Supporting Evidence – Fieldwork** report) in the Supporting Evidence report.

Acknowledgments

The Commission would like to place on record its grateful thanks to all the individuals and organisations who have given evidence to the Commission – often requiring great courage to recount difficult and painful experiences.

The Commission would also like to express its thanks to the wide variety of speakers who gave up their time to prepare and present to the public meetings of the Commission. These sessions provided a wealth of valuable information and insight – without which the Commission's report would be incomplete.

Finally, the Commission would like to acknowledge the time and input from the team (Christian Cole, Emma Corrie, Harry Gray and Joyce Klu) at the Leverhulme Research Centre for Forensic Science (University of Dundee) who have produced the primary analysis of the 'deeper dive of drug-related death data' which was commissioned from ISD Scotland (see **Appendix XII** in the **Part 3** report).

1. FOREWORD – BY THE CHAIR OF THE COMMISSION



The wellbeing of Dundee is significantly affected by the use of drugs. The Dundee Partnership made a courageous decision to set up an independent Commission to consider the nature, extent and impact of drug use, and to look at drug-related deaths. We started our work in May 2018, and since then we have heard from, or spoken to, over a thousand people.

It is well known that the factors which can lead to a person becoming involved in the use of drugs are complex. It may be the result of adverse childhood experiences or other traumatic events. Drug use can have devastating consequences for individuals, families and the wider community and we have seen a growing number of drug-related deaths in Dundee and across Scotland. It is only by working in a consistent, combined and coordinated manner that the complex nature of drug use will be successfully addressed. Every life is precious and every death matters. It is with these thoughts at the forefront of our minds that we have taken forward our work.

The Dundee Partnership has clearly recognised the need to address poverty and other issues of inequality. These issues relate closely to drug use. We heard from too many people about the failings of the current system of support and care provided in Dundee. The current system is fractured. We heard heart-breaking stories from families and friends bereaved by a drug-related death. We heard many stories of the difficulty of receiving the right type of support when a person has mental health difficulties and problems relating to drug use. We met with Dr David Strang who is leading the Independent Inquiry into Mental Health Services in Tayside. Our recommendations in this area will support the work of the Independent Inquiry. We also address stigma and the importance of the use of appropriate language.

Our recommendations focus in the main on treatment and support, drug-related deaths, mental health and leadership. Without strong leadership and a determination to stick with what will be a difficult task, then the Partnership will not succeed in turning things around. Those delivering care and support in Dundee must build relationships which are based on respect and trust. These will provide a starting point for working effectively as a true and equal partnership. We believe that a shared culture is needed which values kindness, compassion and the belief in hope. This is the reason for the title of this report. With **kindness, compassion and hope**, Dundee can be a City which will lead the way in successfully responding to drug use.

The Commission has twenty members who have given their time voluntarily. I am very grateful to them for their hard work and commitment to the task. I am also grateful to the support from Andy Perkins and his colleagues at Figure 8 Consultancy. I would particularly like to thank all those who provided their thoughts and evidence to the Commission, especially those people who have lived experience of using or having used drug services and family members.

A handwritten signature in black ink, which appears to read 'Robert Peat'. The signature is written in a cursive style and is positioned above a horizontal line.

Robert Peat, Chair of the Commission (August 2019)

2. EXECUTIVE SUMMARY

Key findings

The Dundee Drugs Commission has been an intensive and rapid review of the recent history of the impact of drug use across Dundee, and the help available for people who use drugs in the city. Local Commission members have been supported by experts from across Scotland and the wider UK. To be clear, the Commission was set up in part to assess the effectiveness of the strategic planning and delivery of services co-ordinated by the Dundee Alcohol and Drug Partnership and more broadly across community planning partners (Objective #4). During the course of our work, we have learned about inadequacies in our local systems and services. We have frequently heard from individuals and families who feel that the system has failed them. All our recommendations are born out of the experiences of people in Dundee.

As a Commission, over the course of the last year, we have received evidence from over a thousand different people – those with lived experience of problems with drugs (current and past); family members; members of the public; clinicians and GPs; staff who work in drug treatment and support services; staff who work in wider health and social care services; senior officials within NHS Tayside, Dundee City Council and Dundee's third sector; politicians and elected members; and academics.

Some individuals and families have spoken in great detail to us about positive experiences of the help and support they've received and the strategies they have used themselves to move towards recovery from drug use. Many individuals and families shared their grief and loss over the devastation that has been caused by drug use. We have heard numerous stories of immense challenges and barriers put in front of those who require help and support, compounded by the pervasive stigma that is still attached to being a person who experiences drug problems. Staff working in services have shared both positive and enthusiastic accounts of their efforts to help those who present to services, as well as details of immense frustration and anger when things do not work as they should.

Our review of a substantial amount of evidence has taken time to distil and balance. We have been aware that when an independent Commission is set-up then you tend to have all the stories coming to the fore of how things are not working. However, we have also taken the time to seek out and listen to those who have a positive story to tell – whether one of how they've successfully made changes to their drug use by themselves (or with help from family and others) – or whether a story of how they have received the help required from local services. By so doing, we believe that we have achieved a balanced understanding of the reality of issues faced.

Our review has led us to identifying a number of key messages – all of which we have used to form the challenging set of recommendations. The key messages in our report are structured underneath the key themes of our work:

- Leadership and Governance; • Drug Deaths;
- Treatment and Support; and
- Mental Health.

Conclusions

We do not hide from the fact that the recommendations detailed below are going to be challenging to implement, and will also require strong and dedicated leadership over many years to make Dundee a place that delivers on its belief that truly 'every death matters' and, more positively, 'every life matters'. This will require an honest and transparent acknowledgment of the failings that have taken place in the delivery of drug treatment services (in a 'no-blame' environment), and the willingness and determination to learn and exploit the lessons that are evident from these failings.

We have scrutinised and discussed the evidence that has been received and have also looked for examples of best practice from elsewhere in order to:

1. identify immediate steps that can be taken to start improving the situation; and
2. begin a longer-term journey to realising a vision for a high-quality system of treatment and care for some of our most vulnerable citizens who deserve better.

We also recognise that some of the required changes are not solely within the gift of the Dundee Partnership to deliver. This is why a series of 'national considerations' are also offered below. We sincerely hope that these will be responded to by the Scottish Government and the UK Government because many of the levers for change in the local systems are held outside of local control. The changes we are recommending will

require a renewed determination to work much more effectively across local, regional and national structures to deliver them. Our insight of best practice from countries such as Canada, Iceland and Portugal would, similarly, require changes in national policy and legislation and systems/practices in order to allow Dundee to implement fully the changes that are required.

The political interest and support for the Commission has been significant from the beginning. Without it, the Commission would never have been instigated. The time is now right to hand back the evidence and findings of our work to our elected leaders and ask them to set the standard for the leadership and accountability that is going to be required in Dundee (and beyond) to turn around the national emergency that is epitomised by the severe rates of drug-related deaths across Scotland.

Local Recommendations

The following are our set of **sixteen (16)** 'headline' recommendations that we believe are within the abilities of the Dundee Partnership to progress. Our Part 1 Report provides full detail of what will be required to see each recommendation fulfilled.

The recommendations are grouped under the following three headings:

- A. Culture and systems;
- B. A holistic system model - including integrated Primary Care provision; and
- C. Causes and effects of drug use.

A. CULTURE AND SYSTEMS

This first suite of recommendations **(1-6)** is focused around the need for cultural change across drug treatment services, related disciplines and communities of Dundee, and changes in local systems that will help facilitate such cultural change.

Recommendation 1: The Dundee Partnership must do all that is necessary to achieve the required standard of leadership – the test of which will be that agreed changes are owned and supported by the statutory and third sectors, recovery communities, service users and families.

Recommendation 2: Challenge and eliminate stigma towards people who experience problems with drugs, and their families, across Dundee to ensure that everyone is treated in a professional and respectful manner.

Recommendation 3: Language matters. People who experience problems with drugs, and their friends and families, are part of our communities – let's make them feel like that.

Recommendation 4: Level the 'playing field' to ensure that all partners, statutory and third sector are held equally accountable. This is necessary to enhance patient safety and quality of provision. The balance between current centralised statutory and other provision needs to be changed.

Recommendation 5: Meaningful involvement of people who experience problems with drugs, their families and advocates.

Recommendation 6: Learning from the things that have gone wrong – attention to continuous improvement to benefit others who are vulnerable.

B. A HOLISTIC 'SYSTEM' MODEL – INCLUDING INTEGRATED PRIMARY CARE PROVISION

The second suite of recommendations **(7-13)** is concerned with the provision of drug treatment and support services in Dundee. An analysis of the balance of evidence provided to the Commission tells a compelling story of a system that is not fit-for-purpose.

Recommendation 7: Choice is important and having the choice of accessing a full menu of services (including community and/or a residential setting) to support recovery should be available to people in Dundee.

Recommendation 8: The provision of services currently offered by ISMS should be delivered through the development of a new 'whole system' model of care. This should be structured via a joint and equal partnership with both primary care and the third sector, with the key purpose of utilising the unique strengths of all partners.

Recommendation 9: Reframe all substance use services to prioritise access, retention, quality of care and the safety of those using services, in line with the evidence base including, but not limited to: improved retention through having an unambiguous 'no unplanned discharges' policy; optimised OST; psychological treatments; assertive outreach; and broad integrated care.

Recommendation 10: Involvement of primary care and shared care models.

Recommendation 11: Review and refresh the community pharmacy model for OST engaging all stakeholders to develop an integrated and holistic approach to the care and treatment of people who use substances. Look to establish a new Community Pharmacy model with additional support.

Recommendation 12: Commission a comprehensive independent Health Needs Assessment for people who experience problems with drugs.

Recommendation 13: Full integration of substance use and mental health services and support. This is recommended UK and international best practice – and it needs to happen in Dundee. Trauma, violence, neglect and social inequalities lie at the root of both mental health problems and substance use problems and most people with substance use problems also have mental health problems.

C. CAUSES AND EFFECTS OF DRUG USE

The third suite of recommendations (**14-16**) is concerned with a wider understanding of the causes and effects of drug use in order to inform a truly holistic response to one of the most vulnerable, stigmatised and marginalised groups in Dundee.

Recommendation 14: Address the root causes of drug problems.

Recommendation 15: Ensure that the needs of women who experience problems with drugs are assessed and addressed via adoption of gender-mainstreaming and gender-sensitive approaches to service planning.

Recommendation 16: Attend to the intergenerational nature of substance use problems and place the safety and wellbeing of children at the heart of all planning, alongside proactive support for parents. Explore the creation of family support workers in the third sector that can provide support ahead of families reaching crisis point and requiring social work intervention.

National Considerations

In considering how to achieve the significant improvements that are required in Dundee, there are a number of areas that are outside of Dundee's powers to change – resting either with Scottish Government or the UK Government. For Dundee to succeed in its ambitions to effectively tackle the challenges it faces, the Commission needs to highlight the following matters for national consideration:

1. The Commission would ask Scottish Government to consider equal regulation of the whole substance use services/treatment sector.
2. The Commission would ask the Scottish Government to consider how it can change the funding systems in Scotland to allow ADPs to control the whole drug and alcohol spend. This would need to be considered alongside a wholesale review of ADPs to ensure they can function as fully independent commissioning bodies.
3. The Commission welcomes the Scottish Government declaring the drug deaths crisis as a public health emergency. In Scotland, at present, it is unclear whether such a declaration will unlock any new powers or resources. International examples exist that can be learned from, for example in British Columbia, Canada in response to a provincial emergency. The Commission welcomes the moves by the Minister for Public Health and Sport to set up a National Task Force to advise on what further changes, in practice or in law, could be made in Scotland.
4. The Commission is aware of the current inquiry into problem drug use in Scotland being run by the Scottish Affairs Committee and would support the calls for petitioning the UK government to have increased devolved powers to allow for a full 'Scottish' review of drug laws to be conducted and action taken as a result. In the short-term the Commission would ask the Scottish Government to consider how they can make the most of the powers that they already have (including policy) – such as police and enforcement practice.
5. The Commission would ask the Scottish Government to consider convening a National Learning Set for Drug Death Review Groups (including standardisation of processes).
6. The Commission would ask the Scottish Government to consider how 'real time' data (without extensive delays in getting these data into the public domain) can be achieved in order to enhance the ability to respond both locally and nationally.

7. The Commission would ask the Scottish Government to consider allocating appropriate resources to national toxicology testing to enable more effective and quicker reporting.
8. The Commission would ask the Scottish Government to consider developing a plan of work to address the findings in the 2018 Scottish Government report on women and drug-related deaths.

Objectives of the Commission

The Commission was provided with a draft set of objectives from the Dundee Partnership, and refined them slightly to the following:

The Dundee Drugs Commission will:

1. Consider the context, nature, extent and impact of drug use and drug-related deaths in Dundee.
2. Identify and investigate the key causes and consequences of drug use and drug-related deaths for individuals and their families along with policy and practical measures to address these.
3. Seek the views and involvement of all relevant local stakeholders including individuals with lived experience of accessing substance use services, partner organisations providing support and/or treatment, and public-sector service managers and frontline service providers.
4. Assess the effectiveness of the strategic planning and delivery of services co-ordinated by the Dundee Alcohol and Drug Partnership and more broadly across community planning partners as relevant.
5. Consider evidence of what has worked elsewhere to combat drug use and drug-related deaths including approaches to achieve prevention and recovery.
6. Prepare a report for the Dundee ADP and its partners including Dundee City Council, NHS Tayside and the Health and Social Care Partnership with evidence-based recommendations on priorities for practical and achievable action to tackle and reduce drug use and drug-related deaths in the city. Recommendations should also be offered at national and global levels as well as local.

National context

Without doubt, Scotland is currently experiencing a crisis in relation to the rapidly increasing numbers of drug-related deaths.

Recent publication of the number of drug-related deaths in Scotland in 2018 by the National Records for Scotland show a 27% increase from the previous year (rising from 934 to an all-time high of 1,187). Between 2008-2018, the number of drug-related deaths has more than doubled (107% increase from 574 in 2008 to 1,187 in 2018). Over this period a combined total of **7,605** people have died in Scotland from a drug-related death, **404** of whom have been in Dundee.

Scotland's figures imply a drug-related death rate that is nearly three times that of the UK as a whole. It is also higher than that reported for any other EU country. Scotland's reported drug-related death rate is now higher (218 per million of the population) than the one reported for the USA (217 per million of the population), which has previously been considered to be the highest rate in the world.

Local context

Members of the Dundee Alcohol and Drug Partnership [DADP] have been aware of increasing public interest and media coverage in relation to a range of issues associated primarily with the impact of drug use and the response of services in Dundee. These include public concerns regarding disturbing images of the impact of drug use on individuals, families and communities; patients' access to and experience of, treatment services; the reported rise in drug-related deaths in Dundee to the highest (population) rate of drug-related deaths in Scotland; and debate regarding the potential effectiveness of safe consumption spaces.

The DADP was asked to establish a panel based on the model used by the first Dundee Fairness Commission. Members of the DADP subsequently endorsed this proposal and asked officers to make arrangements for an independent Dundee Drugs Commission incorporating the strengths and good practice

of the Fairness Commission including research, community engagement, user perspective, a partnership approach and a focus on practical recommendations for action.

Dundee recorded 66 drug-related deaths during 2018 (up from 57 in 2017 and 38 in 2016). Between 2014-2018 Dundee City averages the highest rate of drug-related deaths per 1,000 population of all council areas in Scotland (0.31 deaths per 1,000 population). Of note, Glasgow City is not dissimilar.

Its rate of drug-related deaths per 1,000 population is 0.30.

To more fully understand the context of drug-related deaths in Dundee, the Commission met with and heard evidence from experts at ISD (**Dr Lesley Graham**, Clinical Lead for Alcohol, Drugs and Health in Justice Settings, ISD Consultant Team; and **Lee Barnsdale**, Principal Information Analyst [Drugs], ISD) in order to try and identify and understand whether Dundee has any specific conditions or factors that are influencing the high rates of drug-related deaths. As a result of these meetings, the Commission requested that a 'deeper dive' of drug-related death data be undertaken by ISD in order to compare Dundee against the Rest of Scotland in respect of a range of criteria (discussed and agreed by the Commission and ISD).

In discussions with ISD, who completed the 'deeper dive', the areas that are worthy of consideration and further exploration are:

- Proportionally (when compared to the Rest of Scotland), in Dundee there are:
 - more deaths in the 25-34 age group;
 - fewer suicides¹;
 - more individuals who live in areas within SIMD 1;
 - more people in treatment (prescription) at time of death;
 - more people on methadone at time of death;
 - more deaths where the individual had been diagnosed with Hepatitis C; and
 - more people diagnosed with a mental illness.
- Higher proportions of DRDs in Dundee with gabapentinoids; etizolam and diazepam implicated in death.

The indication that Dundee has proportionately more drug-related deaths amongst those who live in areas within SIMD 1 (noted above) is of particular interest to the Commission given the work of the Dundee Fairness Commission that has been progressed in the City over the last few years.

Guiding principle of the Commission

The people of Dundee have been and remain our first priority. When systems and services fail it is the people that they were designed to help (and their loved ones and communities) who are disadvantaged. This is the guiding principle that has informed all of our recommendations. This principle should continue to guide all future decision making and action in seeking to help people and communities who are affected by drug use in Dundee.

It's now time for action

As a Commission we are fully aware that we have provided a significant challenge for the Dundee Partnership in terms of the volume of action and work that will be required to implement our recommendations – which are framed over a five year period. Our hope is that all disciplines and

services (including the DADP) quickly (within three months) prioritise the time necessary to reflect upon the findings and recommendations laid out in this report, and provide a detailed response and action plan to the Dundee Partnership to describe the part they can all play in helping to tackle this set of significant challenges.

There are some quick wins to be had in learning from the mistakes of the past to uncover the solutions for the future.

There is a deep passion amongst the people of Dundee to assertively respond to the serious challenges faced. As Commission members we are fully prepared to continue in a supporting role to help ensure Dundee can implement the changes we have sought to describe and understand. We would therefore want to support the Dundee Partnership and the DADP as a 'critical friend' as they look to take the lead on

¹ Care and attention needs to be taken with this as there is difficulty in determining whether a death is suicide or an unintentional overdose – i.e. not all cases of suicide are listed as such on the death certificate.

implementation. Having challenged the Dundee Partnership to pick up the baton and run with an ambitious programme of change, it would be negligent of the Commission to deliver its report and walk away. As an independent Commission we are prepared to support the DADP as it begins a new journey and to reconvene and collaboratively review progress within the next 12 months.

The values of **kindness, compassion and hope** will underpin and guide the support that the Commission is able to provide. In return, we challenge the Dundee Partnership to having 'a year of kindness and compassion' to get things moving in the right direction and reignite the hope that things can and will change.

3. LANGUAGE, TERMINOLOGY AND GLOSSARY

Language

The world of drug treatment is full of jargon and abbreviations. We have made a conscious effort to reduce the volume of jargon in this report and to write using the principles of 'Plain English'.² We have also included a section in our findings and recommendations regarding the importance of language in helping to challenge and reduce the pervasive stigma that is still attached to being a person who experiences problems with drugs.

At our first meeting, we held a detailed discussion regarding the original title for the Commission (i.e. 'Dundee Drug Misuse Commission'). Commissioners experienced the most difficulty with the term 'misuse' in the title. It was agreed that terminology such as 'misuse' or 'abuse' is stigmatising and should not be used, in line with guidance from the Global Commission on Drug Policy³. We had the sense that the current conversation and priority in the drug treatment field is now about whole populations and wellbeing (i.e. a continuum of users and non-users). We therefore agreed to remove the term 'misuse' from the title and agreed on 'Dundee Drugs Commission'.

In considering the role that language has in reflecting and framing critical conversations, we also considered other terms within the wider discourse that warrant some reflections due to their prior use. Perhaps the most obvious and commonly used of these is 'service user', a narrow term applied to those who use or have used treatment services, rather than being a person-centred term to describe a whole population of people (whether in treatment or not) who have chosen (for whatever reason) to use drugs (whether legal or illegal). We have favoured the use of the term 'individual' (who uses services) or 'a person who experiences problems with drugs'. This is a direct approach to help:

- counter the stigma of possible labelling;
- reflect the ambiguities of boundaries and identities; and
- adopt a more inclusive and person-centred position.

We have welcomed the extensive interest of local and national media in the work of our Commission and have noted and appreciated a changing use of reporting language over the course of the last year. For example, at the outset of the Commission the phrase 'shooting galleries' was commonly used in reports, which has been replaced by more accurate and respectful terms such as 'Drug Consumption Rooms' or 'Safer Injection Sites'.

We recommend that great care and attention is given by all relevant stakeholders and groups to developing language that is truly person-centred and aimed at reducing stigma rather than perpetuating it. We recommend that services in Dundee select titles to align with language that avoids stigmatisation. Several helpful resources are already available to aid this task. We would

² Available at: <http://www.plainenglish.co.uk/files/howto.pdf>

³ Available at: http://www.globalcommissionondrugs.org/wp-content/uploads/2018/01/GCDP-Report-2017_Perceptions-ENGLISH.pdf

particularly recommend that the online leaflet ‘Language Matters’, developed by the Network of Alcohol and other Drugs Agencies (NADA) in Australia⁴, is promoted at all opportunities across Dundee (see **Figures 3.1 and 3.2** below):

Figure 1: Language Matters’, developed by the Network of Alcohol and other Drugs Agencies²

Language
matters

Language is powerful—especially when discussing alcohol and other drugs and the people who use them. Stigmatising language reinforces negative stereotypes. “Person-centred” language focuses on the person, not their substance use.

When working with people who use alcohol and other drugs...

<div style="display: flex; align-items: center; justify-content: center;"> 👍 try this </div>	<div style="display: flex; align-items: center; justify-content: center;"> 👎 instead of this </div>
substance use, non-prescribed use	abuse misuse problem use non-compliant use
person who uses/ injects drugs	drug user/abuser
person with a dependence on...	addict junkie druggie alcoholic
person experiencing drug dependence	suffering from addiction has a drug habit
person who has stopped using drugs	clean sober drug-free
person with lived experience of drug dependence	ex-addict former addict used to be a...
person disagrees	lacks insight in denial resistant unmotivated
treatment has not been effective/ chooses not to	not engaged non-compliant
person’s needs are not being met	drug seeking manipulative splitting
currently using drugs	using again fallen off the wagon had a setback
no longer using drugs	stayed clean maintained recovery
positive/negative urine drug screen	dirty/clean urine
used/unused syringe	dirty/clean needle dirties
pharmacotherapy is treatment	replacing one drug for another

Adapted from *Language Matters* from the National Council for Behavioural Health, United States (2015) and Matua Raki, New Zealand (2016).

Figure 2: Language Matters’, developed by the Network of Alcohol and other Drugs Agencies²

⁴ Available at: <http://nadaweb.azurewebsites.net/resources/language-matters/>

Person-centred language in non government AOD services

About this resource

Person-centred language focuses on the person, not their substance use. It is a simple and effective way of showing you respect a person's agency, dignity and worth.

This resource has been developed for people working in non government alcohol and other drugs (AOD) services. It has been developed in consultation with people who use drugs.

The purpose of this resource is to provide workers with guidelines on how to use language to empower clients and reinforce a person-centred approach.

Why have we developed this resource?

Our attitudes towards AOD use and how we respond rests on the concepts and language we use.

Words like 'addict', 'clean' and 'dirty' reinforce negative stereotypes and encourage judgement, blaming and shaming.

Fear of stigma and being labelled as a 'drug user' can and does prevent people from accessing treatment and support. Use of such language also contributes to poorer treatment outcomes.

Being mindful about the words we use is not about being politically correct. Language is powerful and it is the power of language which makes it an important practice tool; a tool to empower clients and fight stigma.

What this resource is not

This resource is not an exhaustive list of 'dos' and 'don'ts'. Language is complex. What is considered 'person-centred' will depend on the individual and the context. Terms, like 'recovery' for example, might be stigmatising for some, while others may prefer such terminology. There is no one-size-fits-all approach. What is important is that we are respectful and person-centred in our approach.



To learn more, visit the International Network of People who Use Drugs website: www.inpud.net.

Better practice guidelines

When working with people who use drugs:

- Don't define a person by their substance use or diagnosis—emphasise the person first. For example, say 'person who injects drugs' instead of 'injecting drug user' or 'person living with hepatitis C' instead of 'they're infected with hep C.'
- Don't impose your language on others. Where appropriate ask the person what language they prefer and respect their wishes.
- Choose terms that are strengths-based and empowering. Avoid terms like 'non-compliant'; use terms like 'chooses not to' or 'decided against' which affirm a person's agency, choice, and preferences.
- Be mindful of the implications of your language. Avoid terms like 'clean' and 'dirty' when talking about urine drug screen results. Consider also the implications of referring to opioid pharmacotherapies as 'substitution' or 'replacement' treatment.
- Avoid expressions like 'has a drug habit' or 'suffering from addiction' which can disempower a person by trivialising or sensationalising their AOD use.
- Use language that is accessible. Don't speak above a person's level of understanding or assume that a person is not capable of understanding. Avoid slang and medical jargon which can be misinterpreted or cause confusion when used incorrectly.
- Don't make assumptions about a person's identity—be inclusive. For example, ask about a person's preferred gender pronouns or, if you are unsure, use gender neutral terms like 'their', 'they' or 'them'. Better still, avoid unnecessary references to gender altogether by using the person's name.
- Be aware of the context of the language being used. Some terms are ok when used by members of a specific community as a means of claiming identity; the same terms can be stigmatising when used by people outside that community.
- The community of people who use drugs, like all communities, can suffer from lateral discrimination. Be careful not to take on the biases of others. Your language should respect a diversity of experience and empower the person who is looking to you for help.
- Remember, we don't just use words to communicate. Use non-verbal cues, like eye contact, tone of voice and body language to demonstrate you respect the dignity and worth of all people.

References

International Network of People who Use Drugs (2011). Statement and Position paper on Language, Identity, Inclusivity and Discrimination.
International Network of People who Use Drugs (2015). Drug User Peace Initiative: Stigmatising People Who Use Drugs.
Matua Raki (2016). Language Matters.
Mental Health Coordinating Council (2015). Language of Mental Health Recovery.

Terminology

When quoting individuals or citing literature sources we will use the terms they have chosen for accuracy of representation. Direct quotes will be clearly identified within speech marks. Where the Commission has paraphrased and summarised its analysis into a particular phrase, this will be identified using italics and should not be misconstrued as a direct quote from an individual.

Glossary

To aid anyone reading this report, we have included the Glossary below to identify any abbreviations used within the report. We have written the full term in the report for the first time each abbreviation is used.

Table 3.1: Glossary of terms used in the report

Abbreviation, Acronym or meaning Key word	Definition and meaning	
DADP	Dundee Alcohol and Drug Partnership	Alcohol and Drugs Partnerships are multi-agency strategic groups tasked by the Scottish Government with tackling alcohol and drug issues through partnership working.
DCR	Drug Consumption Rooms	Drug consumption rooms are professionally supervised healthcare facilities where drug users can consume drugs in safer conditions. They seek to attract hard-to-reach populations of users, especially marginalised groups and those who use on the streets or in other risky and unhygienic conditions. Also known as: Supervised/Safe Injection Sites/Facilities, Drug/Safe Consumption Facilities/Spaces or Medically Supervised Injection Centres.
DRD or DD	Drug-related death or Drug death	<p>'Drug-related death' is the definition used in the national statistics reporting and is a death where the underlying cause is: drug abuse or drug dependence; or drug poisoning (intentional or accidental) that involves any substance controlled under the Misuse of Drugs Act 1971.</p> <p>A 'drug death', reported locally, is specifically a death directly resulting from the presumed non-intentional overdose of illicit (or illicitly obtained controlled) substances.</p>
HAT	Heroin Assisted Treatment	Heroin-assisted treatment refers to the prescribing of synthetic, injectable heroin to those who are dependent on opiates, who do not benefit from or cannot tolerate treatment with one of the established drugs used in
		opiate replacement therapy like methadone or buprenorphine.

HSCP	Health and Social Care Partnership	Health and Social Care Partnerships, (HSCPs) are the organisations formed as part of the integration of services provided by Health Boards and Councils in Scotland. Each partnership is jointly run by the NHS and local authority. There are 32 HSCPs across Scotland.
IJB	Integration Joint Board	The Public Bodies (Joint Working) (Scotland) Act 2014 (the 'Act') required Local Authorities and Health Boards to jointly prepare an Integration Scheme, which sets out how Health and Social Care Integration is to be planned, delivered and monitored within their local area. A separate legal body called the 'Integration Joint Board' is the main decision-making body. It leads on and has devolved responsibility for the planning and monitoring of community health and social care services.
ISMS	Integrated Substance Misuse Services (Dundee)	Formerly known as Tayside Substance Misuse Services [TSMS] or the Drug Problem Centre [DPC]
ORT or OST	Opioid Replacement Therapy(ies) or Opioid Substitution Therapy(ies)	Opioid replacement therapy or Opioid Substitution Therapy involves replacing an opioid, such as heroin, with a longer acting but less euphoric opioid. Medicines commonly prescribed for ORT are methadone or buprenorphine.

4. WHAT WE WERE ASKED TO DO

Background

Members of the Dundee Alcohol and Drug Partnership [DADP] have been aware of increasing public interest and media coverage in relation to a range of issues associated primarily with the impact of drug use and the response of services in Dundee. These include public concerns regarding disturbing images of the impact of drug use on individuals, families and communities; patients' access to and experience of, treatment services; the reported rise in drug-related deaths in Dundee to the highest (population) rate of drug-related deaths in Scotland; and debate regarding the potential effectiveness of safe consumption spaces.

The DADP was asked to establish a panel based on the model used by the first Dundee Fairness Commission⁵. Members of the DADP subsequently endorsed this proposal and asked officers to make arrangements for an independent Dundee Drugs Commission ['the Commission'] incorporating the strengths and good practice of the Fairness Commission including research, community engagement, user perspective, a partnership approach and a focus on practical recommendations for action.

In March 2018, Figure 8 Consultancy [hereinafter referred to as 'Figure 8'] was commissioned to setup and facilitate a Dundee Drugs Commission.

The Dundee Partnership announced that the Commission would be commencing at a launch event at the end of March 2018. Between March – May 2018, Figure 8 recruited twenty members to the Commission, including members with lived experience of substance use and family members affected by a loved one's use of substances. The Commission met for the first time in May 2018 followed by a further eleven formal meetings up until July 2019. Six of these meetings contained an open, public evidence session where members of the public and local media were invited 'into the room' to observe proceedings (full details of these public evidence sessions and details of the evidence speakers is provided in **Appendix XIII** in the **Part 3** report).

Objectives of the Commission

The Commission was provided with a draft set of objectives from the Dundee Partnership, and refined them slightly to the following:

The Dundee Drugs Commission will:

1. Consider the context, nature, extent and impact of drug use and drug-related deaths in Dundee.
2. Identify and investigate the key causes and consequences of drug use and drug-related deaths for individuals and their families along with policy and practical measures to address these.
3. Seek the views and involvement of all relevant local stakeholders including individuals with lived experience of accessing substance use services, partner organisations providing support and/or treatment, and public-sector service managers and frontline service providers.
4. Assess the effectiveness of the strategic planning and delivery of services co-ordinated by the Dundee Alcohol and Drug Partnership and more broadly across community planning partners as relevant.
5. Consider evidence of what has worked elsewhere to combat drug use and drug-related including approaches to achieve prevention and recovery.
6. Prepare a report for the Dundee ADP and its partners including Dundee City Council, NHS Tayside and the Health and Social Care Partnership with evidence-based recommendations on priorities for practical and achievable action to tackle and reduce drug use and drug-related in the city. Recommendations should also be offered at national and global levels as well as local.

⁵ Full details on the work of the Dundee Fairness Commission can be found at:

<http://www.dundeepartnership.co.uk/content/dundeefairness-commission>

5. WHAT WE HAVE DONE

A wide variety of quantitative (data and statistics) and qualitative (expressed views) activities have been used to capture as broad and balanced a set of evidence as possible over the last year. In total, we have grouped these activities into eighteen different categories of evidence, as detailed below.

No.	Evidence source	Notes
1	Initial Call for Evidence	An initial call for evidence was distributed through various networks across Dundee during May 2018. The call for evidence consisted of three key questions, focused on understanding how the work of professionals across Dundee in supporting those who have problematic drug use can make a positive difference to their outcomes. In total 39 responses were received. Full analysis is provided in Appendix XI in the Part 3 report.
2	Deeper Dive of Drug Death Data	Following discussions with and a presentation to the Commission by Lesley Graham (Clinical Lead for Alcohol, Drugs and Health in Justice Settings, ISD Consultant Team) and Lee Barnsdale (Principal Information Analyst [Drugs], ISD) a formal request was made to ISD for provision of a 'Deeper Dive' of Drug-related Death data to compare a set of key parameters between Dundee and the rest of Scotland. The aim was to identify if there are any factors of relevance to Dundee in relation to DRDs, compared to other areas of Scotland. A summary of this Deeper Dive is included in Chapter VI and a full analysis at Appendix XII in the Part 3 report.
3	Public Evidence Sessions	Over the course of the last year, the Drugs Commission has held six public evidence sessions where a range of experts were invited to either present to the Commission or discuss certain topics as part of a panel-based question and answer session with the Commission. Full details of evidence speakers are provided at Appendix XIII in the Part 3 report. Copies of presentations can be seen at: http://www.figure8consultancy.co.uk/latestnews/dundee-drugs-commission/
4	Service user / family focus groups	Seven focus groups, with a total of 60 participants, were conducted by Figure 8 Consultancy with a range

		of groups with people experiencing drug problems and family/carer support groups across Dundee between June – August 2018. Full details are provided in Appendix XIV in the Part 3 report.
5	Service visits	A range of visits to third sector service in Dundee were undertaken by groups of Commission members on 14 th November 2018. In total, six services were visited, with an opportunity for Commission members to meet with staff and service users or family members. Full details are provided in Appendix XV in the Part 3 report.
6	Evidence submissions from the Integrated Substance Misuse Service	<p>Across the lifespan of the Drugs Commission, a wide range of communications (meetings, phone calls and email exchanges) have taken place regarding the Integrated Substance Misuse Service (ISMS) in Dundee. The Commission requested detailed information from ISMS on the services it provides, and ISMS have submitted some detailed documents to the Commission as part of its evidence submissions, with the key documents being:</p> <ol style="list-style-type: none"> 1. Provision of a 'factsheet' from ISMS 2. Written response from ISMS to questions posed by the Commission 3. Written submission to the Drug Commission's Final Call for Evidence 4. Analysis of the Deeper Dive of DRD Data commissioned from ISD (Dundee v's Rest of Scotland) 5. Clinical Guidelines 6. Service Redesign Plans 7. Performance and Governance 8. Carers 9. Guidelines for Medical Treatments for Substance Misuse (ISMS) <p>Full details are provided in Appendix XVI in the Part 3 report.</p>
7	Staff focus groups (ISMS)	Three focus groups were conducted with a total of 16 staff at ISMS during March 2019. Full details are provided in Appendix XVII in the Part 3 report.

8	Key stakeholder meetings and interviews	A whole range of key stakeholder meetings and interviews with professionals took place over the course of the year, on a whole range of themes. Although it has not been possible to write all of these
		up for the purposes of this report, the discussions that have taken place have consistently helped to shape the findings of the Commission's work. A list of meetings conducted is included in Appendix XVIII in the Part 3 report.
9	Service user, family and members of the public – meetings and correspondence	<p>Invitations were extended through the Commission's Calls for Evidence and by word of mouth through services and via meetings for individuals with lived experience and family members to speak directly to the Commission (via discussions with Andy Perkins and or Robert Peat). This has been added as an extra layer of informal evidence gathering to the initial planned methods of the Commission.</p> <p>Over 30 individuals and family members have come forward over the last year to speak of their experiences of the treatment and support that is available in Dundee and to discuss the changes they would like to see to improve the situation in Dundee. Full details are provided in Appendix XIX in the Part 3 report.</p>
10	Drug-Related Deaths survey	<p>The purpose of the survey was two-fold: to gather a rich strand of qualitative evidence of what the problem is in terms of exploring the high rates of drug-related deaths in Dundee, and to gain insight on what can be done about reducing these deaths; and to engage a wider audience in the work of the Dundee Drugs Commission. The survey was distributed online and via hardcopy through various networks and was open during July - September 2018. The survey consisted of demographic questions and one key open-ended question:</p> <p><i>'What has to be done in Dundee (and across Scotland/elsewhere) to radically reduce the increasing numbers of drug-related deaths?'</i></p> <p>In total, 927 responses to the question were analysed. Full analysis is provided in Appendix XX in the Part 3 report.</p>

11	Commission Sub-Groups	Following analysis of its Initial Call for Evidence and other early evidence gathering activities, the Commission considered the main themes that it needed to prioritise in timeframe allocated (one year). There were four consistent themes that were identified, over and above any others: Drug-Related Deaths; Leadership; Mental Health; and Treatment.
		The Commission set-up four sub-groups to explore and report upon these core themes. Further details of each sub-group's composition and work is provided in Appendix XXI in the Part 3 report.
12	Final Call for Evidence	A final call for evidence was distributed online and via hardcopy through various networks across during March-April 2019. There were 112 responses to the survey, although most only completed demographic information. There was a total of 39 respondents who provided answers to the key questions posed – a mixture of individual and corporate responses. Full analysis is provided in Appendix XXII in the Part 3 report.
13	Literature and evidence review and bibliography	Throughout the course of the Commission we have identified relevant reports, documents, articles, policies, strategies, etc. The Figure 8 team have selected and reviewed the most relevant of these to its work and have written these up in summary form for consideration by Commission members. These 76 documents have provided a whole library of evidence that are directly linked to our report recommendations. A wider set of evidence sources (n=181) have been considered throughout the Commission process and are included as a full Bibliography. Full details are provided in Appendix III in the Part 2 report.

14	Rapid review of literature in relation to Low Threshold Methadone prescribing	One of the foremost gaps identified by the Commission in the provision of drug treatment services in Dundee is that of Low Threshold Methadone Maintenance Treatment (MMT). With this in mind, a rapid review of key literature in relation to Low Threshold MMT has been conducted to provide the supporting evidence for recommending a swift move to developing such service provision in Dundee. This rapid review of literature is detailed in Appendix IV in the Part 2 report.
15	International research evidence case studies (Canada, Iceland, Portugal)	The Commission were asked to consider evidence of what has worked elsewhere to combat drug use and drug-related deaths including approaches to achieve prevention and recovery. After due consideration, the Commission requested that Figure 8 look at evidence from Canada (in relation to Harm Reduction approaches), Iceland (in terms of a prevention approach for young people), and Portugal (in terms
		of their approach to decriminalisation). Full details are provided in Appendix V in the Part 2 report.
16	Related Conferences – materials	Across the lifespan of the Drugs Commission, members of the Commission and the Figure 8 support team have attended a number of conferences in Scotland that have had significant relevance to the issues that have been considered by the Commission. A summary of the conferences attended is provided below. The conference materials obtained have been included in our full review of evidence. Full details are provided in Appendix VI in the Part 2 report.

17	Rapid inequalities review (Dundee)	<p>Problem drug use has strong links to poverty and deprivation, with individuals from deprived areas more likely to have experienced psychological trauma and mental health issues, which can result in the use of high-risk drugs to escape psychological stress and trauma. That is not to say, however, that deprivation causes addiction, given the links between poverty and drug misuse are multifaceted. Recent local data suggest that 73% of individuals who died as a result of the presumed non-intentional overdose of illicit (or illicitly obtained controlled) substances in Tayside in 2017 lived in areas that were classified in the two most deprived SIMD quintiles. This suggests an inequality incline associated with drug-related deaths, with more than half of drug-related deaths occurring in areas of greatest socioeconomic deprivation. Full details of this review are provided in Appendix VII in the Part 2 report.</p>
18	Scottish Affairs Committee Inquiry into Problem Drug Use in Scotland – summary of relevant written submissions	<p>The Scottish Affairs Select Committee has been receiving evidence as part of its inquiry into the use and misuse of drugs in Scotland and is due to report in the autumn (2019). All responses to the Scottish Affairs Select Committee have timely relevance to the Dundee Drugs Commission. A rapid review of submissions responding to the questions ‘What are the unique drivers of drugs abuse in Scotland?’, ‘How is drugs misuse in Scotland different from the rest of the UK?’ and ‘recommendations’ has highlighted themes of significant relevance, which are presented in Appendix VIII in the Part 2 report.</p>

What we haven’t done – the limitations

Despite extensive efforts to fully cover all the objectives of the Commission, there are some areas that have not received as much or enough attention as others. The Commission decided at a very early stage to focus its attention on the key themes that arose from the Initial Call for Evidence (Leadership, Drug Deaths, Treatment and Mental Health) in order to ensure that a thorough review of these elements was possible in the timeframe and resources available to the Commission. In doing so, we would like to identify a number of areas which have been beyond the realistic scope of the Commission, but which we feel will require further (detailed) attention down the line so that the Dundee Partnership can have a full, whole-systems review and approach at its disposal.

The key areas that we haven’t been able to give as much attention to as we would ideally have liked to are:

1. The impact of drug use upon children and young people affected by their own use or that of family members/significant others.

We have attempted to provide some evidence within our report on these matters and have conducted some key interviews along the way, as well as utilising the expertise of our Commission members – which have informed our recommendations. However, this area deserves and needs a far greater review than we have been able to conduct and we would welcome moves from the Dundee Partnership

to prioritise this area in the next phase of its development work. Examples of areas that require further attention are:

2. The role of substance use services in Child Protection case conferences and review of resourcing and capacity to ensure this matter is always given utmost priority. See **Recommendation 16** in Chapter 8 for further details.
3. At the very end stage of our evidence gathering, the development of the PAUSE programme⁶ in Dundee was brought to our attention. It was a surprise that this initiative had not been brought to our attention from the outset of the Commission. Due to the late submission of evidence around this service, the Commission has not been able to give due consideration to this initiative. However, some Commission members have expressed concern over the setting up of this project in Dundee and would suggest that wider consultation is required about this initiative.
4. The impact of childhood sexual abuse for those who have used drugs to help cope with the trauma experienced in their early years. Detailed evidence was provided to the Commission in written evidence submissions. Again, we have not had the resources or time to give this matter the necessary and full consideration it deserves and would welcome this being prioritised as a matter for detailed review.
5. The role of criminal justice services and matters of availability of drugs across Dundee and law enforcement of drugs.

⁶ “The purpose of Pause is to prevent the damaging consequences of thousands more children being taken into care each year. Pause works with women who have experienced – or are at risk of – repeated pregnancies that result in children needing to be removed from their care.” [PAUSE Dundee, Updated Scoping Report, April 2018].

Although this is an area that has been (in the main) beyond the realistic remit of the Drugs Commission a wide range of evidence has been presented and obtained in relation to the role of criminal justice for those who use drugs. Good evidence has been provided to the Commission which details the helpful and strong role that criminal justice services across Dundee play, with many reports of good working practices noted. As part of our evidence gathering members of the Drugs Commission visited HMP Perth and spoke to the Governor as well as several prisoners from Dundee and prison staff. The recurring key theme was of the challenges posed to accessing good quality treatment pre- and post-release. It was noted that if you are arrested towards the end of a week and held in custody over the weekend, then you face one of two scenarios. On the one hand, if you go to court on the following Monday and are released from police custody, then you are likely to be suspended from your methadone prescription due to having missed your prescription pick-up for a number of days since your arrest; whereas, on the other hand, if you are remanded into custody by the court then your methadone prescription will be continued upon arrival at HMP Perth. One prisoner explained that he had experienced this and that he was “praying” when he went into court on the Monday after his arrest that he would be remanded into custody so that his methadone would continue and not be stopped.⁶

In relation to availability and enforcement issues this has proved to be beyond the ability of the Commission to give due attention to at this stage. However, one of our Commissioners (Suzie Mertes, Superintendent, Police Scotland) has helpfully provided a precis of current approaches to availability and enforcement in Dundee (see **Appendix IX** in the **Part 2** report). It must be noted though that the Commission has not had the time to review this area.

⁶ The Commission has been advised by ISMS that ‘Current practice is that if prior notice is given to the pharmacy/ISMS that someone was dispensed over the weekend prior to release, then dispensing is continued uninterrupted.’

6. CONTEXT

National context

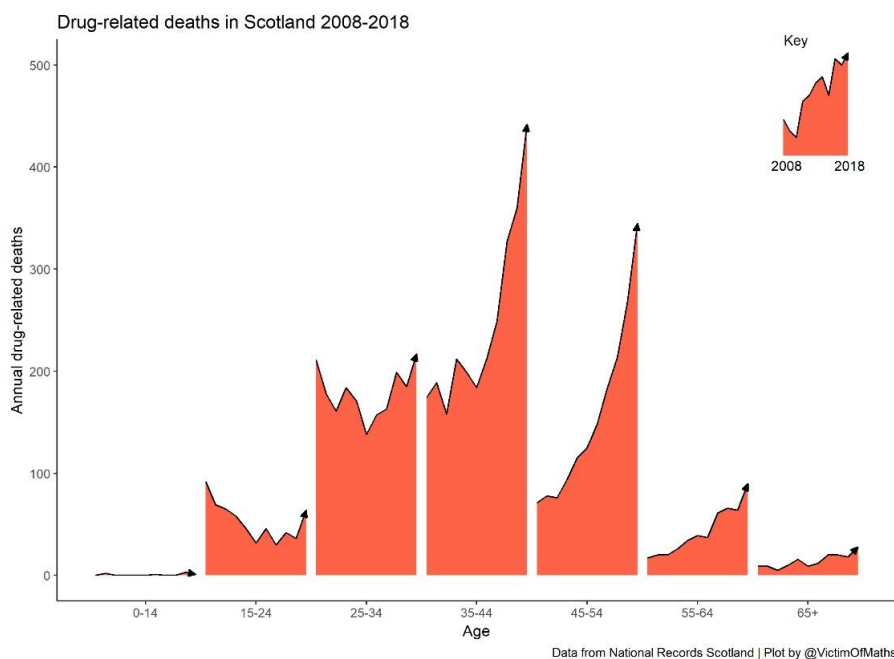
Without doubt, Scotland is currently experiencing a crisis in relation to the rapidly increasing numbers of drug-related deaths.

Recent publication of the number of drug-related deaths in Scotland in 2018 by the National Records for Scotland⁷ show a 27% increase from the previous year (rising from 934 to an all-time high of 1,187).

Between 2008-2018, the number of drug-related deaths has more than doubled (107% increase from 574 in 2008 to 1,187 in 2018). Over this period a combined total of **7,605** people have died in Scotland from a drug-related death, **404** of whom have been in Dundee.

The loss of life, particularly amongst those aged 35-55 years, is such that drug-related deaths are affecting overall life expectancy trends for Scotland⁸.

Figure 6.1: Drug-related Deaths in Scotland – 2008-2018 (by age)⁹



The majority (905, 76%) of deaths in 2018 were of those aged 35 years and older – so called ‘older drug users’. There were 282 deaths among people under 35 years of age during 2018 (up 26% from 224 in 2017).

As in previous years, most drug-related deaths were among men (860, 72%). However, comparing annual averages for 2004-2008 with 2014-2018, the percentage increase in the number of drug-related deaths was greater among women (212%) than men (75%).

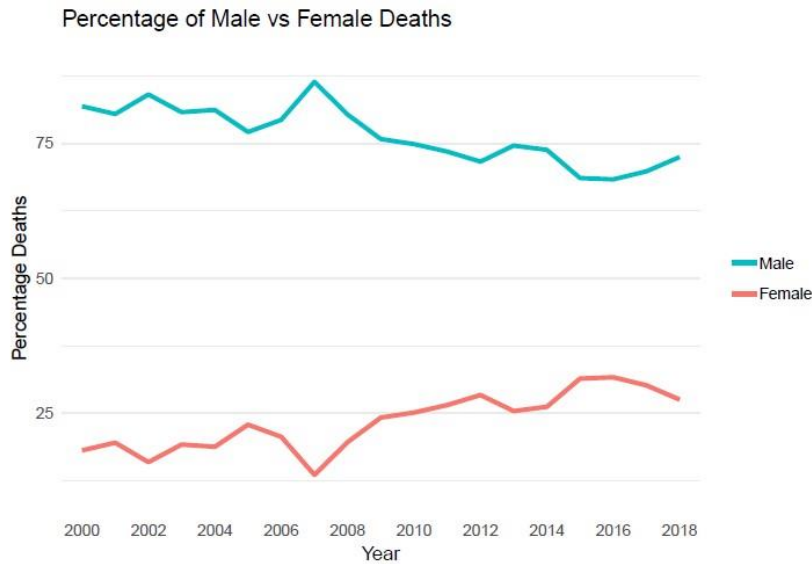
Figure 6.2: Male v Female deaths – by percentage¹⁰

⁷ <https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/drug-related-deaths-in-scotland/2018>

⁸ <https://www.scotpho.org.uk/population-dynamics/recent-mortality-trends/>

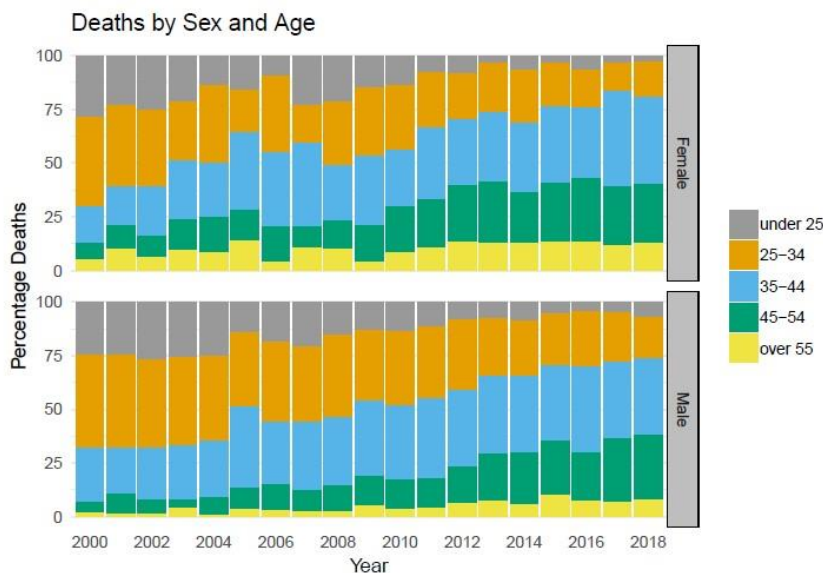
⁹ Thanks to Colin Angus, Senior Research Fellow, Sheffield Alcohol Research Group, University of Sheffield for permission to use this graph.

¹⁰ Thanks to Dr Christian Cole, Leverhulme Research Centre for Forensic Science for permission to use this graph.



Males are mostly affected by drug-related deaths, but females are increasing.

Figure 6.3: Deaths – by sex and age¹¹



In 2000 deaths were largely in the under 35s. In 2018 they are dominated by the 35 and over. Particularly in females.

Opioids (e.g. heroin/morphine, methadone) have continued to be implicated in most (86%) drug-related deaths, whilst the implication of street benzodiazepines (57% in 2018), gabapentinoids (31%) and cocaine (23%) in drug-related deaths has increased over time.

Figure 6.4: Drugs implicated in death – Opioids and Benzodiazepines¹²

¹¹ Thanks to Dr Christian Cole, Leverhulme Research Centre for Forensic Science for permission to use this graph.

¹² Thanks to Dr Christian Cole, Leverhulme Research Centre for Forensic Science for permission to use this graph. ¹⁴

Thanks to Dr Christian Cole, Leverhulme Research Centre for Forensic Science for permission to use this graph.

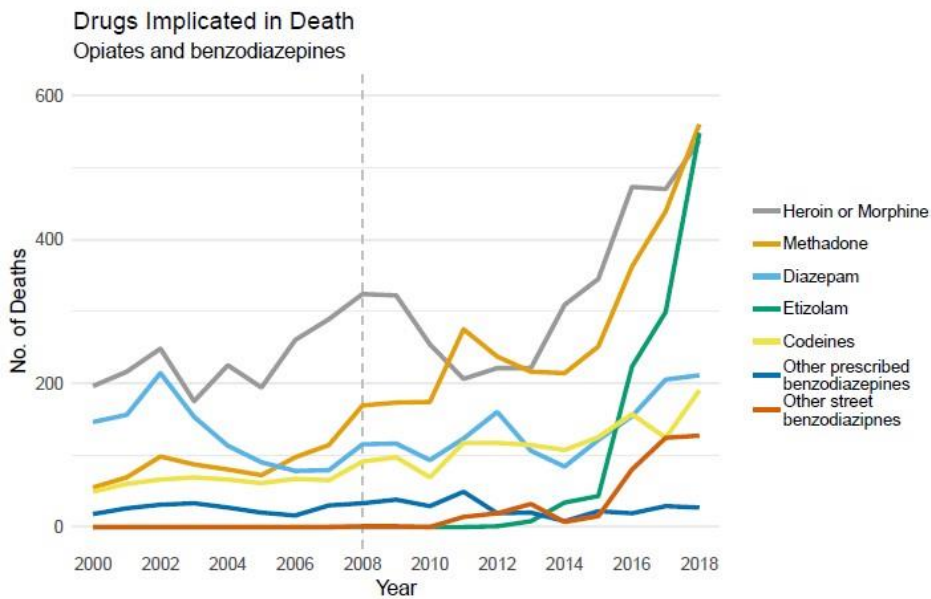
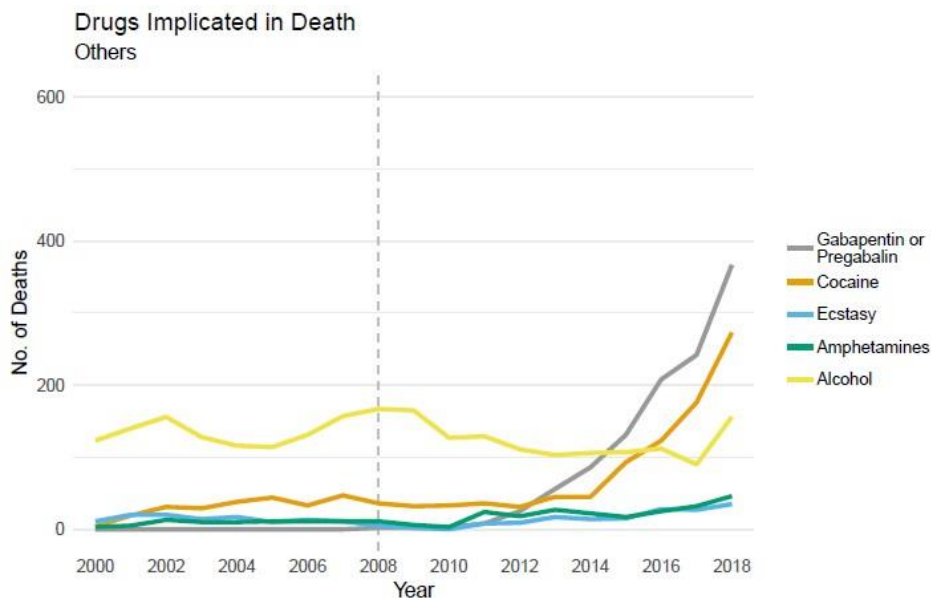


Figure 6.5: Drugs implicated in death – Others¹⁴



NB: data prior to 2008 uses a different definition than the data from 2008. See notes in table 3.

Scotland's figures imply a drug-related death rate that is nearly three times that of the UK as a whole. It is also higher than that reported for any other EU country.¹³

Figure 6.6: Number of drug-related deaths (per million population) – by EU countries

¹³ However, countries differ in how deaths are recorded and coded, and there may be under-reporting in some cases. See <https://www.gov.scot/news/1-187-drug-deaths-in-2018-up-27-percent-in-a-year/> ¹⁶ <https://www.bbc.co.uk/news/uk-scotland-48938509>

European drug deaths per capita

Aged 15-64, cases per million population



Scotland's reported drug-related death rate is now higher (218 per million of the population) than the one reported for the USA (217 per million of the population)¹⁶, which has previously been considered to be the highest rate in the world.

The Scottish Government has recognised that the country is facing a public health emergency over the rise of drug-related deaths and the Minister for Public Health and Sport (Joe Fitzpatrick, MSP) is arranging a high-level summit in Glasgow to discuss the crisis. The Minister has also announced that a new national taskforce is to be set-up to help tackle the crisis.

"A new taskforce to tackle the rising number of drug deaths in Scotland is to be chaired by Professor Catriona Matheson from the University of Stirling. The taskforce will examine the main causes of drug deaths, promote action to improve the health outcomes for people who use drugs, and advise on further changes in practice, or in the law, which could help save lives. It will collate and publish good practice about what has worked in other parts of the UK and internationally, and work with partners to spread and sustain good practice in Scotland.

The group will also examine whether the Misuse of Drugs Act 1971 affects the provision of a

strengthened and consistent public health approach to drug use, recognising that this is reserved to the UK Parliament and that any changes will require their agreement, or for responsibility to be devolved to Scotland. The review will specifically consider what impact the Act has on proposals to provide public health harm reduction services, such as medically supervised drug consumption rooms."¹⁴

Local context

Dundee recorded 66 drug-related deaths during 2018 (up from 57 in 2017 and 38 in 2016). Between 2014-2018 Dundee City averages the highest rate of drug-related deaths per 1,000 population of all council areas in Scotland (0.31 deaths per 1,000 population). Of note, Glasgow City is not dissimilar.

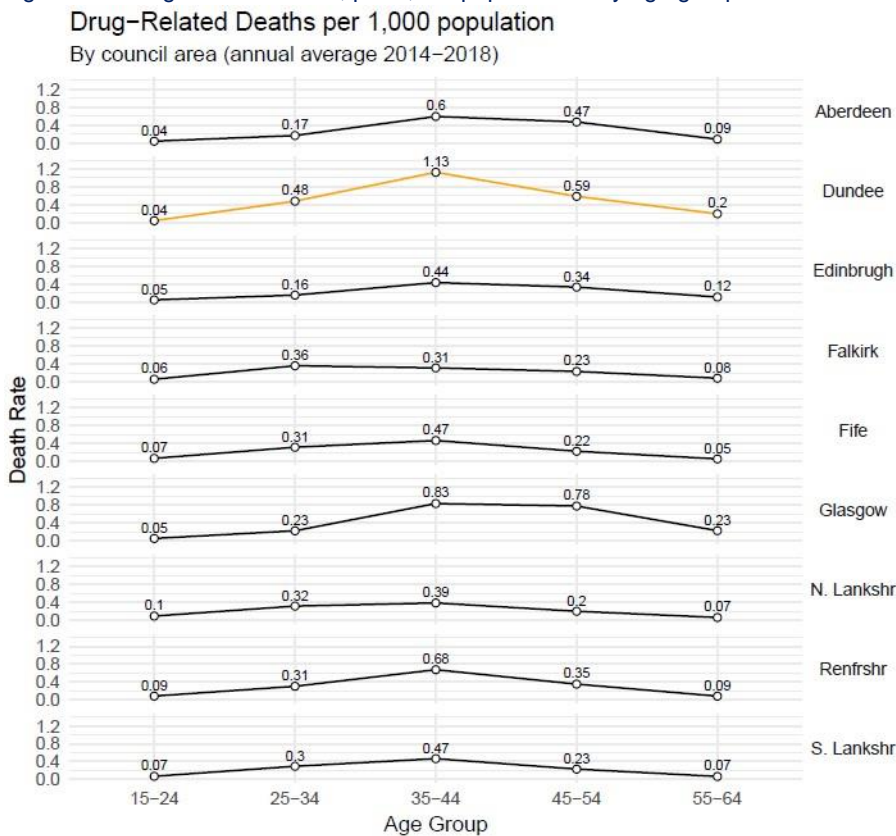
Its rate of drug-related deaths per 1,000 population is 0.30.

Initial analysis of the national (2018) dataset highlights some aspects about the nature of drug-related deaths in Dundee.

Firstly, proportionately there are noticeably more deaths in the 25-34 and 35-44 year old age groups than for other areas of Scotland, as shown in the graph below:

¹⁴ <https://www.gov.scot/news/chair-of-new-drug-deaths-taskforce-appointed/>

Figure 6.7: Drug-related Deaths, per 1,000 population – by age group¹⁵



It is also important to note regional comparisons of drug-related deaths, by drugs implicated in deaths (for all council areas with more than 40 DRDs in 2018), as shown in the figure below:

Figure 6.8: Regional comparisons of DRDs – by drugs implicated in deaths¹⁶

¹⁵ Thanks to Dr Christian Cole, Leverhulme Research Centre for Forensic Science for permission to use this graph.

¹⁶ Thanks to Dr Christian Cole, Leverhulme Research Centre for Forensic Science for permission to use this graph.

Regional Comparisons



To more fully understand the context of drug-related deaths in Dundee, the Commission met with and heard evidence from experts at ISD (**Dr Lesley Graham**, Clinical Lead for Alcohol, Drugs and Health in Justice Settings, ISD Consultant Team; and **Lee Barnsdale**, Principal Information Analyst [Drugs], ISD) in order to try and identify and understand whether Dundee has any specific conditions or factors that are influencing the high rates of drug-related deaths. As a result of these meetings, the Commission requested that a 'deeper dive' of drug-related death data be undertaken by ISD in order to compare Dundee against the Rest of Scotland in respect of a range of criteria (discussed and agreed by the Commission and ISD).

The dataset provided by ISD was submitted to the DADP on 27th May 2019 and then forwarded to the Dundee Drugs Commission. A team of statisticians and data scientists from the Leverhulme Research Centre for Forensic Science, at the University of Dundee, agreed to conduct a rapid, independent review of the data to perform an observational analysis and prepare data visualisations. Their report is provided in **Appendix XII** in the **Part 3** report. Although the numbers for Dundee over the timeframe 2009-2016 are small in some cases, and although the Commission has had very little time to analyse in depth the findings, the Commission believes that the 'deeper dive' has highlighted important information, especially the comparisons with the rest of Scotland, that has not been available previously to help inform planning around drug-related deaths. The Commission believes that there are potential alternative explanations within the data to current thinking, and that the data will need to be interrogated further and triangulated with other qualitative evidence sources to be able to fully understand what is happening in Dundee (when compared to the rest of Scotland). The Commission has not had the time or resource to do this fully and would therefore like to suggest that the 'deeper dive' of data is repeated in due course (with inclusion of 2017-18 data) and included within a full independent health needs assessment (see **Recommendation 12** in **Chapter 8**). This will enable exploration of all possible alternative explanations to ensure credibility and accuracy of findings and conclusions.¹⁷ The Commission remains of the view that strong inferences cannot be made because of the low numbers in some of the data fields and that the data must be viewed with that caveat – and would require further testing by repeating the 'deeper dive' over several years. In discussions with ISD, who completed the 'deeper dive', the areas that are worthy of consideration and further exploration are:

- Proportionally (when compared to the Rest of Scotland), in Dundee there are:
 - more deaths in the 25-34 age group; ○ fewer suicides¹⁸;
 - more individuals who live in areas within SIMD 1¹⁹;

- more people in treatment (prescription) at time of death; ○ more people on methadone at time of death;
- more deaths where the individual had been diagnosed with Hepatitis C; and ○ more people diagnosed with a mental illness.
- Higher proportions of DRDs in Dundee with gabapentinoids; etizolam²⁰ and diazepam implicated in death.

The indication that Dundee has proportionately more drug-related deaths amongst those who live in areas within SIMD 1 (noted above) is of particular interest to the Commission given the work of the Dundee Fairness Commission²¹ that has been progressed in the City over the last few years.

The Commission has conducted a Rapid Inequalities Review (see **Appendix VII** in the **Part 2** report) as part of its evidence gathering, which suggests, through available recent local data, that 73% of individuals who died as a direct consequence of drug use in Tayside in 2017 lived in areas that were classified in the two most deprived SIMD quintiles. This suggests an inequality incline associated with drug deaths, with more than half of drug deaths occurring in areas of greatest socioeconomic deprivation.²²

¹⁷ The Commission has noted that ISMS, in its evidence submissions (see **Appendix XVI** in the **Part 3** report) has undertaken work to understand operational data within the context of the 'deeper-dive'. This work needs to be further developed.

¹⁸ Care and attention needs to be taken with this as there is difficulty in determining whether a death is suicide or an unintentional overdose – i.e. not all cases of suicide are listed as such on the death certificate.

¹⁹ The Scottish Index of Multiple Deprivation (SIMD) measures across seven domains: current income, employment, health, education, skills and training, housing, geographic access and crime. These seven domains are calculated and weighted for 6,976 small areas, called

²⁰ Etizolam was the most common substance found in drug-related deaths (41 deaths) in Dundee City in 2018, more so than methadone (27) or heroin/morphine (34). The role of Etizolam in drug-related deaths should be a top priority for the Tayside Drug Deaths Review Group to investigate. The proposed independent Health Needs Assessment (see **Recommendation 12**) should have an explicit objective to understand the increasing use of Etizolam and other new and emerging non-opioid substances.

²¹ <https://www.dundeefightingforfairness.co.uk/>

²² Tayside Drug Death Review Group. 2018. *Drug Deaths in Tayside, Scotland, 2017*. Available at:

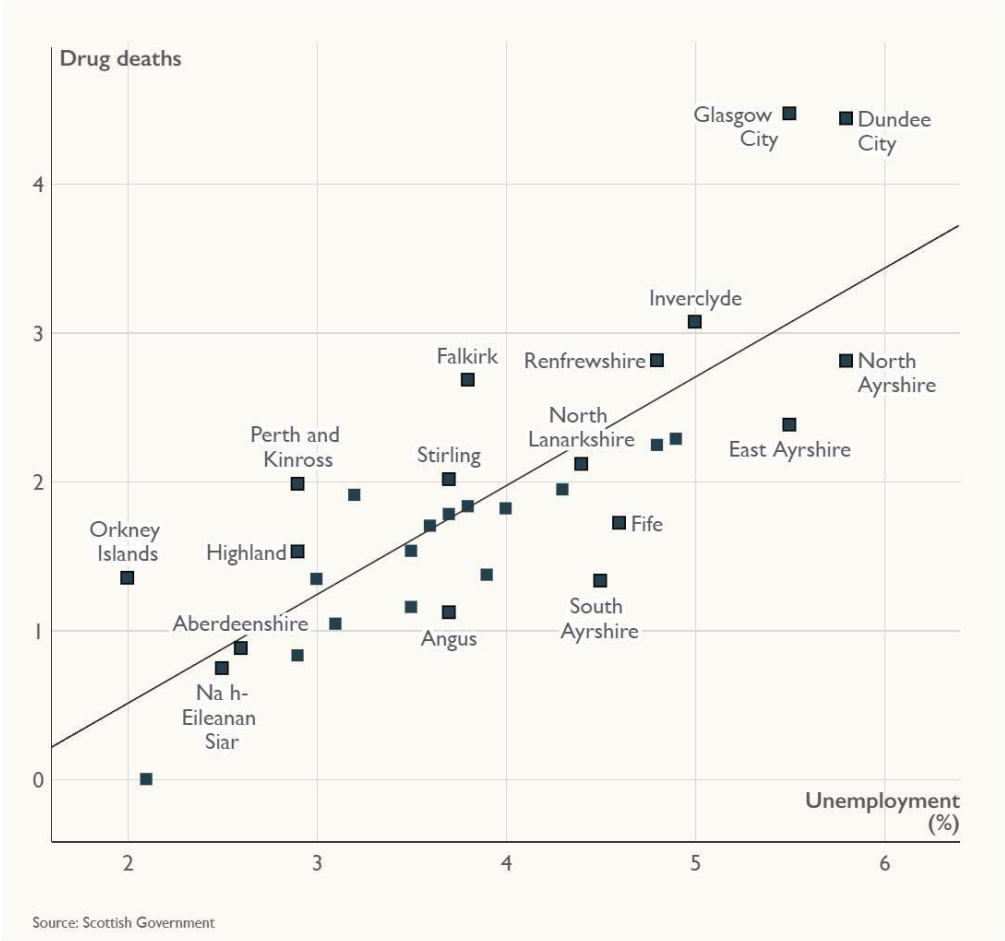
The link to deprivation also appears stronger in Dundee when the 'employment status' of those who have died from a drug-related death is considered, as indicated in the table below. Dundee City can be seen to have the highest (population) rate of unemployment amongst those who have died from a drug-related death of all local authority areas in Scotland – as well as the highest (population) rate of drug-related deaths. Understanding, in greater detail, the links between drug-related deaths and poverty will be critical for the Dundee Partnership to develop robust responses and solutions.

'data zones', with roughly equal population. The SIMD provides a relative measure of deprivation which means that the main output from SIMD - the SIMD ranks - can be used to compare data zones by providing a relative ranking from most deprived (rank 1) to least deprived (rank 6,976).

Figure 6.9: Drug deaths and unemployment in Scotland – by population rates

Drug deaths and unemployment in Scotland

Drug deaths per 10,000 people and the percentage of unemployed working age adults



7. WHAT WE HAVE HEARD

The Dundee Drugs Commission has been an intensive and rapid review of the recent history of the impact of drug use across Dundee, and the help available for people who use drugs in the city. Local Commission members have been supported by experts from across Scotland and the wider UK. To be clear, the Commission was set up in part to assess the effectiveness of the strategic planning and delivery of services co-ordinated by the Dundee Alcohol and Drug Partnership and more broadly across community planning partners (Objective #4). During the course of our work, we have learned about inadequacies in our local systems and services. We have frequently heard from individuals and families who feel that the system has failed them. All our recommendations are born out of the experiences of people in Dundee.

The changes proposed in these recommendations are based on four key sources of information:

1. People in Dundee including people who experience problems with drugs, their families, friends and our wider community;
2. Professionals who work in Dundee;
3. Experts from across Scotland; and
4. International research evidence and best practice guidance.

In total, eighteen (18) different evidence sources were used across the above four groups (which are detailed in **Chapter 5** of this report as well as **Appendix II** in the **Part 2** report and **Appendix X** in the **Part 3** report).

Guiding principle of the Commission

The people of Dundee have been and remain our first priority. When systems and services fail it is the people that they were designed to help (and their loved ones and communities) who are disadvantaged. This is the guiding principle that has informed all of our recommendations. This principle should continue to guide all future decision making and action in seeking to help people and communities who are affected by drug use in Dundee.

Limitations of the Commission

It is important to recognise that, within the time and resource constraints facing the Commission, we do not claim to have conducted a comprehensive review of all the research and evidence on responses to drug problems, nor have we been able to spend as much time as we would have liked talking to those who experience problems with drugs and their families, service providers, or residents of Dundee.

Notwithstanding these limitations, the Commission has facilitated and witnessed many significant and far reaching discussions concerning the nature and extent of the challenges faced and, most importantly, on what can be done to rapidly improve the situation. We have reached consensus on a number of recommendations that we believe could make a material difference to dealing more effectively with drug use related problems across Dundee and, ultimately, result in reductions in the high number of drug-related deaths in the city. Some of our recommendations are aimed at local partners and leadership and some are aimed at national leadership.

Key Messages

As a Commission, over the course of the last year, we have received evidence from over a thousand different people – those with lived experience of problems with drugs (current and past); family members; members of the public; clinicians and GPs; staff who work in drug treatment and support services; staff who work in wider health and social care services; senior officials within NHS Tayside, Dundee City Council and Dundee's third sector; politicians and elected members; and academics.

Some individuals and families have spoken in great detail to us about positive experiences of the help and support they've received and the strategies they have used themselves to move towards recovery from drug use. Many individuals and families shared their grief and loss over the devastation that has been caused by drug use. We have heard numerous stories of immense challenges and barriers put in front of those who require help and support, compounded by the pervasive stigma that is still attached to being a person who experiences drug problems. Staff working in services have shared both positive and enthusiastic accounts of

their efforts to help those who present to services, as well as details of immense frustration and anger when things do not work as they should.

Our review of a substantial amount of evidence has taken time to distil and balance. We have been aware that when an independent Commission is set-up then you tend to have all the stories coming to the fore of how things are not working. However, we have also taken the time to seek out and listen to those who have a positive story to tell – whether one of how they've successfully made changes to their drug use by themselves (or with help from family and others) – or whether a story of how they have received the help required from local services. By so doing, we believe that we have achieved a balanced understanding of the reality of issues faced.

Our review has led us to detailing a number of key messages – all of which we have used to form the challenging set of recommendations (later in this chapter). The key messages are structured underneath the key themes of our work (Leadership and Drug Deaths; Treatment and Support; and Mental Health). **To be clear, the phrases below that are set in *italics* are the words of the Commission rather than direct quotes from individuals.** However, we have paraphrased in order to summarise the consistent and strong messages that we have heard.

Leadership and Drug Deaths

In terms of investigating the role of leadership in the drugs field in Dundee, we have taken evidence from a range of sources, with particular focus on the roles of the DADP, Chief Officers Group (COG), the Dundee Partnership, the Dundee Health and Social Care Partnership, and the Dundee IJB.

The evidence we have received has led us to conclude that leadership in Dundee (related to the drugs problem) has been disjointed, inconsistent and ineffective. We have evidenced this by: (1) an inability and/or lack of accountability mechanisms to follow through on improvement plans and promises; and (2) a lack of ambition ('whatever it takes') in some areas to act to prevent harms and drug-related deaths. Within the initial portion of evidence gathered we identified a clear lack of leadership from DADP members and a lack of 'holding the DADP to account' by the Chief Officers Group (COG), the Dundee Partnership, and the Dundee IJB. Our findings and outputs from further investigations conclude that there has been a lack of leadership across all services to facilitate the changes required to effectively reduce the risk of drugs deaths in Dundee. The governance framework that has been in place has been disconnected and therefore not able to effectively monitor and implement change.

Governance

Overall, the DADP has been lacking a clear governance structure and it is not clear what its current relationship is to the Community Planning Structure or the Health and Social Care Partnership (HSCP). There has also been a lack of clarity around the role and influence of the HSCP Strategic Planning Group (SPG). The DADP has not known its place and therefore has become ineffectual to strategically lead, direct and influence service provision across the city. The SPG is a sub-group of the DADP. It would appear that the group has too many members to be an effective tasking group. The feeling of many of the members is that the SPG provides an information function only. It does not feel like a transparent and inclusive process. There is a power imbalance between the statutory and voluntary sectors where the agenda and control of commissioning and funding is dominated by the statutory sector, which we discuss in further detail below. The Community Planning Partnership has a clear responsibility to ensure the DADP functions and actively addresses the increasing number of drug-related deaths in Dundee. There is little evidence to demonstrate how they have shown leadership in this area.

Leadership

There appears to have been a lack of leadership and direction from the members of the DADP over a number of years. This has resulted in several key pieces of work not being satisfactorily acted upon. The commissioned Prevention Strategy and the Care Inspectorate self-assessment are two examples of this. We are therefore led to question whether there has been a resistance in Dundee to introduce best practice from elsewhere.

The ability of the DADP to provide effective leadership may have been affected by reduced capacity of the DADP support staff over the last two years – for example, the DADP Lead Officer now has other responsibilities as well as the ADP remit, and the previous ADP Support Officer position has not been filled.

Performance Management

There have been no systematic performance management processes across all services funded by the DADP. There is no outcomes framework for the DADP, despite previous reports recommending priority action to rectify this. The commissioned voluntary sector organisations have their performance monitored by the HSCP Contracts Monitoring Group, but performance is not considered through any DADP Committee. The DADP, for many years, has not had any consistent approach to establish how services are performing.²³ Dundee, like all other areas of Scotland, has not been helped in this regard by the substantial delays to the roll-out of the DAISy (Drug and Alcohol Information System).²⁴

There is no overall scrutiny of funding against performance.

There are no Service Level Agreements (SLA's) with NHS Tayside, the Health and Social Partnership, or Dundee City Council, for services delivered by them. In practice, this means there is no accountability to the DADP for performance against any outcome's framework.

There was a pilot of a common assessment tool previously, but this was never progressed by the DADP.

The Scottish Government's Recovery Outcomes Web (ROW) was seen as good practice but has not been adopted uniformly across services.

There is no evidence of a structured process for positively drawing on the insights of people with lived experience to shape and reform service going forward.

Cultural Change

The culture of service delivery in Dundee is inflexible and based on a treatment model. There is little evidence of a joined-up Recovery Orientated System of Care (ROSC). To achieve this will require clear leadership to achieve a combined shift and focus across all service delivery.

The feedback we have received from most of those individuals using statutory services is that they attend with an expectation that they may face a stigmatising attitude. Action will need to be taken to ensure that this situation changes (see **Recommendation 2**).

A cultural change leadership programme is required across all services. However, this is particularly relevant across statutory services – particularly those hosted by NHS Tayside and the Dundee HSCP.

Funding structures

Fundamentally, the 'playing field' in drugs services in Dundee is not 'level' because the majority of funding for drug treatment is held by the NHS and managed by the Integration Joint Board [IJB]. This leaves a situation where one partner commissions and contract manages its third sector partners.

This makes it difficult for the third sector to engage equally and results in concerns about '*biting the hand that feeds them*' by speaking honestly.

The unequal power and control in the drug treatment system, the majority of which is held by the NHS, has led to a breakdown of relationships between statutory ISMS and the third sector – to the point where third sector services have chosen not to speak honestly in meetings for fear that their services will be decommissioned. Some staff members (from a mix of services) have chosen to provide their evidence to the Commission anonymously due to concerns about job security. This breakdown of trust between ISMS and its third sector partners is one of the most worrying findings of the Commission and will require urgent attention. This leaves us with a strong sense of a 'them and us' scenario.

The DADP only has direct control of about one third of the total drug and alcohol budget, of which almost four-fifths is spent on Treatment and Support, with a further 10% spent on Prevention and Recovery activities, and the remaining 10% spent on 'dealing with the consequences of problem drug and alcohol use in the ADP locality'.

Analysis of recent DADP annual returns to Scottish Government identify approximate proportions of the overall budget being allocated to: (1) Treatment and Support Services; (2) Prevention; and (3) Recovery – as identified in the Table below:

²³ The Commission has noted recent developments by the DADP. Information is now being provided to the DADP from all contracted services through the use of a 'balanced scorecard'. This has been in place since the start of 2019.

²⁴ <https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Drug-Alcohol-Information-System/>

Figure 7.1: Total drug and alcohol spend – Dundee City

% of overall expenditure spent on Treatment, Prevention and Recovery			
	TREATMENT	PREVENTION	RECOVERY
2017-18	79.83%	7.76%	2.73%
2016-17	79.00%	7.24%	4.41%

Treatment and support

This is the area which has dominated the time of our Commission for evidence gathering. When we began our inquiry, our primary objective was to review the impact of drug use across Dundee. However, the reality of our evidence gathering has been dominated by people wanting to talk about the main specialist treatment service, the Integrated Substance Misuse Services (ISMS), in Dundee, and the problems they have faced with access, engagement and lack of choice. Indeed, the service has a very high level of unplanned discharge.²⁵

The system, driven by a national direction to get individuals into ‘specialist treatment’, focuses on ‘funneling’ individuals into the prescribing service, rather than having a prevention-based philosophy (which would be aimed at avoiding the need for individuals getting to a place where they

require specialist treatment in the first place), and therefore leaving the specialist service to work with those who really do require specialist input. Our review has led us to a clear feeling of *‘all roads lead to ISMS’*. The reports we have heard at the Commission are dominated by accounts of how the service treats so many people that they struggle to deal with the people with the most complex circumstances (the people that they should fundamentally be dealing with); and at times not working with them until they have managed their drug use to a certain degree. It is a scenario where specialist treatment almost becomes the only option in Dundee for those who use drugs and who desire help.

Many of the stories we have heard were of people struggling to access Opioid Substitution Therapy (OST) and then struggling with the rigidity of the programme (with numerous reports that if you do not meet the established service criteria (see Treatment Agreement, **Section 2 of Appendix XVI** in the **Part 3** report - **question 4**) or expectations at any one point of the system, no matter how small, then that apparent failure is used as a reason to put somebody back to the start of the process for receiving treatment).

Some individuals currently using the service reported how the service requires individuals to complete a drug diary prior to initiation of treatment, and at all intervals where there may be a change in prescription. Drug diaries are not an accurate reflection of an individual’s use of drugs or their motivation to change and should not be used to either demonstrate motivation, or to delay access to treatment.

Additionally, some service users report the need to do multiple drug tests prior to commencing treatment and perceive that these are often used to delay (or even deny) access to treatment, rather than being used as a tool to support treatment.

Ultimately, there needs to be greater flexibility and choice for individuals.

The conclusion we have drawn from the evidence is that the ‘system’ in Dundee is currently heavily focused on a bureaucratic, centralised model, narrowly delivering OST at the expense of delivering a more joined-up integrated system of care which involves a range of stakeholders. Despite the narrow focus on OST, we believe it is not being delivered in line with contemporary evidence-based practice. There are all too often long waits for treatment and high drop-out rates. We consider that this requires urgent and immediate attention. There is a lack of swift access to treatment, followed by unnecessary barriers that then delay OST starting and, in many cases, then high risks of being suspended from treatment for not complying with a regime that appears to be too rigid.

The Commission has heard multiple accounts of challenges at all levels of the system in Dundee – in relation to access, retention, quality of care and the safety of those using services. Our recommendations will prioritise and focus attention on taking a whole systems approach to dealing with these challenges.

Our overarching observation is that there is limited choice in the current system of care and support. A new member of the Community Health Team in Dundee reported, as part of her induction, going around the

²⁵ ISMS report 452 unplanned discharges in the last 12 months – see **Appendix XVI** in the **Part 3** report for further details.

[named area] of the city to find out what community organisations and groups exist. She reported counting at least ninety different groups in the one area of the city. This reinforces the point that drug treatment services in Dundee are operating over-capacity and in silos, often detached from the wealth of support opportunities available to people across Dundee. The development of a 'Recovery Road Map' by the Parish Nursing Team at The Steeple has been a significant step forward in helping services to take an outward-looking approach, to counter the historic inward-looking approach.

Let us be clear that, although there are significant problems within the current system, there are also some real positives. There are passionate, skilled and experienced professionals (in all services) who are often working over-capacity but who are constantly battling the 'system' to be able to do their jobs to the best of their ability. We have, however, heard many reports from staff that they are often 'unable to see the wood for the trees' because of the high numbers of individuals they are having to work with, and because of the systems that require a whole range of procedures to be followed – some of which are perceived as being unnecessary and risk-averse.

We have also heard numerous stories of how, for some people, once they are in ISMS, it is very difficult to come out the other end and leave the service. For others, often some of the most vulnerable individuals, their experience is that they struggle to comply with the perceived rigid regime and therefore opt out of treatment altogether (or never present). The service reports 452 unplanned discharges over the last 12 months which is a significant proportion of those on prescribed OST in Dundee. The service also reports very few planned discharges (22 in the last 12 months), and has informed the Commission that, 'There is no service to discharge people to who are stable on OST.' This is where GPs and Community Pharmacists need to be an active part of the system and solution. GPs have been disengaged from prescribing over many years in Dundee, a situation which requires urgent attention. At one of our public evidence sessions we heard from three Edinburgh-based GPs who reported that out of the 4,000+ individuals on prescribed OST in Edinburgh, around 3,000 are prescribed within Primary Care across the city. Pharmacist prescribers are supporting GP practices to provide OST in other areas of Scotland. In Dundee, there are only two GP practices currently prescribing OST. Therefore, the vast majority of individuals have to be seen by ISMS. ISMS staff reported a significant element of their client group as being stable enough that their care should be transferred back to Primary Care, but unfortunately this is not currently a widely available option.

We experienced significant and unnecessary delays in accessing the data and detailed information required to fully consider the role and performance of statutory treatment services and arranging opportunities to speak to service staff and users. In contrast, the access we have had from all other services in Dundee could rightly be described as providing 'unfettered access'. The time needed to address the significance of statutory treatment services in Dundee therefore limited the capacity of the Commission to consider a wider set of issues (for example, the impact on children and families, prison liberations, availability/enforcement), all of which are vital parts of the bigger picture.

As of September 2018, ISMS stated an aim to get patients on prescription within 10-14 days, although evidence presented to the Commission suggests that this has not been routinely achieved. The expert evidence heard by the Commission confirms that this target is too slow. The Commission heard from two GPs in Edinburgh who are moving toward 'same-day' prescribing in certain cases where people experiencing problems with drugs are at particularly high risk of a range of harms. This has left us with the view that the system is too slow and insufficiently responsive.

Drug treatment is viewed by many in Dundee as a 'specialism'. This allows disciplines, such as mental health services, to be distant or not fully engaged with those who are currently using illicit substances by asserting that the drug problem needs to be tackled before other help can be offered²⁶. Additionally, this 'specialism' view allows ISMS to take the position that they are the only ones skilled to deal with people who experience problems with drugs and is a possible reason why there are so few planned discharges from the service.

This will require some sort of normalisation – i.e. there should be '*no wrong door*' for people who need help to get the help they need, no matter which service they present at. There are also some parallels to the advent of 'Getting It Right For Every Child' in Scotland, in that a mandating of '*it's everyone's responsibility*' may be required nationally to deal with the massive challenges of stigma faced by those who use drugs.

We have reflected on the range of widely held and polarised views that we have heard over the course of the last year and it is clear that certain deep seated perceptions have been built up over time that exacerbate the tensions and feelings of professionals, people who need help with drug problems and affected families alike. Staff at ISMS have had little access to allow them to feed in their views directly to the Commission. This has led to the perception that the Commission is a threat to the service, rather than an opportunity to engage with a process to improve the situation in Dundee for the benefit of everyone.

²⁶ In relation to those with co-occurring drug use and mental health problems, this is contrary to widely accepted contemporary evidence which outlines the need for both conditions to be worked with 'simultaneously'.

The overwhelming perception of almost everyone else that has provided evidence to the Commission is that the service is risk averse and that the system is sometimes punitive. This has led to an ingrained view that there is little point in speaking up and a loss of hope that things can change.

Neither of these perceptions represent the truth of the matter as we have found it to be, although they do shine a light on the state of the sector and the challenges that lie ahead. An analysis of the balance of evidence provided to the Commission tells a compelling story of a system that is not fit-for-purpose rather than any one particular service.

The reality is that the situation is not all bad. There are success stories, there is passion, there is belief that people and the system can change. It is time for all parties to take a step back and seek to find common ground to engage in a new and constructive conversation. It is time for leaders (at all levels of the system) to lead by example. This will need to be done on a 'no-blame, solution focused' basis.

Everyone in the drug treatment system in Dundee will need to work hard and commit to changing these unhelpful perceptions in order to see the improvements that are desperately needed – starting with a reduction in the barriers to quick and effective treatment.

Mental Health

The most common and consistent message we heard across all our evidence gathering was of '*a lack of mental health support for those who experience problems with drugs.*' This message was usually expressed as either: a reluctance of statutory drug treatment services to work with mental health problems (i.e. where those presenting to substance use services are told '*we only deal with drug problems, not mental health*')²⁷; or the perceived refusal of mental health services to work with individuals unless they deal with their drug use first.

During the course of our evidence gathering, we also received approaches from the Dundee 'Fighting for Fairness' Commission (Mental Health Working Group) who, during 2018, collected and analysed 39 survey responses (out of a total of 122) where respondents reported that at some point they had struggled with their mental health; and Dundee Service User Network who conducted a series of ten Focus Groups during 2018 with one hundred individuals as part of the evidence gathering for the Independent Inquiry into Mental Health Services in Tayside²⁸. Both of these pieces of work highlighted significant issues in Dundee (and Tayside) for those who experience problems with drugs, in relation to access and support for mental health problems. Through our discussions with both the Fairness Commission and the Independent Inquiry, it became clear that their data sources and those of the Drugs Commission were identifying the same key issues.

The Dundee 'Fighting for Fairness' Commission, in its most recent report (November 2018)²⁹, recommended that: 'The Dundee Drug Commission and the Dundee Alcohol & Drug Partnership [should] utilise the Fairness Commission's mental health research findings to ensure that people with substance misuse issues are offered and can access appropriate mental health support.'

We are fully supportive of this recommendation and have fully considered the evidence provided by the Fairness Commission (as well as that provided by the Dundee Service User Network) in developing our key recommendation around this issue (see **Recommendation 13**).

Further, we have discussed our findings with the Chair of the Independent Inquiry and expect the Independent Inquiry (in its forthcoming report) to make 'whole system' recommendations to support the development of services for those with co-occurring drug and mental health issues in addition to our own recommendations. Our emphasis would be to focus on developing services in line with the two key principles

²⁷ Numerous reports were made to the Commission in this regard. This contrasts with the evidence provided to the Commission by ISMS which indicates established policies and procedures for working simultaneously with drug and mental health problems.

²⁸ <https://independentinquiry.org/>

²⁹ Available at: https://docs.wixstatic.com/ugd/725539_993c625815b74e2182517772df578fdd.pdf

identified by Public Health England in its 'Better care for people with cooccurring mental health and alcohol/drug use conditions' report (2017)³⁰:

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- '1. Everyone's job. Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.
 2. No wrong door. Providers in alcohol and drug, mental health and other services have an open-door policy for individuals with co-occurring conditions and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point.'

³⁰ Public Health England (2017). Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for Commissioners and Service Providers. London. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Cooccurring_mental_health_and_alcohol_drug_use_conditions.pdf

8. OUR RECOMMENDATIONS

As an independent Commission, in collating and analysing the vast amount of evidence that has been gathered over the last year, we have taken our time to reflect upon, and attempt to balance, the wide variety of views presented. In doing so, we have met physically as a whole Commission on eleven (11) occasions over the last year, with a further substantial layer of sub-group meetings around our four key themes, and additional telephone calls and email exchanges, in order to develop the following set of recommendations and considerations.

The recommendations are aimed at the Dundee Partnership which was courageous enough to open up the issue of drug use in Dundee to independent (and highly public) scrutiny. From the outset we unanimously agreed that we needed to respond to the request of the Dundee Partnership with a commitment to formulate a set of bold and brave recommendations.

We do not hide from the fact that the recommendations detailed below are going to be challenging to implement, and will also require strong and dedicated leadership over many years to make Dundee a place that delivers on its belief that truly 'every death matters' and, more positively, 'every life matters'. This will require an honest and transparent acknowledgment of the failings that have taken place in the delivery of drug treatment services (in a 'no-blame' environment), and the willingness and determination to learn and exploit the lessons that are evident from these failings.

We have scrutinised and discussed the evidence that has been received and have also looked for examples of best practice from elsewhere in order to:

3. identify immediate steps that can be taken to start improving the situation; and
4. begin a longer-term journey to realising a vision for a high-quality system of treatment and care for some of our most vulnerable citizens who deserve better.

We also recognise that some of the required changes are not solely within the gift of the Dundee Partnership to deliver. This is why a series of 'national considerations' are also offered below. We sincerely hope that these will be responded to by the Scottish Government and the UK Government because many of the levers for change in the local systems are held outside of local control. The changes we are recommending will require a renewed determination to work much more effectively across local, regional and national structures to deliver them. Our insight of best practice from countries such as Canada, Iceland and Portugal would, similarly, require changes in national policy and legislation and systems/practices in order to allow Dundee to implement fully the changes that are required.

The political interest and support for the Commission has been significant from the beginning. Without it, the Commission would never have been instigated. The time is now right to hand back the evidence and findings of our work to our elected leaders and ask them to set the standard for the leadership and accountability that is going to be required in Dundee (and beyond) to turn around the national emergency that is epitomised by the severe rates of drug-related deaths across Scotland.

Local Recommendations

The following are our set of **sixteen (16)** recommendations that we believe are within the abilities of the Dundee Partnership to progress. They detail three parallel areas of required work:

1. **Immediate action in the next 12 months** to address the challenges in the current system and to draw a line in the sand to enable all parties to effectively work together in the future.
2. **Transition planning and arrangements over the next 3 years** to allow time for longer-term plans to be designed, approved and resources allocated.
3. **Creation and implementation of a long-term vision over the next 5 years** for a high-quality and person-centred treatment and care system in Dundee, where drug-related deaths are eradicated³¹.

The Commission has referenced these timescales within some of the recommendations below. Where timescales aren't indicated within the recommendations, we would expect the Dundee Partnership to identify appropriate timescales when prioritising and developing their action plan in accordance with the above framework.

The recommendations are grouped under the following three headings:

³¹ The Commission acknowledges that this will not be possible in isolation from wider national and UK changes – due to poverty and drugs supply/criminalisation issues etc. that keep existing harms in place.

- D. Culture and systems;
- E. A holistic system model - including integrated Primary Care provision; and
- F. Causes and effects of drug use.

A. CULTURE AND SYSTEMS

This first suite of recommendations (1-6) is focused around the need for cultural change across drug treatment services, related disciplines and communities of Dundee, and changes in local systems that will help facilitate such cultural change.

Recommendation 1: The Dundee Partnership must do all that is necessary to achieve the required standard of leadership – the test of which will be that agreed changes are owned and supported by the statutory and third sectors, recovery communities, service users and families.

Leadership, accountability and governance should be addressed first as an immediate priority as this will take the greatest effort and change to improve. Drug deaths are not inevitable and are absolutely preventable. This is a message that needs to be driven home from the top of all public organisations in Dundee.

Leadership needs to mean taking clear responsibility for the problem and putting in place a dynamic, responsive, cohesive plan to address the harms created by substance use, as well as a transparent

framework of accountability for the action that is required to reduce drug-related deaths in Dundee. A ‘whole system’ approach needs to be taken, inclusive of people who use (and have used) drugs, family members and local community responses.

Leadership needs to be strong and distributed, along with themes of accountability, which should be mutual at times of trouble. The Chief Officers are accountable, but they must work in an environment that places clear roles and responsibilities on them. Political leadership is important, and so is listening leadership – and there was plenty that the Commission heard that shows that leaders haven’t been connected with people who experience problems with drugs and affected families.

‘Civic’ leadership is required here, including: political leadership (which is connected with local and national (Scottish, UK) elected leaders, who are in a position to take action); and Chief Officer leadership (which is mutually accountable, strongly bonded and clear about the key priorities and the action that is required).

The Commission welcomes the appointment of an independent Chair for the DADP which increases our confidence that significant and swift change is possible.

In order to fully implement this recommendation, the Commission considers that the following elements of action need to be initiated as a matter of urgency:

- Restructure the membership of the DADP:
 - The DADP should operate as an impartial and effective commissioning and strategic leadership body. [For the avoidance of all doubt, this means that no individual with current drug service provision responsibility should be a core member of the DADP.]
 - The Finance and Performance DADP Sub-Group (or any future equivalent group) should be chaired by an independent person who has no service delivery/operational responsibility.
 - There must be senior representation from GPs³² and Community Pharmacy.
 - A service providers group should be set up with regular attendance being a requirement from all drug service providers to report into the DADP on a regular basis. A rotation system for the Chair of the group should be adopted to ensure equality of participation amongst all members. The Chair should be invited to provide written and verbal updates to the main DADP meetings (as a standing item).
 - The correct level of representation needs to be achieved (in terms of both seniority and commitment to regular attendance and participation) to enable strategic accountability and

³² So long as any GP representative does not have any commissioning or funding conflict of interest.

avoid any 'conflicts of interest' for individual members. Attendance at meetings should be monitored and publicly reported.

- The DADP needs a formal Constitution as a matter of urgency, with clear lines of accountability. The Community Planning Partnership should oversee implementation of the new DADP and structure. A new governance structure needs to demonstrate and deliver

(within 12 months) mutual and visible accountability. This provides a unique opportunity going forward to pilot a new model for ADPs across Scotland, that all face a similar challenge.

- Given the increased public health focus of the new national Drug and Alcohol Strategy³³, NHS Tayside's Public Health department must take a leading role in supporting and guiding the DADP in its future planning and commissioning. An essential component of this has to be an increased attention to prevention; the starting point of which must be that DADP formally approves and implements the recommendations of the previous prevention research and strategy development it commissioned in 2016-2017.
- A comprehensive performance management and monitoring structure (with key quality indicators) should be in place for all service provision for substance use services.
- A detailed transformational change programme requires to be established to change the culture within treatment services. This needs to be underpinned by the Scottish Human Rights Commission's PANEL principles³⁴ (Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality). The cultural problems we have seen in our evidence have to be changed by dynamic changes at the very top of all organisations in Dundee that have responsibilities that intersect with drugs and drugs harms. Specialist treatment services must be ambitious on behalf of the people they work with. Consistent and comprehensive evidence has been heard which details specialist services that can be experienced as having low expectations of, and lack of respect for, the people they were set up to help.
- Clinical governance is seen as a barrier to undertaking transformational change, rather than a facilitator. This requires clear leadership from NHS Tayside to ensure that change can be managed with a 'can do' attitude and 'no-blame' culture, but which ensures evidence-based practice (which has patients' needs and safety at the heart). The Commission recommends that NHS Tayside develops a clinical governance transformation plan for substance use and mental health, based on the values and substance of 'realistic medicine'³⁵, as well as inclusion of a full Equality Impact Assessment (EQIA)³⁶ related to all change and transition plans.

³³ Scottish Government (2018). Rights, Respect and Recovery: alcohol and drug treatment strategy. Available at:

<https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2018/11/rights-respectrecovery/documents/00543437-pdf/00543437-pdf/govscot%3Adocument/00543437.pdf?forceDownload=true>

³⁴ Scottish Human Rights Commission 'PANEL principles' [Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality]. Available at: http://www.scottishhumanrights.com/media/1409/shrc_hrba_leaflet.pdf

³⁵ Scottish Government (2017). Realising Realistic Medicine: Chief Medical Officer for Scotland annual report 2015-2016. Available at: <https://www.gov.scot/publications/chief-medical-officer-scotland-annual-report-2015-16-realising-realistic-9781786526731/>

³⁶ "An Equality Impact Assessment (EQIA) involves assessing the impact of new or revised policies, practices or services against the requirements of the public sector equality duty. The duty requires all Scottish public authorities to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. It covers people in respect of all aspects of equality (age, disability, sex, race, religion or belief, sexual orientation, gender reassignment and pregnancy and maternity). It helps to ensure the needs of people are taken into account during the development and implementation of a new policy or service or when a change is made to a current policy or service." Available at: <https://www2.gov.scot/Topics/People/Equality/Equalities/EqualFramework/EvidencePSED/EQIA>

Recommendation 2: Challenge and eliminate stigma towards people who experience problems with drugs, and their families, across Dundee to ensure that everyone is treated in a professional and respectful manner.

Stigma comes in all shapes and guises. The Commission has heard countless stories and experiences where those affected by drug use and their families have been stigmatised in the forms of labelling, stereotyping, social rejection and exclusion, as well as the internalisation of negative attitudes in the form of shame by the person/family being discredited. Stigma can also be keenly felt when using services with poor quality physical environments, such as buildings that are not fit for purpose. In particular, the Commission has heard many detailed views about the main building used for drug treatment service provision (Constitution House) from those who use and have used the service. The Commission concurs that this building is not fit-for-purpose (in either design or physical fabric), as it is neither welcoming nor respectful of those who need to attend for their appointments. A review of all premises used for drug treatment services should be conducted as a matter of priority. The review should have the key aim of finding creative solutions to developing more appropriate accommodation and spaces in Dundee, where negativity towards people who use drugs and stigma is challenged and addressed, so that individuals attending feel safe and respected. The review should be conducted in full partnership with those who use services to fully understand their experiences and ideas of how the right type of space and environment can aid treatment. We would hope that this could contribute towards improved and increased engagement of people in need, and, ideally also retention in services.

The Dundee Partnership should consider comprehensive methods for proactively challenging stigma in Dundee. Various strategies and initiatives have been highlighted in the Literature and Evidence Review (see **Appendix III** in the **Part 2** report) which should be considered for developing in Dundee. The principles of the 'Inclusive Cities' concept and project³⁷ are of particular interest in this regard.

The Commission is also aware of the current Recovery Friendly Dundee project (coordinated by the Community Health Team), which is aimed at challenging and reducing stigma across the local communities of Dundee. The Commission welcomes this approach and suggests that the Dundee Partnership fully support and expand this initiative. This is something that will require a long-term commitment and an encouragement of as many groups, organisations, services and individuals to sign-up to the 'Recovery Friendly Dundee' pledge.³⁸

Beyond the pervasive nature of the stigma that people who experience drug problems and their families face on a daily basis in their lives and communities, the Commission has also heard regular

reports that individuals have had to face responses that do not meet best practice from the services that are supposed to be helping. This evidence must be taken seriously by all services, with commitments made to act upon such reports and provide assurances that such attitudes will not be tolerated. The Commission would like to see the values of kindness, compassion and hope take centre stage in improving the experiences of people who experience problems with drugs and their families in Dundee. Services should be tasked by the DADP with developing a plan (within 3 months) for combating stigma and discrimination based on these core values. Each plan should be developed from the bottom-up and be conducted in equal partnership with those who use each service. Evidence of 'how' the plan is produced in such a partnership should be included in the submission to the DADP. Each plan should have an in-built mechanism for review – which should focus on 'lessons learned' and 'progress made'. Service providers should share their plans with each other to encourage joint learning and encourage working together.

³⁷ <https://www.inclusivecities.info/>

³⁸ Recovery Friendly Dundee Pledge - Your pledge is a commitment to the Recovery Friendly Dundee ethos as follows: 'We believe that people should be treated with respect and dignity and that Dundee should be a city where everyone feels valued, respected and supported rather than defined by their health condition or life circumstances. Dundee should be a safe and supportive city and the efforts of people in recovery should be recognised and encouraged.' Your commitment may include: Attending an awareness session; Treating everyone with dignity and respect; Providing people with access to information and support; Challenging negative attitudes and language that stigmatises people in recovery; Building your awareness of what is available to support people in your area. More information can be sought from: Recovery Friendly Dundee, c/o Community Health Team – Room 21 Mitchell Street Centre – Mitchell Street Centre, Dundee, DD2 2LJ. robin.falconer@dundeecity.gov.uk / 01382 435854

Recommendation 3: Language matters. People who experience problems with drugs, and their friends and families, are part of our communities – let’s make them feel like that.

The Global Commission on Drugs Policy’s 2017 report is clear that the language used to talk about substance use creates a myriad of additional harms. We recommend that the words ‘addict’, ‘abuse’, ‘junkie’, ‘misuse’, ‘dirty’ and ‘clean’ are not used, and that Dundee creates an accessible guide to appropriate language use for the city based on the Global Drugs Commission report and other resources, such as the excellent ‘Language Matters’ leaflet developed by the Network of Alcohol and other Drugs Agencies (NADA) in Australia³⁹. We recommend that the local media are invited to be part of these guidelines and principles and sign up to a protocol regarding changing their language and presentation of the problem to a health and harms focused reporting where drugs use is ‘everyone’s problem’. This has been a key element of the overdose prevention response in other jurisdictions such as British Columbia. There is international evidence that this helps to reduce stigma, shame and fear. The Commission would like to note and express its thanks to the local media in Dundee who have attended the open Commission meetings and in many cases reported accurately and compassionately on what journalists heard in these meetings.

Language used to talk about drugs, drugs deaths and harms, and people whose lives are directly impacted by drugs, both in and out of formal public services, needs to change to be compassionate and non-stigmatising.

The Commission has noted the name of the main treatment service in Dundee as being the ‘Integrated Substance Misuse Service’ and would recommend that a consultation exercise is conducted to create a new identity for the service without the word ‘misuse’ in the title. Interestingly, a significant proportion of those providing evidence do not know of the service, or still refer to the service, as the Drug Problem Centre (DPC), despite that name being changed many years ago. This suggested consultation could help provide a significant opportunity and starting point for a service, which is perceived by many to be a fundamental part of the issues for which the Commission has

been set-up to respond to. The opportunity is to wholeheartedly focus on creating the culture, system and relationships that it will need to be able to learn from errors rather than be threatened by them. The consultation should (organisationally) be bottom-up in nature rather than yet another venture which is imposed top-down by management. The new identity should provide an opportunity for the service to acknowledge previous failings and to detail a new vision for the years to come. More details of the roadmap for this are provided in the Recommendations below.

Recommendation 4: Level the ‘playing field’ to ensure that all partners, statutory and third sector are held equally accountable. This is necessary to enhance patient safety and quality of provision. The balance between current centralised statutory and other provision needs to be changed.

DADP needs to create the right conditions to allow all partners to speak openly and honestly about how a level playing field should be created. A report should be presented to the Dundee Partnership within six months to enable action to be taken. The report should be focused on how the ‘17 elements of Recovery-Oriented Systems of Care and Services’⁴⁰ should be embedded and evolved in a future system design. We suggest that a ‘no-blame, solution-focused’ approach is taken from now on, when consultation and future planning is taken forward.

Consideration should be given to making the necessary moves towards a singular joined-up commissioning plan over the next five years, not just for current ADP spend, but for the entire provision of drug and alcohol spend so that future planning can allow for the combined funds to be spent more holistically. This will be essential in order to tackle some of the evident inequalities that currently exist in service provision and reach. Any joint commissioning plan should not be based on maintaining existing provision but rather on a preferred new landscape – some of which we have proposed within this report, but which we also envisage would come from a new approach to leadership and vision setting. However, this is a situation that the Dundee Partnership cannot change by itself but will need to escalate to Scottish Government to find a solution. This will be discussed under ‘national considerations’ later in this chapter. In the short-term, the Dundee Partnership needs to ensure the DADP has the delegated authority to set the tone of funding conversations with immediate effect.

To achieve equal accountability for all services, the new DADP group (as defined in **Recommendation 1**) needs to ensure that all services have a robust service level agreement in place. This should be achieved within 12 months with Service Level Agreements to run through for a further 2-3 years. This should be

³⁹ Available at: <http://nadaweb.azurewebsites.net/resources/language-matters/>

⁴⁰ https://www.samhsa.gov/sites/default/files/partnersforrecovery/docs/Guiding_Principles_Whitepaper.pdf (page 2)

considered a 'transition' period to allow current contracts to continue until a new 'system model' (as discussed in the Recommendations below) has been designed and instigated. Each Service Level Agreement should require routine and proportionate independent evaluation to be undertaken.

Recommendation 5: Meaningful involvement of people who experience problems with drugs, their families and advocates.

Peer-led, advocacy and mutual aid groups, as well as Recovery Communities, must be resourced effectively to build capacity for people who use services and peers to become partners in care. They must also be valued as equal partners. This is one of the most effective ways to address power imbalances that create service-led rather than people- or beneficiary-led care. Resources should be redirected into rebalancing the sector to support more community-based provision. This will increase choice and enable all those who require services and support to exercise their rights.

Support is required to foster and nurture the evolving recovery community in Dundee and to appreciate that different approaches exist (i.e. independent recovery groups as well as serviceled/supported recovery groups). The Scottish Recovery Consortium is well placed to offer advice and support in this regard. The Dundee recovery community (as a whole) has a vital role to play in ensuring that the changes recommended in this report are implemented. They could be a tremendous asset to support positive change but will undoubtedly be the loudest critic if required changes are not forthcoming. The power of lived experience needs to be fully harnessed to drive improvement across the city.

The DADP must prioritise and resource capacity building over the next three years for a range of advocacy provision in Dundee for those who use substances. This was highlighted consistently in the Commission's evidence gathering as one of the biggest gaps in provision, and one of the areas of greatest concern for families and other professionals currently supporting those with drug issues.

The Commission is aware of, and welcomes, the discussions between the Scottish Recovery Consortium and REACH Advocacy (Lanarkshire) with the DADP to explore their plans for Lived Experience Representative Councils and to train Recovery Advocacy Workers as part of a National Recovery Advocacy Network. This should be prioritised by the DADP to complement and add capacity alongside other advocacy approaches and the well-developed peer research approaches that have been developed in Dundee. Peer research surveys should be used at regular intervals over the coming years to help assess whether local services change their practices in line with the recommendations.

Peer researchers, Advocacy Workers and Recovery Communities need to be engaged to help coproduce measures of success for the new system model that will be discussed below. Additionally, these groups need to be fully involved in ensuring a robust response to complaints.

While we return to the issue of gender-sensitive approaches below, we would like to highlight that involvement of women who experience problems with drugs in the design and delivery of services and policies should be specifically considered, recognising that wider efforts to involve people who experience problems have not always succeeded in reaching women, and that women who use drugs have a diversity of preferences and needs.⁴¹

In terms of the experience of family members, the evidence that the Commission gathered illustrated a predominant experience that they had of being **judged and stigmatised**, which is covered in our wider recommendation around stigma and discrimination. Evidence was gathered in our process that indicated that families are largely being excluded by statutory treatment services (they are more included by third sector services) which runs counter-to the commitment in the national drug and alcohol strategy, 'Rights, Respect, Recovery', that states that families have the right to be involved in treatment and care as appropriate. The Commission recommends that:

- All commissioned services undertake family inclusive practice training within twelve months. Our understanding is that this is part of the Scottish Government's emerging workforce development framework.

⁴¹ Tweed, Miller, Matheson (2018). Why are drug-related deaths among women increasing in Scotland? A scoping of possible explanations. Scottish Government Social Research. Available at: <https://www.gov.scot/publications/drug-related-deaths-womenincreasing-scotland-9781787810129/pages/8/>

- All commissioned services adopt and follow good practice standards for family inclusive practice which includes pro-actively seeking consent to involve the individual's supporter in their care, and seeking consent on an ongoing basis if it is refused at first appointment, as well as explaining the treatment/ care process to family members, and encouraging family members to share information with the service, even if information cannot be shared back the way. Scottish Families Affected by Alcohol and Drugs is a national organisation that is able and willing to support services to do this at no cost.

Evidence received showed that there is a lack of dedicated and visible **family support** for families in their own right, in particular of one to one support, structured group support, and advocacy. The existing family support groups in Dundee are well established but we believe that they would benefit from wider assistance with publicity, including treatment and care services routinely sharing information on available support with families, and pro-actively encouraging engagement.

- The DADP should work with the existing groups on an expansion and publicity plan. Scottish Families Affected by Alcohol and Drugs would be happy to assist with this at no cost.
- We would also encourage all groups to use evidence-based, solution-focused programmes such as CRAFT, SMART Family and Friends or 5-Step, to ensure that families are given tools and techniques to manage their situation and improve their self-care.

It is important to acknowledge that most people who are experiencing problems with drugs are not accessing formal treatment, so promotion and engagement methods must also reach to other places families are engaging, such as primary care services, workplaces and carers centres etc.

Recommendation 6: Learning from the things that have gone wrong – attention to continuous improvement to benefit others who are vulnerable.

Progress and success are only possible when mistakes are confronted rather than reframing the evidence to avoid having to change deeply held beliefs. Too many people have lost their lives to drug use in Dundee and the leaders in Dundee must now act swiftly to learn the necessary lessons and take significant action to turn this situation around. Total drug deaths in Scotland significantly exceeded 1,000 for the first time in 2018. If 1,000 people or more died each year in Scotland from another preventable and avoidable cause, then there would undoubtedly be a national outcry.

The Dundee Partnership needs to develop, and be recognised for, having a progressive attitude and approach, in order to tackle the immense challenges that it faces in this area. By so doing the Commission firmly believe that the Dundee Partnership (in time) will be able to demonstrate progress, inspire creative solutions, and help nurture resilience amongst the groups of people that the Commission has had the privilege of listening to over the last year (whether it be those who face the reality of life affected by drug use or the many professionals across Dundee who seek to support and help those who are affected). It will also then set the standard for the type of leadership that is required by the organisations we have encountered who have historically worked in silos and who have demonstrated defensiveness rather than an active willingness to move forward together.

Additionally, improved and timely use of intelligence needs to be prioritised in Dundee by utilising a 'lessons learned' approach. Intelligence, learning and subsequent recommendations need to be integrated into DADP and Dundee IJB action plans as a matter of urgency (as well as all other Community Planning Partners). The Commission requested a 'deeper dive' of drug death data (Dundee vs the rest of Scotland) from Information Services Division (ISD) Scotland to aid understanding of underlying causes of, and reasons for, the high levels of drug-related deaths in Dundee. When the data is integrated with the interviews and submissions to the Commission from those with lived experience and families, a clearer picture emerges of the lessons that need to be learned. The Commission recommends that this thorough Dundee versus rest of Scotland analysis of the complexity of circumstances of people who have died is conducted on an annual basis to help NHS Tayside's Public Health department with further developing its understanding of the profile of drug deaths in Dundee. The DADP needs to take a lead in identifying the lessons that can be learned from the data, putting swift actions in place, with timely reviews and holding all parties to account for actions they are responsible for. Transparent and prompt reporting is required from the DADP with a focus on what action has been taken as a direct consequence of the annual drug death report.

The Dundee Partnership should instigate a review of local Drug Death Review processes (as well as non-fatal overdoses and near misses), to take account of other models of enhanced death reviews e.g. Ruby Reviews for Child Deaths. All services (secondary care, primary care, police, social care etc.) have a duty to reflect on the support, care and/or treatment they each have provided to an individual who has died of a drug death and the purpose of a drug death review group should be to identify common areas of process that can

be improved, emerging trends, have an oversight as to how well services work together in providing care, and be there to present the evidence and advocate for change going forward (in collaboration with the DADP). These reviews should also support the broader Dundee service provider group with learning and change, as well as aiding integrated practice.

B. A HOLISTIC 'SYSTEM' MODEL – INCLUDING INTEGRATED PRIMARY CARE PROVISION

The second suite of recommendations (7-13) is concerned with the provision of drug treatment and support services in Dundee. An analysis of the balance of evidence provided to the Commission tells a compelling story of a system that is not fit-for-purpose. The Commission believes it is a system that is characterised by siloed working of services, a breakdown of trust and relationships between statutory and third sector services, and an overly risk-averse prescribing service. The current system is dominated by a five-year transformation plan for ISMS which has been imposed upon the sector with the expectation that everyone outside of ISMS needs to work to support the new ISMS model. The Commission considers it to be a 'service-led' plan, rather than being a joined-up 'whole system model' developed in collaboration with all partners and those with lived experience.

The Commission's recommendations are focused on outlining the roadmap that is urgently required to re- envision and establish a high-quality and person-centred treatment system in Dundee, where the first and foremost aim to keep people alive, and where all possible efforts ('whatever is required') are made to achieve this. Indeed, the recently published Tayside Drug Death Review Group's Annual Report for 2018⁴² states: *"Drug deaths in Tayside continue to rise. A drug death occurs as the result of a non-intentional overdose of illicit (or illicitly obtained controlled) substances and therefore **should be avoidable**. Yet we are still seeing increasing numbers of drug deaths occurring, with each one a tragedy affecting families, friends and communities."* The drug deaths being experienced in Dundee are preventable and the view of the Commission is that a whole system prioritisation should be put in place to turn this tide around. As a starting point, the DADP needs to resurrect and refresh the ten-year 'Prevention and Recovery' Strategy (2017-2027) which it commissioned yet never implemented. The Strategy was titled 'Stop People Starting and Supporting People to Recover', ambitions which would serve Dundee well in moving forward.

Recommendation 7: Choice is important and having the choice of accessing a full menu of services (including community and/or a residential setting) to support recovery should be available to people in Dundee.

As discussed earlier, one of the strongest messages that the Commission has heard repeatedly over the last year is a frustration with the lack of choice and options for treatment for people who use drugs. The widely held perception amongst those who use services is that it is 'methadone (opioid substitution treatment) or nothing.' Although the reality is not as blunt as this, it is important to recognise that this is how the treatment system is perceived by many of the people who are closest to it. Whilst it is acknowledged that pharmacological treatments including methadone are a vital part of the system response, the perception, and sometimes reality, of the predominance of methadone prescribing in Dundee seems to take place at the expense of a system that should have a broad spectrum of options for the wide range of people who require help. The following recommendation proposes a complete change of course and, in so doing, it will enable a whole system review to take place, at the heart of which needs to be a plan to increase choice of treatment options.

There needs to be greater flexibility and choice for individuals. This includes choice in prescribing options beyond just methadone. Buprenorphine could be used more widely, including the new slow release preparation. Heroin Assisted Treatment (HAT) should also be considered.

Repeated calls have been made to the Commission for Dundee to either get its own substance use rehabilitation unit, or for provision to be made for those who require a longer-term, intensive, structured period of treatment to be able to get access to an existing rehabilitation unit outside of Dundee. Dundee has historically only invested a small proportion of existing resources to fund such placements, compared to most

⁴² NHS Tayside. *Drug deaths in Tayside 2018 annual report*. Available at: https://www.nhstayside.scot.nhs.uk/News/Article/index.htm?article=PROD_322284

other areas of Scotland and the UK. It has been clear that those who are calling for such a unit in Dundee see it as a vital part of the solution to Dundee's problems. However, when listening in depth to the calls for such a service, what becomes evident is the intense frustration that there is so little choice for those who want and need help. There are great examples around the UK of traditional rehabilitation models, as well as new and innovative variations (based around Recovery Communities). Interestingly, in their recent submission of written evidence to the Scottish Affairs Committee Problem Drug Use in Scotland inquiry⁴³, the DADP has noted 'improved access to residential rehabilitation' as one lesson that Scotland could learn from other countries. The Commission recommends that Dundee consider the approach in Fife where there is a dedicated budget held by the third sector, with people being appropriately prepared to access Residential Rehabilitation and then picked-up upon discharge. The Fife service is based within the Fife Intensive Rehabilitation and Substance Misuse Team (FIRST)⁴⁴.

The Commission believes that the Dundee Partnership should invest in an options appraisal of both community and residential rehabilitation models, as well as a review of evidence-based responses for people who do not use opiate drugs, to inform decisions regarding what might be suitable developments to meet needs in Dundee. This options appraisal needs to be considered alongside the Commission's recommendation for a full independent Health Needs Assessment for people experiencing drug problems (see **Recommendation 12**).

Recommendation 8: The provision of services currently offered by ISMS should be delivered through the development of a new 'whole system' model of care. This should be structured via a joint and equal partnership with both primary care and the third sector, with the key purpose of utilising the unique strengths of all partners.

These services should be born out of, and embedded within, a new whole system of care and treatment for drug use. The vision for a new 'system' model needs to be formed by fully embracing the lessons that have to be learned, and by harnessing the incredible and tangible passion and determination of the wide range of stakeholders who have provided evidence to the Commission,

and who have demanded (rightly so) that things have to change quickly for the good. The vision should aim to be nothing less than a high-quality and person-centred example of care and treatment.

This will not happen overnight and the Dundee Partnership needs to take care and pay significant attention to providing immediate and long overdue support to a service that is over capacity and struggling to provide even the basic level of treatment that is required in a timely manner.

There is now an important and timeous opportunity for the Dundee Partnership to work with the Scottish Government, and other relevant national bodies, to address the findings of the Commission and shape future services that reflect the principles contained within the new national strategy 'Rights, Respect and Recovery'. Since moving to the HSCP the Commission has noted that ISMS have highlighted issues relating to capacity and skills mix. The Commission has been advised that this has resulted in an increase in nursing and social work staffing levels, the introduction of the direct access clinic, an increase in clinical psychology and a programme to increase the number of prescribers. This has been reported through a range of forums and recorded through risk systems.

Despite the above, the Commission is extremely disappointed that a robust effort from all responsible partners has not been evidenced, when the challenges that the service has faced over a considerable time are well known and documented. Lessons need to be learned and humility needs to be shown by asking for help. Success can only happen when past mistakes are confronted with honesty and sincerity.

At the same time, the Dundee Partnership needs to start transition planning for a period of the next three years whilst the new 'whole system' of care is designed, agreed, and resources restructured to allow it to come to fruition. The transition period should be framed around the development of clear and proportionate Service Level Agreements (as outlined in **Recommendation 4**). The Service Level Agreements should be configured to run through to a realistic and agreed timepoint where the new system model can be instigated – likely to be somewhere between three-five years from now. All Service Level Agreements should require all

⁴³ Available at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/scottish-affairscommittee/problem-drug-use-in-scotland/written/99493.pdf>

⁴⁴ <https://www.firstforfife.co.uk/residential-rehabilitation>

partners to work closely with the primary aim of reducing and removing the current barriers to quick and responsive treatment. The Service Level Agreements should be explicit about the evidence-based elements that allow high quality treatment to be a highly protective factor against the potential for drug-related deaths. The vision for a high-quality and person-centred treatment and care system in Dundee needs to start once the DADP has been restructured (as per **Recommendation 1**) to be an independent commissioning group, so that they can take the lead in facilitating discussions and the forming of the new vision. The starting point for discussions should be the agreement of a set of clear principles to allow creativity, inspiration, enthusiasm and determination to be expressed and owned by all. The principles, as a minimum, should include (but not be limited to):

- agreement to a no-blame and solution-focused culture;
- agreement to confront past mistakes with a progressive attitude;
- agreement to take a bottom-up approach to discussions, consultations and decision-making; and
- agreement to include all relevant parties.

Although the Commission does not want to be prescriptive about what the new model should look like, it would like the Dundee Partnership to consider the following elements for inclusion within a new system model:

- Be directly commissioned and monitored by the DADP as an independent commissioning body (as previously described);
- Be an equal partnership of statutory, third sector and primary care, including a lead partner and support partners;
- Include an OST service of a combination of addiction psychiatry, physicians, sessional GPs and non-medical (nurse and pharmacist) prescribers that can adapt to the breadth of needs, and integrated with the third sector;
- Include integrated mental health support and psychological interventions, and meaningful engagement with Children's Services, where this is appropriate (see **Recommendation 13**);
- Be adaptive to urgent needs and specific vulnerable groups such as: those who are homeless; those with high physical care needs; and those who are most at risk of drug-related death;
- Deliver via a locality hub model, to ensure community-based delivery and enable co-location of services.

The new model should be informed by exploring the very best contemporary models for working with people experiencing problems with drugs. As a minimum, the new service must include options (as a matter of urgency) for low threshold prescribing,^{45,46} as well as low intensity provision,⁴⁷ which will allow the specialist services to work with the more vulnerable population in an integrated fashion (intensive, complex needs and crisis provision).

The Commission would like to highlight a very useful document on ways to deliver trauma-informed, low threshold Opiate Replacement Therapy (ORT) services in Scotland. This was brought to the attention of the Commission after the session with three Lothian based GPs and developed by Dr Joe Tay⁴⁸. We believe this document is worthy of full consideration for the new system model, as well as the holistic drop-in service that runs in Midlothian.⁴⁹

⁴⁵ Low Threshold Prescribing is based around (1) fast access to treatment, usually within 1-2 days, with little or no expectation for abstinence, and (2) retention in treatment with no possibility of suspension from treatment.

⁴⁶ Strike, C. et al (2013). *What is low threshold methadone maintenance treatment?* The International journal on drug policy 24(6) DOI: 10.1016/j.drugpo.2013.05.005

⁴⁷ Low intensity provision aims to stabilise the patient and settle them back with primary care/GP as soon as possible, with no push to stop.

⁴⁸ The document shared with the Commission by Dr Joe Tay is concerned with the development of trauma-informed, low threshold Opiate Replacement Therapy (ORT) services using principles of safety; transparency and trustworthiness; choice; and collaboration, respect and empowerment. Crucial is the removal of any barriers to limit or delay access to ORT, In addition it welcomes open referrals and self-referrals and minimises intake assessments.

⁴⁹ Details can be provided by the Commission.

Finally, it is important to note that the remit of the Commission has been to look at drugs only, and not alcohol. The main statutory treatment service (ISMS), like many others, is a combined drug and

alcohol service, therefore the Commission would like to acknowledge that the changes being proposed for this service must ensure that alcohol treatment provision is not downgraded or adversely affected as a result. The following commentary was provided to the Commission by a senior clinician in NHS Tayside:

'ISMS, as well as having responsibility for drug addiction, are also supposed to provide services for alcohol. Currently this provision is sub-optimal. Any recommendations the Commission makes will have impacts on alcohol services...Services [need] to ensure they consider the impact on alcohol services of any responses that they propose to the Commission's report. The anecdotal feedback from patients is that there is only one type of service for all patients with addictions, and if you are not on heroin then they are not interested in you. Clearly this is not high-grade evidence, but it is a substantial change in the patient feedback from the days when there was a specific alcohol service.'

Recommendation 9: Reframe all substance use services to prioritise access, retention, quality of care and the safety of those using services, in line with the evidence base including, but not limited to: improved retention through having an unambiguous 'no unplanned discharges' policy; optimised OST; psychological treatments; assertive outreach; and broad integrated care.

The Commission acknowledges that a vision for a high-quality and person-centred treatment and support system in Dundee will take time and considerable courage and efforts to come to fruition. In the short-term it is therefore critical that efforts are focused on reframing current substance use services so that they can come out of their silos and repair the trust that has broken down between them. This will require strong and distributed leadership, with a clear focus on the evidence base that will help improve services and which will result in fewer drug-related deaths (as a primary and key measure).

The evidence base is clear that engaging and retaining individuals in opioid substitution treatment (OST) should be a 'protective' factor. Attention therefore needs to be placed squarely upon prioritising and improving access, retention, quality of care, and the safety of those using services. Quick access and strong retention should be for all: those returning from prison, those who dropout of service, those who are discharged from hospital and new attenders. Independent (expert) external support needs to be provided (via a 'mutual aid' request to Scottish Government) to develop an action plan around these high-priority areas. The Commission recommends the development of regional support for prescribers (medics and non-medics) to support and create a governance structure. The Commission believes that such a support framework will help to sustain different types of interventions and enable people to have a broader competency framework. The Commission recommends that all efforts are focused immediately on speeding up access to treatment and removing any barriers to quick access. The stated goal of ISMS to get people on Opioid Substitution Therapy within 10 days from first contact is welcomed as a step in the right direction. However, from the reports heard since this target was implemented in September 2018, the Commission is left with little confidence that this goal is currently being met (see **Section 2 of Appendix XVI** in the **Part 3** report – question 13, which indicates that the time to start treatment is 'currently sitting at three weeks'). In the short-term all efforts need to be focused on meeting this target as a minimum requirement, and the service needs to report monthly to the DADP on progress and compliance with this target. Beyond this, the service needs to prioritise much quicker access. The aspiration should be a service which can deliver same day OST. However, we are not persuaded that the existing service model will deliver this and that is why we are calling for a complete reconfiguration of the service with different models of delivery including those in the voluntary sector and primary care.

There must be a broad menu of evidence-based services, supports and interventions to reflect the range of needs of people who experience problems with drugs. Priority focus should be on following contemporary evidence-based practice around optimising OST, and a clear ambition set for offering low threshold (same-day) prescribing treatment when needed by the person seeking help. There should be a spectrum of drug treatment and support interventions, from prescribing and harmreduction through to inpatient detoxification and residential rehabilitation when need is clearly assessed. It is also vital to ensure access to a range of psychological and social interventions within the new system model, including welfare support, housing and mental health support. Attention should also be paid to providing nurse-led hospital liaison services for people who experience problems with drugs in the same way as Alcohol Liaison nurses are provided in NHS Tayside.

The Commission is aware of and welcomes the recent funding received to pilot an assertive outreach nursing service (based in the third sector but co-ordinated as a partnership approach) to focus on preventing and responding to non-fatal overdoses. This is a small-scale, time-limited initiative, but is exactly the type of

response where current resources need to be expanded. Assertive outreach needs to be positioned as a fundamental ingredient of both the transition plans and the longer-term system redesign.

Recommendation 10: Involvement of primary care and shared care models.

It is the view of the Commission that local General Practitioners are a severely under-utilised resource in the provision of services to people who experience problems with drugs in Dundee. The Commission therefore strongly suggest that the Dundee Partnership prioritise immediate discussions with local GPs regarding how they might be much more actively involved in supporting the delivery of high quality services to people who experience problems with drugs in Dundee, especially with regard to taking a prescribing role in OST.

The Commission firmly believes that meaningful and wider involvement of primary care, and specifically GPs, would support and enhance the other recommendations that are made in this report. Crucially, where done well, involvement of primary care and GPs can expand reach and access to people who can be supported almost entirely in primary care because their needs can be met there without substantive involvement of more specialised services. GPs (and primary care based nonmedical prescribers) can also take on shared care arrangements with specialist services if there are local arrangements in place. This can help specialist services to discharge people into safe and supportive care and prevent the bottle necks that we have seen develop in Dundee where specialist services have nowhere to discharge their clients to. While we are also very keen to see primary carebased non-medical prescribing supported we do believe that the very low numbers of involved GPs is itself a problem that needs to be specifically addressed. This should be done in addition to providing support more generally for wider primary care involvement in the care of people who experience problems with drugs, such as non-medical prescribing professionals.

The Commission does understand that there are substantial challenges within primary care/general practice more generally, nationally and locally, in terms of shortages of staff, succession planning, and concerns about working in an area where practitioners can lack confidence and sometimes willingness to work with this client group. However, there are many areas of Scotland where shared care arrangements are working very well notwithstanding having similar generic challenges. There are initiatives that can be developed locally to provide good training and support that practitioners need to practice safely and confidently. There is also a need for national training such as the Royal College training on addictions that used to be supported by the Scottish Government.

There is therefore the need to create immediate open and participatory discussions with local GPs on how to develop the right terms and conditions to support their increased involvement. The Commission would suggest that NHS Lothian is a good model for Dundee to explore because of the long-term nature, and extent, of primary care involvement in OST and shared care arrangements. The Commission would also note the work done in Forth Valley to develop a GP Prescribing Service (GPPS) which has been operating for 14 years as a partnership model of holistic care between people who experience problems with drugs, GP, third sector recovery worker and community pharmacy⁵³. Another recent and complementary model is also worth noting. In Greater Glasgow and Clyde there are steps being taken to employ Medical Officers in Alcohol and Drug Recovery Services. They state: *'Medical Officers, many from a GP background, are part of a medical and prescribing workforce that includes psychiatrists and independent prescribers. They deliver a wide range of interventions to problem drug and alcohol users with the aim of improving health and social outcomes. These include assessment and review of their health needs, substitute prescribing, detoxification and relapse prevention prescribing, providing testing and treatment for Hepatitis C and HIV. Medical Officers are based in integrated community teams, carry a caseload, work closely with specialist services and GPs and are professionally accountable to senior clinicians. They assess and review individuals with drug and/or alcohol dependency.'*

In terms of meeting the very complex needs of people who experience problems with drugs, who may not be able to be well managed/supported in primary care settings by GPs (or primary care

⁵³ Forth Valley GP Guide to Managing Substance Misuse (2016) sets out the criteria for GPPS below;

- Opiate dependency where there is no problematic alcohol or polysubstance use.
- Stable accommodation
- Willingness to work towards recovery, reduction and a drug-free lifestyle.
- Good general health, (caution with significant co-morbidities).
- Good mental health, (caution with significant co-morbidities).
- Commitment to attending GP and regular key-worker sessions, and working towards positive outcomes.

based non-medical prescribers), the salaried health board employed Medical Officer model would also be one that Dundee could actively explore.⁵⁰

Recommendation 11: Review and refresh the community pharmacy model for OST engaging all stakeholders to develop an integrated and holistic approach to the care and treatment of people who use substances. Look to establish a new Community Pharmacy model with additional support.

An increased role for Community Pharmacy in Dundee should be welcomed and developed as part of a comprehensive solution to the challenges currently faced. A new model for Dundee should include the following elements:

1. Explore and test the use of Pharmacist Independent Prescribers to support Recovery Oriented Systems of Care in selected pharmacies.
2. Invest in the training of community pharmacy teams by developing a programme of protected learning accessible to all staff to support the delivery of pharmacy services within a Recovery Oriented System of Care across NHS Tayside. This programme of protected learning should:
3. Address stigma and attitudes;
4. Provide pharmacist prescribers with opportunities for work shadowing and support from designated medical practitioners to improve communication and appreciation of workflow;
5. Help the wider integrated workforce to understand the role of Community Pharmacists.
6. Support communication systems between treatment services and Community Pharmacists to become two-way, easy, fast and secure to support recovery and safety.
7. Develop weekend contacts and ensure advice is available consistently across Dundee.
8. To prevent a repetition of the practice frequently reported to the Commission where people have had to travel significant distances to access methadone prescriptions, the prescribing services should seek to find person centred and recovery focussed solutions through collaborative working.

Recommendation 12: Commission a comprehensive independent Health Needs Assessment for people who experience problems with drugs.

Although the Commission has not had sufficient time to consider in detail a wider set of evidencebased supports and services in respect of their applicability and appropriateness for Dundee, a number of such supports and services have been consistently referred to, and requested by, those submitting evidence to the Commission.

With this in mind, the Commission strongly recommends that an independent comprehensive health needs assessment for people who experience problems with drugs is conducted, along similar lines to the 'Taking Away the Chaos' Health Needs Assessment conducted in Glasgow in 2016⁵¹ (utilising a tripartite health needs assessment framework, comprising epidemiological, comparative, and corporate approaches). The Glasgow Needs Assessment report details a comprehensive view and suggested approach to implementing evidence-based supports and services such as Safer Injecting Facilities (SIFs) and Heroin Assisted Treatment (HAT) as a response to the high numbers of individuals injecting drugs in public places. The process of engagement used throughout the needs assessment proved to be equally as important as the final report in that it allowed all stakeholder groups to participate in a detailed discussion and debate of the

⁵⁰ https://gallery.mailchimp.com/c4876cb152fa1983ef265ad1b/files/b6b5d4d4-b3cb-41e4-acc5b848c7ee3186/SP_Flyer_Final_Version_002_.pdf?mc_cid=c0251cef58&mc_eid=ce9fba1d08

⁵¹ Tweed, E. and Rodgers, M. 2016. *Taking away the chaos: a health needs assessment for people who inject drugs in public places in Glasgow, Scotland*. Available at: https://www.nhsggc.org.uk/media/238302/nhsggc_health_needs_drug_injectors_full.pdf

evidence around such interventions. This work has proved to be the catalyst for the steps that the Glasgow Health and Social Care Partnership has taken towards successful implementation of a broader range of interventions, including the garnering of essential political support.

A long-term plan should be developed to establish, on the basis of this independent health needs assessment, evidence-based services such as SIFs (Overdose Prevention sites, Drug Consumption Rooms [DCRs]) and HAT in Dundee, with enough spaces to accommodate all who require these additional services. The Commission has noted that, in its recent submission of written evidence to the Scottish Affairs Committee Problem Drug Use in Scotland inquiry⁵², the DADP named ‘Supervised drug consumption facilities’ as one lesson that Scotland could learn from other countries. Additionally, the Commission requested Dundee-specific evidence from the national Needle Exchange Surveillance Initiative (NESI)⁵³ in relation to Drug Consumption Rooms (DCRs). As part of the annual NESI survey a question is asked of people who inject drugs (PWID) as to whether they would be willing to use a DCR if one was made available. The results for those who completed the survey from Dundee are shown in the table below:

Table 8.1: Proportion of PWID in Dundee willing to use a DCR, 2017-18

	Willing to use a DCR if one was made available		
	Yes (%)	No (%)	Total
All people who inject drugs (PWID)	110 (70)	47 (30)	157 (100)
Current PWID (reported injecting in the last 6 months)	91 (86)	15 (14)	106 (100)

Data source: Needle Exchange Surveillance Initiative (NESI)⁵⁴

An assessment of the needs for drug checking and testing services should also be included within the independent health needs assessment.

As mentioned previously in this report, the Commission recommends that this needs assessment should include in its scope further detailed analysis of the ‘deeper-dive’ of data that has been undertaken. Further, the Commission recommends that the ‘deeper-dive’ is repeated (with inclusion of 2017-18 data).

In the short-term, the Dundee Partnership should work proactively with the Scottish Government and UK government to remove barriers to evidence-based services that have demonstrated their positive impact on harms and overdoses.

⁵² Available at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/scottish-affairscommittee/problem-drug-use-in-scotland/written/99493.pdf>

⁵³ The aim of the Needle Exchange Surveillance Initiative (NESI) is to measure and monitor the prevalence of the Hepatitis C virus (HCV) and injecting risk behaviours among people who inject drugs (PWID) in Scotland.

⁵⁴ Many thanks to Dr Andrew McAuley (NESI Study Manager) and colleagues for extracting this Dundee-specific data for the purposes of the Dundee Drugs Commission.

In the longer-term, the above action will help to ensure implementation of missing yet essential evidence-based supports and services. By so doing, unnecessary additional harms for people who experience problems with drugs, and their children and families, will be prevented.

Recommendation 13: Full integration of substance use and mental health services and support. This is recommended UK and international best practice – and it needs to happen in Dundee. Trauma, violence, neglect and social inequalities lie at the root of both mental health problems and substance use problems and the majority of people with substance use problems also have mental health problems.

A worrying number of those giving evidence to the Commission have expressed the view that when people with co-occurring mental health and drug use problems present themselves at either mental health or substance use services in Dundee, that one issue should be dealt with first. Apparently, this erroneous view is still current among a range of professionals across Dundee. The evidence has been clear for many years (and has recently been re-iterated in the 2016 NICE guidance⁵⁵) that mental health and substance use issues should be addressed concurrently.

Substance use and mental health services need to be commissioned to deliver evidence-based interventions that are aligned with relevant guidance (e.g. NICE). It should not be acceptable that any professional express views that are contrary to the evidence⁵⁶. This is a contract management issue. There may also be implications for continuing professional development, supervision and training. People living with mental ill health and those with substance use problems experience stigma, prejudice and discrimination. These experiences can be mitigated by addictions services that are actively engaging with, and sensitive to, mental health issues and by mental health services that are active and competent in addressing addictions. There are no wholly integrated statutory services that respond to the needs of people with mental health and substance use challenges in Scotland. The existing model of integration in Dundee (which is reported as often being based on having a file open in two services), as well as services, are not delivering for people, their families or the city. There is therefore an urgent need for radical rethinking of service models. High quality integrated models are suggested⁵⁷ as the best way forward and the Commission therefore recommends that advice, guidance and support are sought from the Glasgow Integration Joint Board and the Glasgow Health and Social Care Partnership who have made successful strides forward in commissioning integrated services (across homelessness and substance use services, as referenced earlier in the report). There are now good UK and international examples of integrated services from other jurisdictions (Public Health England have recently highlighted examples of good practice, and other examples are noted in Australia, Canada and the USA) which should be considered as part of an options appraisal exercise. These could provide the basis of new integrated models of care for Dundee to adopt (including Crisis Care), once the Tayside Mental Health Services Independent Inquiry has delivered its final report. The Dundee Partnership should approach Scottish Government with a view to commissioning Scotland's first fully integrated mental health and substance use service.

An opportunity also exists for the Dundee Partnership to work with researchers and practitioners from Australia and Canada to develop a standardised but flexible process for the sustained uptake of integrated care in mental health and drug and alcohol services. Further details will be provided to the Dundee Partnership.

In summary, the Commission view the urgent task of the Dundee Integration Joint Board and the Dundee Health and Social Care Partnership in this regard to be: (1) state clearly the things that need to change; (2)

⁵⁵ National Institute for Health and Care Excellence (NICE), (2016), *Co-existing severe mental illness and substance misuse: Community Health and Social Care Services*, (2016), Available at: <https://www.nice.org.uk/guidance/cg120>

⁵⁶ It was reported to the Commission from a range of sources (and across sectors) that there is a widespread view within mental health services that substance use issues should be dealt with separately. This is sometimes articulated as substance use should be dealt with before mental health issues (i.e. sequential treatment). This is contrary to national guidance (2016, 2002) and defies the principle that individuals should be able to choose their own 'door' into services (i.e. 'no wrong door' principle).

⁵⁷ Public Health England (2017). *Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for Commissioners and Service Providers*. London. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Cooccurring_mental_health_and_alcohol_drug_use_conditions.pdf

conduct an immediate options appraisal on what models could work in Dundee; (3) act swiftly to commission a new model and phase out elements of old service models that do not work, protecting care for vulnerable people and their families meantime and with an Equalities

Impact Assessment conducted throughout to ensure that potential negative outcomes for particular groups are considered and addressed in advance; and (4) involve people and families and services in the change process whilst actively developing feedback loops.

As noted in a letter from the Dundee Suicide Prevention Partnership, the risks for those with intersecting mental health and substance use (including alcohol) problems are heightened considerably. This has also been highlighted in the Tayside Multi-Agency Suicide Review Group Annual Report 2017. The Commission is very supportive of the intention to work in partnership with the DADP to prevent suicide in Dundee.

SMART actions need to be agreed and implemented with a clear procedure produced for how they will be measured. Integrated services need to be a core part of such partnership working.

Additionally, the Commission recommends that the Dundee Partnership explores the potential future roll-out of the Distress Brief Intervention (DBI) Programme⁵⁸ as part of an integrated substance use and mental health service model in Dundee. The DBI programme is currently being piloted in four sites across Scotland. The initial results of the DBI pilot sites appear positive with an extension of the programme having already been granted to cover 16-17 year old's across the four pilot sites.

C. CAUSES AND EFFECTS OF DRUG USE

The third suite of recommendations (14-16) is concerned with a wider understanding of the causes and effects of drug use in order to inform a truly holistic response to one of the most vulnerable, stigmatised and marginalised groups in Dundee.

Recommendation 14: Address the root causes of drug problems.

The root causes of drugs use are poverty, trauma, violence, neglect in childhood and adulthood, incarceration and criminalisation, stigma towards people who experience problems with drugs, drug and health policies that exclude rather than include, and lack of access to effective and high-quality treatment and support⁵⁹.

Studies are increasingly identifying the importance of early life experiences to people's health throughout the life course. Individuals who have adverse childhood experiences (ACEs), during childhood or adolescence, tend to have more physical and mental health problems as adults than do those who do not have ACEs, and ultimately greater premature mortality.⁶⁰ ACEs include harms that

affect children directly (e.g. abuse and neglect) and indirectly through their living environments (e.g. parental conflict, substance use, or mental illness).

The Commission has heard detailed accounts of second, third and even fourth generation substance users in Dundee – all of whom have devastating stories which highlight the root causes of substance problems being about the issues above rather than the substances themselves. Drugs should not be looked at in isolation of the reasons why people can use them to the point of becoming dependent upon them. Most drug use does not lead to problems or dependence.

⁵⁸ <https://www.dbi.scot/>

⁵⁹ See recent relevant submissions to the Scottish Affairs Committee's Inquiry into the Use and Misuse of Drugs in Scotland, including NHS Health Scotland/NHS National Services Scotland joint response. Available at:

<http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/scottish-affairs-committee/problem-drug-use-in-scotland/written/100340.html>

⁶⁰ Bellis MA, Hughes K, Leckenby N, Hardcastle KA, Perkins C, Lowey H. Measuring mortality and the burden of adult disease associated with adverse childhood experiences in England: a national survey. *J Public Health* 2015; 37: 445–54.

The Commission would like to stress the importance of enhancing the provision of employability, education, training, and volunteering opportunities, to address the boredom, social isolation, and lack of opportunities many encounter when attempting to reduce or cease drug use.⁶¹

Given the high prevalence of drug deaths occurring for those who live in areas of higher deprivation, it is imperative that the work of the Dundee Fairness Commission is joined-up and considered when putting action plans together to tackle the recommendations in this report.

Recommendation 15: Ensure that the needs of women who experience problems with drugs are assessed and addressed via adoption of gender-mainstreaming and gender-sensitive approaches to service planning.

The Commission recommends that the Dundee Partnership specifically considers the particular needs of women in Dundee who experience problems with drugs. Recent work undertaken in Scotland⁶² on women and drugs related deaths suggests that women might need different approaches or types of services to address their specific needs and associated potential risks and harms. Tweed et al. (2018) state that, on the evidence gathered by their scoping review, women who use drugs are likely to be particularly affected by the adverse impacts of welfare reform and public sector austerity measures and that such changes “may interact with other risk factors such as abusive or coercive relationships, commercial sex work, experiences of trauma, mental health issues, and changes in drug treatment services” (page 4). Stakeholders consulted in their review highlighted that recent changes to drug treatment services in Scotland, as well as in the wider health and social care landscape, may have particularly affected women. They state: “*Cuts in funding were felt to have resulted in the withdrawal of services, reduced provision, reductions in staffing levels and skill-mix, lack of continuity in relationships, and changes in ethos*” (page 4). Other review informants highlighted the potential role of poor drug treatment practices and insufficient throughcare support for women in the criminal justice system. These are areas that clearly resonate with the evidence that the Commission has gathered over the past year. Drawing on the scoping report’s practice and policy recommendations,

the Commission recommends that the Dundee Partnership recognises: the commonalities between men and women who use drugs as well as the differences; the diversity of experiences within genders; and the intersections between gender and other axes of inequality, such as deprivation (please see the quantitative analysis that shows the high numbers of people dying in Dundee from the poorest communities – see **Appendix XII** in the **Part 3** report). Our view is therefore that the Partnership should take cognisance of this far-reaching report that explores both women’s potential particular risks and the gender-sensitive recommendations for policy and practice therein. Some of Tweed et al’s (2018) recommendations have been highlighted below.

- Adopt gender mainstreaming approaches - this refers to a systematic and meaningful consideration of the implications for both women and men when developing, implementing, and evaluating changes in policy and practice, with a view to promoting gender equality.
- Prioritise the development of trauma and violence-informed, and psychologically-informed, approaches and services which recognise and respond to previous experiences of adversity and their ongoing influence on people’s circumstances and engagement with treatment.
- Provide enhanced support at specific times of vulnerability, such as bereavements and loss of child custody.
- Provide additional assistance for individuals with benefits, housing, and legal issues, to help mitigate challenging financial and social circumstances - particularly those associated with welfare reform. These might usefully be delivered through integration or co-location with drug treatment services and

⁶¹ Tweed, Miller, Matheson (2018). Why are drug-related deaths among women increasing in Scotland? A scoping of possible explanations. Scottish Government Social Research. Available at: <https://www.gov.scot/publications/drug-related-deaths-womenincreasing-scotland-9781787810129/pages/8/>

⁶² Tweed, Miller, Matheson (2018). Why are drug-related deaths among women increasing in Scotland? A scoping of possible explanations. Scottish Government Social Research. Available at: <https://www.gov.scot/publications/drug-related-deaths-womenincreasing-scotland-9781787810129/pages/8/>

in other healthcare settings (see Edinburgh Access Practice as an example of this working well in Scotland).

- Explore the feasibility, evidence base, and preferences for gender-concordant workers and female-specific support and recovery groups.

Recommendation 16: Attend to the intergenerational nature of substance use problems and place the safety and wellbeing of children at the heart of all planning, alongside proactive support for parents. Explore the creation of family support workers in the third sector that can provide support ahead of families reaching crisis point and requiring social work intervention.

For decades, the intractable problems faced by generations of those using drugs, have been impossible for traditional services to resolve. Dundee's children deserve better and they (and their parents) need a future filled with hope and aspiration. There is now a desperate need for radical change, and it feels that, both locally and nationally, there is the impetus to deliver.

This does not necessarily mean removing children from their birth family, which can place children and parents at additional risk of harms, but this may result in supporting parents and kinship networks in a wide variety of ways, including the provision of high quality treatment services and helping to support compassionate communities, with interventions and support for children and young people in their own right. Services in Dundee need to take a greater pro-active role in engagement with these issues and challenges. One of the findings of the Commission, as mentioned earlier in the report, is the lack of engagement of ISMS in attending Child Protection Case Conferences where children are deemed to be at greatest risk, and to Core Group Meetings in Dundee when plans are established to ensure the safety and protection of the child. This has to change with immediate effect and should become a mandatory requirement that the service attends the maximum number of case conferences as possible, or for the exception where attendance is not possible, a detailed report should be submitted.

Records indicate that from January 2018 until 15th May 2019 (16.5 months) there were 380 case conferences (both initial and review) for 290 children in Dundee; 134 of whom were affected by substance use (83 drugs, 18 alcohol and 33 both). ISMS staff attended just one of these conferences and provided a report to a further three conferences overall providing recorded input for four children.⁶³

The Commission recommends that options for bereavement counselling and support for children, young people and families affected by a drug death in Dundee are made available as soon as practicably possible. The Dundee Partnership must require more services to address substance use from a 'whole family perspective'.⁶⁴ There is little merit in supporting a child independently, or to try to address an adult's use of substances as a sole focus, when we know they are a parent. Neither of these exist in isolation and there are many complex wider family issues which make sense to be considered simultaneously.

Services in Dundee appear to have been developed in 'silos' with limited reference to other key partners who can offer support, advice and assistance. The whole 'Getting It Right For Every Child'⁶⁹ (GIRFEC) approach is universally understood for children and young people in Scotland and this can be applied equally to adults but, for some reason, when an adult has a drug problem it is most frequently the 'risks' posed for any children that become the sole focus. This can be enhanced by improved engagement between those providing statutory and third sector drug services with those in Children's Services and directly with families and communities.

Greater awareness of the impact of adverse childhood experiences (ACEs), improved traumainformed practice, and the building of resilience and self-esteem for the whole family, should be the ambition for Dundee and would lead to much better outcomes for all. However, this is not a 'cheap' option and would need a genuinely well-resourced responsive service, potentially with 24/7 availability and the commitment of a range of flexible and creative practitioners who are invested in the family's functioning. The Commission would like to challenge the Dundee Partnership to consider this recommendation in detail as this would require a 'transformational approach' and would require

⁶³ The Commission has welcomed a submission from ISMS which highlights attendance at Child Protection Case Conferences as a risk, with mitigating actions put in place.

⁶⁴ Whole family approaches are currently being practised through the third sector (in some cases funded by the DADP). ⁶⁹

Available at: <https://www.gov.scot/policies/girfec/>

a far more detailed scoping report than the Commission has had time to produce in this regard. As Tweed et al (2018) have noted:

“Child- and family-sensitive treatment services, and support for family relationships: Such approaches would recognise the importance of family relationships and parenting to recovery and harm reduction, and might include options which make childcare arrangements easier (for instance through suitable timing and location of appointments, including home visits), residential treatment services which support family integration, and support for parenting and re-establishing family relationships. One such approach cited by stakeholders as an example of best practice was a residential facility permitting women to live with their children whilst undergoing rehabilitation: however, this facility is now closed, apparently due to funding issues. Another example is a recently initiated home detox programme run by Barnardo’s in Fife.”

The Commission would like to see the establishment of a multi-disciplinary service built around the family. This would include:

- clinical psychology to address long-term trauma and distress, speech and language therapy to promote cognition, as so many of our drug users cannot ‘process’ information in the way they are required to in order to benefit from the services that can currently be provided;
- social work and social care services to enhance family dynamics to help repair family relationships and to promote community engagement;
- housing support to help families move to appropriate accommodation (away from high risk) and the associated development of welfare/budget management skills;
- community learning opportunities to encourage education, training and employment and the aspiration of families to do more than simply ‘recover’ to support other users; and
- wider, reparative, family support to help rebuild relationships and enhance community-based support.

The Dundee Partnership needs to nurture a vision for increasing expectations of what is possible and a focus on removing the barriers to allow children and young people to see that people can correct the choices they make and it need not define who they are for the rest of their lives.

National Considerations

In considering how to achieve the significant improvements that are required in Dundee, there are a number of areas that are outside of Dundee’s powers to change – resting either with Scottish Government or the UK Government. For Dundee to succeed in its ambitions to effectively tackle the challenges it faces, the Commission needs to highlight the following matters for national consideration:

1. Inspection of all substance use services. Unlike England where all substance use services are subject to regular inspections from the Care Quality Commission (which is the independent regulator of all health and social care services in England), only certain categories of substance use services are inspected by regulatory bodies in Scotland. This only adds to the unequal ‘playing field’ as discussed in Recommendation 4. **The Commission would ask Scottish Government to consider equal regulation of the whole substance use services/treatment sector.**
2. Funding of substance use services. Unlike England, ADPs across Scotland only have direct control of a minority of funds for drug treatment. For example, in Dundee, the DADP only has direct control of approximately one third of the total drug and alcohol spend⁶⁵, with the NHS retaining control of the majority two thirds with decisions taken by the Dundee IJB. The Commission believes this maintains an unhealthy balance and explains why ADPs have largely been ineffective across Scotland in making a decisive shift towards prevention (as outlined by the Christie Commission). They are unable to redistribute funding in the manner needed to fulfil the Christie mandate. **The Commission would therefore ask the Scottish Government to consider how it can change the funding systems in Scotland to allow ADPs to**

⁶⁵ See Table 7.1 in Chapter 7 ‘Key Messages’ earlier in report.

control the whole drug and alcohol spend. This would need to be considered alongside a wholesale review of ADPs to ensure they can function as fully independent commissioning bodies.

3. Public Health Emergency. Given the rapidly increasing number of drug-related deaths across Scotland, and the seriousness of the issues the Commission has reported on in Dundee (which are similar to other areas of Scotland), **the Commission welcomes the Scottish Government declaring the drug deaths crisis as a public health emergency.** In Scotland, at present, it is unclear whether such a declaration will unlock any new powers or resources. International examples exist that can be learned from, for example in British Columbia, Canada in response to a provincial emergency. The Commission welcomes the moves by the Minister for Public Health and Sport to set up a National Task Force to advise on what further changes, in practice or in law, could be made in Scotland.
4. Decriminalisation. As part of its work over the last year, the Commission has looked at several different approaches from other countries. The Commission was highly impressed with the decriminalisation approach of Portugal over many years now (which also focused on better treatment, employability and housing, as well as welfare improvement), and the improved outcomes it is experiencing (see **Appendix V** in the **Part 2** report). **The Commission is aware of the current inquiry into problem drug use in Scotland being run by the Scottish Affairs Committee and would support the calls for petitioning the UK government to have increased devolved powers to allow for a full ‘Scottish’ review of drug laws to be conducted and action taken as a result. In the short-term the Commission would ask the Scottish Government to consider how they can make the most of the powers that they already have (including policy) – such as police and enforcement practice.**
5. Drug Death Review processes - learning. There is currently no standardisation of local drug death review processes or systems for shared learning across different Health Board areas. There is a group whereby data co-ordinators can meet and discuss processes related to data assimilation and recording, but there is no co-ordination of Chairs/strategic leads in this area, which provides little opportunity to learn from one another. **The Commission would therefore ask the Scottish Government to consider convening a National Learning Set for Drug Death Review Groups (including standardisation of processes).**
6. Drug Death Review processes – speed. Enhanced surveillance and utilisation of overdose data to inform practice and policy is required. **The Commission would ask the Scottish Government to consider how ‘real time’ data (without extensive delays in getting these data into the public domain) can be achieved in order to enhance the ability to respond both locally and nationally.** Current data processes have lags of between 12-18 months. The British Columbia Drug Overdose and Alert Partnership (DOAP) model provides an excellent example for proactive multi-sectoral action related to harms from substance use, including overdose.⁶⁶
7. Toxicology. Reporting of toxicology findings on post-mortems are too slow (currently ~8 to 10 weeks). **The Commission would ask the Scottish Government to consider allocating appropriate resources to national toxicology testing to enable more effective and quicker reporting.**
8. **The Commission would ask the Scottish Government to consider developing a plan of work to address the findings in the 2018 Scottish Government report on women and drug-**

⁶⁶ <http://www.bccdc.ca/resource-gallery/Documents/Opioid%20Overdose%20Response%20Strategy.pdf> Website info:
<http://towardtheheart.com>

related deaths.⁶⁷ Many of the areas identified in this far-reaching report address issues that have resonated in the Dundee Commission's work over the past year and we suggest that the policy and practice recommendations therein offer the potential for much needed "cross-sectoral collaboration and policy synergy – for instance, with mental health, social security, justice, community cohesion, housing and homelessness, and the equalities agenda more broadly" (Tweed et al, 2018). One of the recommendations from this work that relates centrally to the Dundee experience is the need for a more co-ordinated and holistic approach across substance use treatment, mental health, physical health, and social support (including housing, employment, legal and financial advice). This approach has been recommended by recent reports from the Scottish Drugs Forum, the European Monitoring Centre for Drugs and Drug Addiction, and Public Health England. Elements of this approach might range from workforce training,

multidisciplinary meetings, and robust referral pathways to a holistic approach to treatment eligibility and thresholds and greater integration of services. Integration of trauma- and violence-informed, and psychologically-informed, approaches must be led at a national level - as well as actively supporting and promoting cross-sectoral collaboration across substance use, homelessness, justice, mental health, education, and children's services. Protecting and, where possible, enhancing funding for drug treatment services – particularly harm reduction – and mental health care will be required. Strengthening efforts will also be needed to mitigate the adverse impacts of welfare reform, especially among those who may experience disproportionate harms, as well as ensuring sufficient attention to the intersection between gender, substance use, mental health, and other inequalities in the design of Scotland's new social security system.

It's now time for action

As a Commission we are fully aware that we have provided a significant challenge for the Dundee Partnership in terms of the volume of action and work that will be required to implement our recommendations – which are framed over a five year period. Our hope is that all disciplines and services (including the DADP) quickly (within three months) prioritise the time necessary to reflect upon the findings and recommendations laid out in this report, and provide a detailed response and action plan to the Dundee Partnership to describe the part they can all play in helping to tackle this set of significant challenges. There are some quick wins to be had in learning from the mistakes of the past to uncover the solutions for the future. For example, we were struck by the high-quality evidence provided to the Commission by Professor John Dillon (Professor of Hepatology & Gastroenterology, School of Medicine, University of Dundee, and Ninewells Hospital and Medical School) about the major successes in Dundee of efforts to eradicate Hepatitis C. This has been achieved in large part by a simple reframing of how services engage with those who require help – to offer a more welcoming, humane and respectful approach. The irony is that the Hepatitis C population (who are benefitting from the new approaches) include members of the drug using population that have experienced (and report) a very different type of specialist provision for their drug use issues.

Another high-quality example was provided to the Commission by Ann Eriksen (Head of Strategic Planning, Executive Lead - Sexual Health & BBV, NHS Tayside). Dundee once had the title of 'Teenage Pregnancy Capital of Europe'. No more though. Dundee has successfully changed its approach over the last decade to ensure better outcomes. It is time to apply these approaches to the issues of drug use so that Dundee is able to shed the label of 'Drug Death Capital of Europe' once and for all, and ensure that Dundee is a city where every life and death matters.

There is a deep passion amongst the people of Dundee to assertively respond to the serious challenges faced. As Commission members we are fully prepared to continue in a supporting role to help ensure Dundee can implement the changes we have sought to describe and understand. We would therefore want to support the Dundee Partnership and the DADP as a 'critical friend' as they look to take the lead on implementation. Having challenged the Dundee Partnership to pick up the baton and run with an ambitious programme of change, it would be negligent of the Commission to deliver its report and walk away. As an independent Commission we are prepared to support the DADP as it begins a new journey and to reconvene and collaboratively review progress within the next 12 months.

⁶⁷ Tweed, Miller, Matheson (2018). Why are drug-related deaths among women increasing in Scotland? A scoping of possible explanations. Scottish Government Social Research. Available at: <https://www.gov.scot/publications/drug-related-deaths-womenincreasing-scotland-9781787810129/pages/8/>

The values of **kindness, compassion and hope** will underpin and guide the support that the Commission is able to provide. In return, we challenge the Dundee Partnership to having 'a year of kindness and compassion' to get things moving in the right direction and reignite the hope that things can and will change.

9. OUR REFLECTIONS

Reflections of members of the Dundee Drugs Commission

Full details of Commissioners can be found in **Appendix I** in the **Part 2** report and at:
<http://www.figure8consultancy.co.uk/wp-content/uploads/2018/11/DDMC-Commission-Members->

Alex Baldacchino, Professor in Medicine, Psychiatry and Addictions at the St Andrews University

“It is never easy to ask the right questions as you might find yourself involved in finding the wrong answer. My time with the Commission was fruitful and productive in trying to tease out what is actually happening in Dundee, whilst identifying the core elements that will allow ALL individuals who are asking for support to get the best available support in a timely manner. Polarisation and segmentation of ideas and persuasion is never a useful tool to conduct the piece of work that the Commission were tasked to do. It certainly allowed Dundee stakeholders to focus their minds and energy to support the Commission in producing suggested action points. Some very uncomfortable messages, but necessary to read and act on.”

Sharon Brand, Co-Founder, Recovery Dundee

“My biggest hope is that the Commission’s report is received in the spirit that it is given. It is every individual’s responsibility in the City to reflect upon the serious issues presented in this report and to play their part in implementing the changes that are needed. The time for action is now.”

Andrew Fraser, Director of Public Health Science, NHS Health Scotland

“Being part of the Dundee Drugs Commission offered me a clear view of the pain and raw sense of not being heard when disasters strike and persist in families, and services that are under strain can’t or don’t work together to piece together a system of support that benefits users, on their terms. Businesses such as illegal drugs suppliers that prey on people who are dependent on drugs are not around the table, discussing their contribution to the rising numbers of younger people losing their lives. But communities can and must come together with the organisations that can help, from all sectors in a much more joined up way, focussing on the needs of people, putting aside differences. Policy-makers, leaders and professionals need to remain accountable to the people they serve, through the quality of their work and their relationships, caring about and learning from the consequences when failures occur.”

Eilish Gilvarry, Consultant Psychiatrist in Addictions, Newcastle Addictions Service and Professor of Addiction Psychiatry, University of Newcastle upon Tyne

“The composition of the Commission demonstrated broad skills and experience of all aspects of drugs: policy, treatment, prevention, experience, families, criminal justice systems and health. This was a setting then for seeking evidence and challenge, and the commission heard from multiple related areas (e.g. primary care, statistics on deaths, liver specialists) in presentations, in focus groups, in written material and oral advice. The most striking learning point for me was the involvement of families. To hear their stories, their difficulties, their problems as they perceived them with services, what they wished to happen was so forceful and reflective. Reviewing statistics, evidence, etc was important but they demanded action and change with such passion and compassion that our recommendations must demand that change too. Drug-related deaths are not just statistics but those who die belong to families, have families and all are so effected by their deaths.”

John Goldie, former Head of Addiction Services (South Glasgow), Glasgow Addiction Service

“I very much welcomed the invitation to join the Dundee Drugs Commission and did so with the hope that I could share some of my experiences of a career spent trying to improve the provision for those affected by substance use. In the past 12 months I have experienced highs and lows from humbling life shares from those and their families having been through and in the midst of chaotic drug use to

extraordinary stories of recovery and inspiring insights into committed staff and volunteers, but also exasperation at what seems to be a professional dislocation from the reality of the crisis within Dundee. The treatment and care services had already undertaken a full review of its provision prior to the start of the Commission and this appeared at times to be seen as their rationale not to engage fully, although this did improve towards the end. The recommendations of their review are central to change in Dundee but the past evidence is that treatment and care services cannot be left alone to ensure all changes are fully implemented, it is my ask that the Commission requires a revisit in 12 months to ensure that improvements are in place to ensure Dundee has a service provision that all Dundonians need and deserve.”

Cllr Kevin Keenan, Leader of the Labour Group, Dundee City Council

“The Dundee Drugs Commission has been an eyeopening experience for me and quite humbling to have heard evidence from many families who have been affected. Individuals have shared some extremely personal experiences and they have done this in the hope that the Drugs Commission and its recommendations will be taken forward in order to make a difference to people’s lives in Dundee. I have also gained a considerable insight into the various problems that exist and the potential solutions, many of which will come without a great deal of cost. Treating people with respect and doing everything we can to help sort out what sometimes are chaotic lifestyles will make a real difference. There are a number of organisations that need to modify how their services are delivered, working with others taking a multi-agency approach to support and treat those individuals affected.”

Eric Knox, Chief Executive Officer, Volunteer Dundee

“I have been moved by the evidence that the commission has heard from the people who have lost loved ones and who use services. Individuals have the right to receive support and treatment from our services and we must ensure that no one is turned away. I am committed to ensuring that to commission’s findings a fully implement across Dundee in the years to come.”

Dave Liddell, Chief Executive Officer, Scottish Drugs Forum

“The Dundee Drugs Commission has allowed me, and fellow members of the Commission, important insights into the lives of people who are suffering greatly. They are not being provided with the care and support they have a right to expect in a civilised society. The Commission’s findings must not be just be another report but be a springboard for real change; firstly, enabling people to stay alive and secondly, being provided with the help and support they need to live full lives. It remains shocking that we continue to maintain a system that can treat people so inhumanely and seemingly without care and that we see so many tragic outcomes. What is incredible is that the key specialist service has changed so little over a very long period of time despite several reviews taking place. This sadly highlights the lack of leadership and compassion which has allowed the status quo to persist. Staff in all services need to be supported to work through change because radical change must be delivered to services in Dundee now if we are to keep people alive and ensure they have opportunities to flourish.”

Jean Logan, Associate Director of Pharmacy, Community Services, NHS Forth Valley

“It has been a real privilege to be part of the Dundee Drug Commission. As a healthcare professional it has been extremely hard to hear the stories of people seeking help who have been failed. Stigma is clearly still evident, and we all need to listen carefully to feedback, both good and bad. There is an opportunity for services to create a cohesive and compassionate environment working collaboratively with people affected by drugs to help them realise their full potential. It was a bold move by the Dundee Partnership to commission this work and I hope they will now be bold and brave in taking action.”

Suzie Mertes, Superintendent (Partnerships and Performance, D Division), Police Scotland

“Having spent 25 years in policing in Tayside and have seen at first-hand the trauma caused by drug-related deaths, and know only too well the harm and damage that drugs can do to individuals, their friends and families, and to our communities. However, even with that experience, it would be fair to say that prior to joining the Commission I didn't fully understand all of the causes, interconnections and circumstances that made Dundee particularly, but I suspect not uniquely in Scotland, vulnerable to such high rates of harmful substance use. The Commission has thrown a light onto those connections. Every person who has died in Dundee as a result of harmful substance use was a person with potential and the recommendations allow us, as a community, to now work better together to save lives.”

Justina Murray, Chief Executive Officer, Scottish Families Affected by Alcohol and Drugs

“This is the first time I have been a member of a Commission and I thought I knew what to expect (lots of meetings, reading, visits). This bit turned out to be true, but what I was not expecting was the (at times overwhelming) power, volume and consistency of the personal testimony that people have shared with the Commission. In my role, I meet a lot of families and others involved in the world of drugs and alcohol. I have heard many stories which are moving and upsetting, and which motivate everyone in Scottish Families to campaign for better support and involvement of families and their loved ones. However, the evidence from Dundee has come thick and fast with no holds barred, and people have shone a powerful light on a broken system which is full of injustice, judgement and complacency. I feel a massive responsibility to all of the people who have shared their stories with us to ensure that their words do effect unprecedented change and improvement across the city.”

Niamh Nic Daeid, Director, Leverhulme Research Centre for Forensic Science, University of Dundee

“It has been a privilege to be asked to be a Commissioner on the Dundee Drugs Commission. Our work has been greatly enhanced by the quality and probing nature of the questions the Commission has asked and the honesty and frankness of the answers we received. The evidence and experience provided to us from agencies in Dundee, elsewhere in Scotland and further afield has been most welcome and informative. The lived experience has been hugely impactful and has greatly enriched the statistical evidence with which we have been provided bringing the challenges into life beyond the sometimes coldness of numbers. This combination of experience and statistical fact allowed us to both frame our findings and to make evidenced based recommendations. We need now to move forward in partnership with each other, all sections of the community working together, to address positively the challenges which have been highlighted.”

Hazel Robertson, Head of Services for Children, Young People and Families, Perth & Kinross Council

“The Dundee Drug Commission has offered a unique opportunity to examine local need and scrutinise existing service provision through a ‘forensic lens’. This has enabled members to test the appetite for change and explore innovative solutions which may genuinely benefit the city's residents. To achieve the momentous change required, Dundee requires truly audacious leadership. Change is tough and the road may be long and bumpy but there is a degree of enthusiasm to be more creative and to try to ensure existing services become more nimble and able to respond, much more quickly, to changing need. Drug users in Dundee have made their views clear, they need greater access to opportunities to support the changes being proposed and robust, high quality and responsive services that are ‘barrier free’. The Drugs Commission has, in part, fulfilled its role, but there needs to be assurance that proposed changes will be implemented and that progress will be monitored. There must continue to be clear expectations on all those with responsibility to ensure the improved provision of services.”

Jardine Simpson, CEO, Scottish Recovery Consortium

“Joining the Dundee Drugs Commission in October of 2018 I was struck by the City of Dundee’s challenges being an extreme example of what is happening (or not happening) across Scotland. Dundee needs confident and competent leadership to reduce Drugs Related Death and improve treatment and support responses. Leadership and staff of all services must learn to communicate better amongst themselves and authentically include the people presenting to them for support in this process. All staff in Dundee are Duty Bearers – they have a responsibility to respect, care for and work with, patients and service users who themselves are Rights Bearers; Rights Bearers who are entitled to improved quality in the treatment they receive and accountability throughout their engagement with Public and third sector services.”

Pat Tyrrie, Family Member

“Notwithstanding my own ‘lived experience’ of the impact of addiction on family life I have become more informed of the struggles for people with addiction, the gaps in services and the effect on families. I have a sense that public understanding on the daily struggles for people with an addiction is changing. There appears to be a more compassionate view for those who are essentially our sons and daughters, brothers and sisters, mothers and fathers. I am also more informed of the success of other countries e.g. Iceland where prevention work has had a positive outcome in reducing the use of drugs and alcohol by young people. I sincerely hope the findings of the Commission will be acted upon to prevent drug deaths, provide appropriate mental and drug addiction health services and develop links with young people to work towards stopping drug and alcohol use in the first place.”

Maureen Walker, Family Member

“Having personal experience of living alongside someone who has a problem with drugs, and how it affects not only the user but also family members, I was very interested in the Drugs Commission. I was invited to take part, and I felt it would be very worthwhile to do so. To be part of what after all is very important. It is encouraging to see so many professionals work so hard to put together recommendations that may help to make changes that will have more success than in the past. Drug users are real people. Stigma is still a real problem, but drug users are still human beings that for some reason have taken the wrong path in life. Many are crying out for help. The Commission is putting forward recommendations, not criticism, and hopefully will be looked on as positive, not negative. The past didn't work, so if we all work together now, there is hope.”

Dundee Partnership: Action Plan for Change

RESPONDING TO THE REPORT OF THE INDEPENDENT DRUGS COMMISSION

This plan has been developed on behalf of the Dundee Partnership and as such it reflects a broad partnership approach for working with vulnerable individuals and families affected by substance use. Existing structures, including the Protecting People approach, will be key to the implementation of this plan.

We recognise that in the past when planning and structuring services, we have tended to consider substance use in isolation of the underlying issues that cause it, with not enough consideration to other vulnerability issues, including mental health, adverse childhood experiences (ACE) and gender-based violence.

This plan contains a focus on specific substance use issues: including prescribing practices, access to and maintaining engagement with specialist services, rapid response to non-fatal overdoses, tackling stigma and being informed by lived experience. In addition, the plan also incorporates efforts to tackle trauma and mental health (including ACE), working with vulnerable women and children (affected by a whole range of other issues, including substance use), linking to sexual health, and resilience and prevention work within schools focusing on health and wellbeing. Moreover, elements of this plan have been linked to on-going transformation processes, including the Transforming Public Protection process (and specifically the Leadership improvements being progressed through this programme).

The implementation of this plan is the responsibility of the entire Community Planning system, with the ADP taking a lead on monitoring / scrutinising progress and escalating any areas that are not being progressed at the required pace to the Chief Officers Group and onwards to the Dundee Partnership.

Following an initial period of action to address some of the most urgent issues identified by the Drug Commission report, such as establishing the Non-Fatal Overdoses test of change, this action plan has been developed in collaboration with a wide range of stakeholders. It represents our current assessment of the actions required to address the findings of the Drugs Commission, however the plan will be an evolving document. We are committed to the implementation of the actions contained within the plan but know that there will be a need to recognise quickly where any actions are not progressing as we have anticipated or are not having the predicted impact and to adapt our approach accordingly.

The timescales identified within this plan are ambitious and will require collective prioritisation across all Community Planning partners. They represent our best assessment of likely timescales for completion of actions at this point in

the development of the plan. Chief Officers from across the Community Planning Partnership are committed to supporting the workforce to deliver against these timescales.

This plan will be supported by a separate performance management framework that will support the ADP, and other relevant Community Planning groups, to not only track the completion of actions but to evaluate their impact on the wellbeing of individuals, families and communities. Each action within the plan will also be supported by a more detailed delivery plan that identifies key milestones for implementation with associated timescales and identifies appropriate measures of impact. These detailed action plans are currently being developed by the lead officer, supported by the working groups they are chairing.

Although this plan has a focus on Dundee it does not exist in isolation. There is an expectation that the lead officers and working groups identified within it will take an approach that is evidence based, cognisant of best practice across Scotland and beyond, and supports innovation. There will also be a need to consider in further detail how the work in Dundee links to and is supported by work at a national level including the work of the National Task Force.

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1	9	Drug Death Action Plan workgroup (DDAP), supported by work of the TDDRG and Tayside Overdose Prevention Group	<p>Lead the implementation, evaluation and subsequent sustainable delivery of the Non-Fatal Overdose Pathway, including:</p> <ul style="list-style-type: none"> - Design, run and evaluate the Test of Change; - Support the securing of resources to implement findings from the ToC; - Utilise learning from the ToC to review organisations' approach to non-fatal overdose and develop a partnership brief intervention model and associated staff training. <p>Commission the design and delivery of a behaviour change intervention to prevent further overdose using a health psychology model</p> <p>Establishing and evaluate an Early Trends Monitoring system to co-ordinate and support the delivery of proactive and reactive harm reduction messages of emerging drug death trends</p> <p>Explore the development of a Risk-Assessment tool for multi-agency use to guide the response to supporting people affected by drug use.</p>	<p>Chair of the DDAP workgroup/ Lead Pharmacist</p> <p>Sexual Health & BBV MCN / ADP</p> <p>Public Health Consultant/ Chief Inspector Communities/ Tayside OD prevention group/DDAP group</p> <p>Chair of DDAP Workgroup</p>	<p>May 2020</p> <p>Summer 2021</p> <p>December 2020</p> <p>March 2020</p>	<p>All NFODs in Dundee are responded to within 72 hours.</p> <p>There is a defined early trends monitoring system in place, which provides an initial response within 72 hours.</p> <p>Relevant and proportionate information is shared to keep individuals safe.</p> <p>There is optimal cover of the Take-Home Naloxone programme to keep individuals safe.</p> <p>Reduction in the number of overdoses.</p>

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			Extend the Take-Home Naloxone Programme to provide optimal coverage and ensure front-line staff, individuals / families and friends are able to access the training to ensure participation in the programme.	Naloxone Lead (Access Directorate NHS Tayside)/ H&SCP	By April 2020	
2	9	Whole System of Care workgroup/ H&SCP/ ASP Committee/ Mental Health SPG	<p>Evaluate direct access clinic model to determine future capacity requirements and options in line with the development of a pathway</p> <ul style="list-style-type: none"> Agree the business case for bridging resources to increase capacity of treatment services to manage current and predicted levels of demand for treatment and ensure a response case management model of support; Work with partners to identify a different name to ISMS Review and test options for same day prescribing; Implement models to support quick access to treatment options. <p>Increase the level of non-medical prescribing through recruitment and training opportunities</p>	<p>Whole System of Care workgroup</p> <p>ADP</p> <p>H&SCP/ Consultant Psychiatrist</p> <p>H&SCP Head of Service</p>	<p>June 2020</p> <p>End January 2020</p> <p>March 2020</p> <p>January 2022</p>	<p>There is an increase in the number of people (in line with estimated prevalence) accessing support and treatment.</p> <p>The option of same day prescribing is available to all the individuals assessed to benefit from it.</p> <p>There is a reduction in the waiting times for access to OST and improve retention of people in treatment.</p> <p>There is improved progression of individuals through support and recovery pathways.</p>

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3	9	Whole System of Care workgroup (under discussion)	<ul style="list-style-type: none"> Pilot assertive outreach model within ISMS to support those at risk withdrawing from support Pilot assertive outreach models within the community delivered by third sector services 	H&SCP Head of Service	June 2020	<p>The number of people discharged from services in an unplanned way is reduced to a minimum.</p> <p>There is an increase in treatment and support options available to individuals and uptake of these options.</p> <p>Individuals are better supported to maintain engagement and progress with their recovery.</p> <p>People leaving prison custody with an identified need have a recovery service access point in the community</p>
		H&SCP	Embed a range of service provision (statutory and third sector services) in key sites across Dundee with the aim of supporting people to continue to expand substance misuse services providing support within various community locations across Dundee	Whole System of Care workgroup	June 2020	
			<ul style="list-style-type: none"> Expand the Housing First Model, including additional support for vulnerable women. As part of the review of temporary accommodation consider the need for women-only accommodation options. 	Whole System of Care workgroup	June 2020	
			<ul style="list-style-type: none"> Progress the on-going development of a Peer-Support Framework and support the implementation of the Framework; Develop a whole-system Advocacy Framework and commission supports for the Framework 	Whole System of Care workgroup	October 2020	
			Work in partnership with the Harm Reduction Nursing Team to develop referral pathways and shared care models	Whole System of Care workgroup / SHBBV MCN	June 2021	
			Develop a commissioning framework to support access to residential rehabilitation options	Whole System of Care workgroup	April 2020	
			Tayside/Fife Throughcare	In partnership review and update the Tayside “Pathways” for people leaving prison custody to ensure there is a clear	Chair of the Throughcare Network	

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		Network Group	route to access community based recovery services for those who have an identified need	reporting through the ADP			
4	Implement a revised person centred, seamless, sustainable and comprehensive model of care	7,8,10,11,13	Whole System of Care workgroup/ HSCP	Map and development and co-produce an agree pathway for people who use substances which supports a recovery model, built on integrated service delivery based within local communities, that provides access to a range of treatment and support options	Whole System of Care workgroup	December 2020	Individuals and families in Dundee affected by substance use have easy access to services within their localities.
			Redesign service pathways, functions and delivery models in line with agreed pathway and commission services to implement the model	Whole System of Care workgroup	December 2020	There is access to high quality shared care model for people experiencing mental health issues who use substances.	
			Agree a model of shared care within general practice <ul style="list-style-type: none"> - Test out model of shared care within the three 2c practices - Evaluate and consider how the model can be delivered within communities and/or near where people live 	H&SCP Head of Service	December 2020	Dundee has in place a whole-system model of care, including statutory and 3 rd sector organisations and based on a locality model (including the 3 community hubs).	
			Improve access to Mental Health Services <ul style="list-style-type: none"> - Review and develop protocols for referral and access to service - In line with decision of Scottish Government funding decisions, review options to develop service which have an integrated response for 	Whole System of Care workgroup	June 2020		

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				people with mental health issues who use substances			
				Implement the recommendations from the Independent Evaluation of the 3 Community Hubs	Whole System of Care workgroup/ Resilient Communities	December 2020	
		Conduct a comprehensive Independent Needs Assessment	NHS Tayside Public Health Directorate	Consult and agree on an initial HNA scoping document	Director of NHS Tayside Public Health	End December 2019	Robust and up to date information is available to direct planning, improvement and commissioning decisions.
				<ul style="list-style-type: none"> Agree collaborative commissioning model with national colleagues for timely delivery of a HNA for consideration by the Partnership. This proposal will contain timescales and resource requirements including consideration of how to undertake qualitative elements of the HNA Undertake qualitative work to understand why people are disengaging from care. 	Director of NHS Tayside Public Health	End January 2020	
5	Win the trust and confidence of all stakeholders through effective Leadership, Governance and Accountability	1,4,6	ADP / Chief Officers Steering Group	<ul style="list-style-type: none"> Implement and support the new Governance of the ADP; ensuring explicit lines of accountability and actions are clear and measurable; and Complete and implement the revision of structural arrangements for the governance of Multi-Agency Public Protection strategic groups and ensure the ADP transitions effectively into the new PP governance arrangements 	ADP Chair / ADP H&SCP Senior Manager, Strategy & Performance/ COG	February 2020 April 2020	Effective governance arrangements are in place to lead on and progress efforts to protect vulnerable individuals and families in Dundee.

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			<ul style="list-style-type: none"> Revise the role of the Independent Chairs to establish a shared expectation of their contribution to leadership, governance and accountability; Establish a strategic risk register for the COG to guide focus of work and to support accountability arrangements for the Protecting People structure; and Implement a Risk Assessment framework specifically focused on the ADP 	H&SCP Senior Manager, Strategy & Performance/ COG ADP Implementation Group	March 2020	Chief and Senior Officers are aware of and respond to risks in a joint-approach. The ADP has robust and up to date information to inform its decisions.
			Negotiate and implement an initial Key Performance Indicators (KPI) framework that provides up-to-date insight into the performance of all key services in both the statutory and third sector.	ADP Implementation Group	March 2020	Leaders in Dundee are supported to make informed decisions and exercise robust scrutiny.
			Work to enhance the knowledge, understanding and engagement of all Elected Members around the underlying causes of substance misuse issues.	Protecting People Team	December 2020	
			With support from Scottish Government, adopt the <i>Partnership Delivery Framework to Reduce the Use of and Harm from Alcohol and Drugs</i> (focus specifically on section 10 of the Framework)	Dundee ADP/ Scottish Government	April 2020	
			Participation in Scottish Trauma Informed Leaders Training and proposed pilot activity	See details in Priority 9 below.		
6	5	Resilient Communities workgroup	The actions within Key Priority 6 will be informed by the work on Trauma-Informed Leadership pilot, specifically the lived experience element (see Key Priority 9 below)			Increase in recruited volunteers.
			Expand the recruitment of volunteers to support recovery and tackle stigma within communities, incorporating a volunteer training programme	Chief Executive DVVA/ Lead Officer to the	December 2020	People with lived experience are actively participating in all

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	problems with drugs, families and carers and those that advocate for them				Peer Recovery Network		aspects of the implementation of this plan.
				Establish a Lived Experience Quality group to ensure that involvement of people with lived experience is embedded effectively and meaningfully across the ADP structure and the wider delivery of support.	Chief Executive DVVA / Peer Support Co-ordinator/ ADP Implementation Group and all Workgroups	March 2020	The work of all ADP Workgroups is informed by and engages with individuals with lived experience.
				Support the delivery of two development sessions, each year to bring together people who use supports, families and service providers to share information and test out progress.	ADP Implementation Group	December 2020 and annually	
7	Confront and address stigma and strengthen mutual and community support	2,3	Resilient Communities workgroup / Fairness Commission	Further develop and expand delivery of awareness workshops to local community groups and services within every locality to raise awareness of how stigma impacts on individuals' health and wellbeing.	Community Health Team; DVVA	December 2020	Individuals and family affected by substance use are treated in a professional and respectful manner.
				Promote and increase uptake of the Recovery Friendly Dundee pledge across organisations, businesses and community groups	Community Health Team	December 2019	There is a city-wide support for recovery and a reduction in stigma from local communities.
				Implement a <i>Language Matters</i> campaign to challenge use of stigmatising language.	Senior Health Promotion Officer/ DVVA/ Community Planning Manager/ Fairness Commission	June 2020	Individuals in recovery are active and contribute to their communities.

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			Promote the range of community groups and opportunities which contribute towards positive health and wellbeing and wider Local Community Planning Partnership priorities, supporting involvement of local communities, including people with lived experience of substance use.	Communities Officers via LCPPs/ DVVA	By October 2020	
			Work in partnership with the Sexual Health and BBV Managed Care Network to reduce stigma associated with Hepatitis and HIV	Resilient Communities workgroup / SHBBV MCN	December 2020	
8	16	Children and Families Workgroup/ Child Protection Committee/ C&Fs service	<p>Three new non-medical prescribing trainee nurses will be placed within Children & Families Teams (one at the East locality, one at the West and one with the Intake Team).</p> <p>Support the 3 nurses to complete their NMP qualification</p>	Service Manager (Acting) C&Fs Service/ Service Manager ISMS	<p>January 2020</p> <p>January 2021</p>	<p>Parents who are affected by substance use receive fast access to treatment and are supported to maintain engagement.</p>
			Progress work with 3 rd sector organisations (including Aberlour, children 1 st and TCA) to establish and agree their role in delivering Tier 2 support to families (and ensure the children are supported) earlier on and throughout the recovery process.	Service Manager (Acting) C&Fs Service/ Service Manager ISMS/ 3 rd sector	April 2020	<p>Children & families are safer and better supported.</p> <p>There is a whole-family multi-agency model of care in place to ensure vulnerable children at significant risk are safe.</p>
			Hold 4 joint development sessions for front-line staff within ISMS, C&Fs Teams and key 3 rd sector organisations to progress and facilitate the interface and joint working between C&Fs and Adult services, and encourage a focus on the whole family.	Service Manager (Acting) C&Fs Service/ Service Manager ISMS/ Senior Advisor Learning and OD Development	December 2020	<p>There is active participation from the substance use workforce in child care and protection processes.</p>

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			ISMS will work closely in partnership with the Children & Families Service to identify a process which will support the increased attendance of staff at CP conferences and the provision of relevant information to support the decision-making at conferences	H&SCP Head of Service/ Service Manager (Acting) C&Fs Service/ Service Manager ISMS	December 2020	There is improved recognition, awareness and response within substance use services to women, children and young people experiencing gender-based violence.
			Increased meaningful contribution at CP conferences, through attendance of staff and other appropriate mechanisms, to address significant risk currently noted on Datix Risk Register.	H&SCP Head of Service/ Service Managers ISMS/ PP Lead Officer Child Protection	February 2020	
			Develop a continuum of services (following on from the New Beginning Service) for vulnerable women (those with multiple and complex needs), and broaden the range of gendered services that provide intensive and tailored programmes to address their needs	Gendered Services Group	April 2020	
			We will continue embedding the Safe and Together and MARAC approaches in Dundee with a specific focus on embedding this approach within substance use services.	Lead Officer VAW/ Service Manager (Acting) C&Fs Service/ H&SCP Head of Service	December 2020	
			Through the Transforming Public Protection work: <ul style="list-style-type: none"> strengthen and evaluate the focus on chronologies and risk assessment and roll out to all practice teams; Revise early screening arrangements for people of all ages to facilitate whole family approaches to risk assessment and risk-management. 	Protecting People Lead Officers H&SCP Head of Service / C&F Head of Service	December 2020	

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9	Implement trauma informed approaches, targeting those at increased risk of substance use / and death	13	Protecting People Team/L&OD team, local Transforming Psychological Trauma Implementation Coordinator (TPTIC)	<p>The Trauma Training steering group will complete a needs assessment for frontline workers (in line with the National Trauma Training Framework and Plan), including:</p> <ul style="list-style-type: none"> • a mapping of the workforce • an assessment of their training needs in relation to trauma-informed work; and • Identifying the key gaps and priorities for training. <p>This will link to the NHS Tayside Trauma Training Strategy currently being implemented with a strong focus on trauma training.</p>	Lead Officer VAW/ TPTIC Consultant Clinical Psychologist L&OD Manager	March 2020	<p>Key workforce groups are trauma informed</p> <p>Our leaders and organisations are trauma informed.</p> <p>Services are delivered through trauma informed environments and practice</p>
				Trauma training at levels 1, 2 and 3 will be delivered by the TPTIC in conjunction with L&OD team and the local level 3 trainer. A review of the Protecting People training framework will incorporate trauma training at all levels.	As above	March 2021	
				Trauma-Informed Leadership – Dundee has been invited to apply for funding from the Scottish Government/NHS Education Scotland to pilot a trauma informed leadership test of change in Dundee, building on the TPP Leadership strand. This includes utilising Trauma Lived-Experience of the workforce.	As above	March 2021 (dependent on outcome of funding bid)	
10	Tackle the root causes of substance use	12,14	Prevention Workgroup	The work on prevention will be informed by the Comprehensive Health Needs Assessment that will take place during 2020	As in Key Priority 4 above	As in Key Priority 4 above	<p>Robust information and up to date is available to inform the development of prevention interventions.</p> <p>There is a streamlined, coherent and co-</p>
				Undertake a Prevention Scoping Exercise to establish the activities currently taking place at environment, community and individual levels (targeting issues including sexual health and gendered-based issues, mental health and	Prevention Subgroup (PP Team & H&SCP)	December 2020	

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			trauma, and substance use) with the aim of developing a consistent, coherent and joint approach in Dundee, and identifying gaps	Contracts to organise)		ordinated approach to prevention in Dundee, focused on the root causes of substance use.
			Work with the Children & Families Service (Education) to support the implementation of the Dundee Substance Misuse Curriculum Framework in schools and relevant community settings.	Public Health Naloxone Lead/ Senior Health Promotion Officer	April 2020	Prevention intervention in Dundee are in line with evidence of good and effective practice.
			Development of a Recovery Friendly Pledge for schools	Education Support Officer Health & Wellbeing/ Community Health Team Lead	December 2020	Best use is made of prevention material and key prevention messages that are developed nationally.
			Support greater engagement with Emotional Health and Wellbeing for children and young people – A toolkit for all staff.	Health and Wellbeing Strategy and Action Group/ Sarah Anderson	June 2020	
			Continued development of Mentors in Violence Prevention programme.	Education Support Officer Health & Wellbeing	To be identified	
			Development of Community Mental Health and Wellbeing model.	Children Services Manager	March 2021	
			Introduction of access to Counselling in schools – aged ten years and up.			

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				Organise one annual meeting for a multi-agency Dundee-wide (this be a Tayside Forum) Prevention Forum to review progress, discuss evidence and agree priorities.	Prevention workgroup	November 2020	
				Support and learn from the Youth in Iceland Model research project currently taking place in Dundee.	Senior Health Promotion Officer/ Chief Inspector Communities	September 2020	
				Promote the National Count 14 Prevention Campaign in Dundee and ensure the campaign's messages around safe and responsible consumption of alcohol are widespread.	Senior Health Promotion Officer	September 2020	
				Link to the local implementation of the new partnership between Scottish Association of Mental Health and SportsScotland to support mental health in young people.	Education Support Officer Health & Wellbeing/ Active-Schools manager	March 2020	
11	Ensure Gendered Approaches are considered in all activities and accommodated in design and delivery of services	15	All ADP workgroups/ VAW Partnership's Gendered Services Working Group (GSWG)	The Dundee Violence Against Women Partnership (VAWP) will ensure information about existing women's services, including the services on offer and how to access them, is widely available and continuously updated.	Gender Services Working Group	March 2020	Communities/ individuals and service providers are well informed about available support for women, children and young people experiencing gender-based violence. All services and supports to vulnerable individuals
				The learning & recommendations from the research project (conducted by Dundee University/ funded by the Challenge Fund) on the specific needs of vulnerable women will be implemented across all the Protecting People services.	PP Lead Officer VAW/ CEO Women's Aid	June 2020	
				Specific training on appropriate Gendered-Responses will be develop and delivered to all mainstream services.	VAWP Training Consortium/	December 2020	

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					L&OD service/ Dundee Uni		are gendered-informed and appropriate.
				The learning & recommendations from the project (conducted by SHBBV MCN) on the needs of vulnerable women in relation to sexual and reproductive health will be implemented across all the Protecting People services.	Lead Officer VAW / Health Psychologist - SHBBV MCN	December 2021	Children & Families affected by gender-based violence and substance use are safe
				Lead on the development of pathways for women with complex needs including substance misuse. Identify and implement ways to streamline and integrate to make better use of available resources, and seek to attract additional resources to develop collaborative responses.	Gendered Services Group (VAWP)	December 2020	Vulnerable women can have easy access to and maintain engagement with services
12	Ensure clear and consistent communications are delivered through a partnership approach.	All	Protecting People Cross-Cutting Communications Subgroup	Implement a strategic Protecting People (PP) Cross-Cutting Communications strategy (workforce and public) to deliver communication messages around all PP areas, including substance use.	DCC Service Manager, Communications	April 2020	Coherent, up-to-date and accurate shared messages are communicated.
				Develop a coherent multi-agency/multi-service communication protocol to ensure all planned and reactive communication messages follow due process and all individuals are clear about their role.	DCC Service Manager, Communications	February 2020	Communities and the workforce are well informed of agreed plans and approaches.
				Establish a framework to ensure the communications messages are fully informed and up to date at all times, reflecting progress across the Partnership action plan.	ADP/ DCC Service Manager, Communications	May 2020	