March

2022

Time for Kindness, Compassion and Hope: The Need for Action Two Years On

A two year on review report from the Dundee Drugs Commission

PART ONE – THE REPORT

Presented to the Dundee Partnership

FOR FURTHER INFORMATION PLEASE CONTACT

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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 several 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)

NOTE: For a variety of reasons a number of our original Commission members were unable to participate in the review (Sharon Brand, Eric Knox, Jean Logan, Suzie Mertes, John Owens, and Dr Tessa Parkes). However, three of the members noted above (Carole Hunter, Karyn McCluskey, and Nicola Russell) were able to join the Commission for the review and cover some of the areas of expertise that had been lost through those who had to step aside.

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Reports

This Part 1 report is the main report of the Dundee Drugs Commission. There is one accompanying (Part 2) report which contains all the supporting evidence collected over the course of the Commissions Review in a set of six (6) Appendices:

Disclaimer

This report contains the views of members of the Dundee Drugs Commission who also considered data, intelligence, evidence and views from invited participants and experts as well as **276** local people and professionals 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 other sources. The report is not intended to reflect the entire breadth of the discussions that have taken place over the last six months 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.

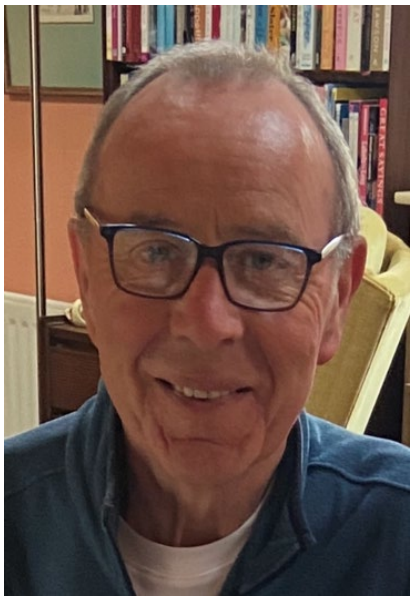
For details of the Commission members involved in the review please see **Appendix I** in the **Part 2 – Supporting Evidence** report. A list of the numbers of individuals who attended and contributed to the wide variety of discussions is provided at **Appendix II** in the **Part 2 – Supporting Evidence** 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 leaders from the Dundee Partnership Management Group who have committed their time and efforts to support the work of the Commission during its review.

1. FOREWORD – BY THE CHAIR OF THE COMMISSION



The Commission's Report, *Responding to Drug Use with Kindness Compassion and Hope* was published in August 2019. That report laid out sixteen key recommendations alongside associated findings for the Dundee Partnership to action in order to help address the drugs death crisis in Dundee.

Our two year-on review is set out in this 2022 report. The key questions we asked are what progress would we have expected to see over the last two years and has the Partnership response been proportionate to the scale of the challenge. It was clear that we needed to set these questions in the context of the Covid-19 pandemic and how this has, and is, impacting on the ability of the Partnership to progress its plans to address our recommendations. This has been a challenge as we have all faced situations over the past two years never experienced in our lifetimes.

We found that the Partnership has made genuine and extensive efforts to address the drugs challenge in Dundee. However, we believe that the scale of the challenge has been greater than the Partnership anticipated. There is obviously a great deal more to do and we have concluded that the Partnership needs help to tackle this problem.

We conducted our review over a six-month period (June to December 2021). During these six months we spoke to a significant number of people, conducting interviews and meetings virtually and meeting to a much lesser extent face to face with some people. We also carried out an on-line survey.

We need to restate our original recommendations which remain valid and we have set out twelve further recommendations for the Partnership. We remain of the view that with determination, clear communications, and a willingness to work as a true partnership, particularly with the third sector and those with lived and living experience and an acceptance that support is required, then Dundee can effectively address the Public Health crisis of drug deaths.

This review report is entitled: ***Time for Kindness, Compassion and Hope. The Need for Action Two Years On***. The cultural change which is required is key to success and it is now time for this to come to the fore alongside the continuing reconfiguration of services to ensure that people are provided with the time from support services to progress their recovery. It is also time for more focused, coordinated, and combined action to deal with this crisis.

As we conclude our work I would once again like to thank my colleagues on the Commission for their ongoing commitment in undertaking this review and for the continued support from Andy Perkins and his colleagues at Figure 8 Consultancy.

A particular thanks also to all those who provided their thoughts and told us about their experiences.

It is four years since the Commission was set up and with this review report I believe our work has come to an end. However, the drugs death crisis continues to be a major challenge and I trust the Dundee Partnership will take the necessary action to implement our recommendations and that internal scrutiny is strengthened and external independent scrutiny is put in place to assess and assure future progress.

Robert Peat, Chair of the Commission (March 2022)

2. 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 2.1: Glossary of terms used in the report

Abbreviation, Acronym or 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.
DDARS	Dundee Drug and Alcohol Recovery Services	Formerly known as Integrated Substance Misuse Services [ISMS]
DRD or **DD**	Drug-related death or Drug death	'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. A 'drug death', reported locally, is specifically a death directly resulting from the presumed non-intentional overdose of illicit (or illicitly obtained controlled) substances.
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.
KCH	Kindness, Compassion and Hope	The Commission's first report, titled *'Responding to Drug Use with Kindness, Compassion and Hope'*, was presented to the Dundee Partnership in August 2019

		and launched at a Dundee Partnership event in October 2019. The report is split into three parts, all of which are available at: Dundee Drugs Commission | Dundee City Council
MAT	Medication Assisted Treatment	The Scottish Government's Drug Deaths Taskforce was set up in September 2019 and prioritised the introduction of standards for Medication Assisted Treatment (MAT) to help reduce deaths, and other harms, and to promote recovery. The standards provide a framework to ensure that MAT is sufficiently safe, effective, acceptable, accessible and person-centred to enable people to benefit from treatment for as long as they need. Medication Assisted Treatment (MAT) standards: access, choice, support - gov.scot (www.gov.scot)
NFOD	Near-Fatal Overdose	
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.
ROSC	Recovery Oriented System of Care	A ROSC is a co-ordinated network of community-based services and supports that is person centred and builds on strengths and resilience of individuals, families, and communities. It recognises there are many pathways to recovery, including treatment, mutual aid groups, faith-based recovery, cultural recovery, natural recovery, medication-assisted recovery, amongst others. It offers choice by providing a flexible menu of services and supports designed to meet each individual's specific needs. It builds on assets rather than emphasising deficits and pathologies.

3. WHAT WE WERE ASKED TO DO

3.1 Background

Dundee has a significant number of challenges around public protection given the socio-demographic characteristics of the city alongside high prevalence rates of domestic abuse, drug and alcohol use, drug related deaths and mental health issues.

The number of drug related deaths in the city had increased every year for the ten years leading up to 2019 when there were 72 (46 males, 26 females) drug deaths in Dundee. In the latest available data (2020)[1] this figure has decreased to 57 (38 males, 19 females).[2] Despite this decrease, the five-year rolling average deaths rate (for 2016-2020) for Dundee City is still the highest in Scotland, standing at 39.0 per 100,000 population. Glasgow City is nearly on a par with Dundee City at 38.7 deaths per 100,000 population with Inverclyde at 34.0. For comparison, all other areas of Scotland are between 6.7 and 27.2 per 100,000.

The Dundee City Plan[3] identifies community safety and the protection of vulnerable people as a top priority and recognises the importance of excellent collaborative working between the Council, NHS Tayside, Police Scotland, the third sector and local communities if services are to be effective. The City Plan also identified reducing substance use as a key priority in efforts across the Dundee Partnership to improve health, care, and wellbeing.

Within a community planning context, the Dundee Alcohol and Drugs Partnership [DADP] leads on the multi-agency strategic activities to address the issue of drug use and drug-related deaths in Dundee. This includes leading the development of the Action Plan for Change, supporting local services with the delivery, monitoring its implementation, and reporting on progress. The DADP reports to the Dundee Chief Officers Group for Public Protection and through them to the Dundee Community Planning Partnership. The Community Planning Partnership owns the Action Plan for Change. A range of Officers actively participate in the DADP, the Chief Officers Group and the Dundee Partnership, and there is representation from Elected Members at the DADP.

3.2 Terms of Reference for the Dundee Drugs Commission's Two-Year on Review

In February 2021, the Dundee Partnership Management Group agreed a proposal to reconvene the independent Dundee Drugs Commission (the 'Commission') in order to conduct a two-year on review of progress against the recommendations it made in its *'Responding to Drug use with Kindness, Compassion and Hope'* three-part report (August 2019)[4] [hereinafter referred to as the **'KCH report'**].

[1] Drug-related deaths in Scotland in 2020, Report (nrscotland.gov.uk)

[2] See Table C1- Summary contained in drug-related-deaths-20-tabs-figs.xlsx (live.com)

[3] Available at: City Plan for Dundee 2017-2026 | Dundee City Council

[4] The three-part report is available at: Dundee Drugs Commission | Dundee City Council

The terms of reference provided by the Dundee Partnership to the Commission for its review were as follows:

- Review progress achieved in implementing the Commission's recommendations from the 'KCH – Part 1 report' (2019).
- Consider the impact of, and the lessons learned from, measures taken in response to the COVID pandemic.
- Agree any new findings emerging from the review and make additional recommendations if required.
- Prepare a final report for the DADP and its partners including Dundee City Council, NHS Tayside and the Health and Social Care Partnership [HSCP].

The purpose of the two-year on review is not to repeat the extensive research and discussions of the initial commission. Instead, the Commission was tasked with focusing on the work undertaken in the city to deliver the change set out in the recommendations that were accepted, in full, by the Dundee Partnership in 2019.

3.3 Our approach to conducting the Two-Year on Review

In conducting our two-year on review of progress made by the Dundee Partnership against the Commission's recommendations we have sought to conduct our work based on the same guiding principle that we agreed at the outset of our work back in 2018, namely:

> *'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.'*

Although our review has not constituted a re-run of the extensive evidence that was collected in the first phase of the Commission's work, we have managed to speak to, and received views from, a significant number of individuals (**167** in total) through a series of key stakeholder interviews, focus groups and other meetings between July – November 2021. We have also gathered a further **109** views from those who completed the Commission's survey. It is possible that some/many of those people that we spoke to also completed a survey. However, given that the survey was anonymous, it is not possible to give an exact total of the combined numbers of unique individuals who participated in the evidence gathering. All we can say is that it is somewhere between 167 (if all those we spoke to completed a survey) and 276 (if none of those we spoke to completed a survey).

All our evidence gathering activities focused on the following three key thematic areas which Commission members agreed at our first meeting of the review period in June 2021):

- The extent to which progress has been made in relation to the Dundee Drugs Commission's 2019 recommendations?

- The extent to which progress has been made in the last two years with kindness, compassion and hope being visible in Dundee for those affected by their own (or someone else's) drug use?
- What more needs to be done across Dundee to substantially reduce the high number of drug-related deaths? What should the next steps be? How confident can the Commission be that this issue is being treated with the correct and proportionate response?

At the outset of our review in June 2021 we discussed what level of expectation we had as a Commission regarding the level of progress and change that we should reasonably be able to evidence. This was a critical starting point for us, especially given that the Covid-19 pandemic started within five months of the Commission's first report being published. With this in mind, we have sought to be mindful of the extensive impact and challenging circumstances of Covid-19 on the ability of the Dundee Partnership, the DADP, and all local services to pursue the ambitious plan of change that we had asked to be prioritised following publication of our report 'KCH report' in 2019. The impact of the pandemic has proved to be one of the most challenging considerations for the Commission in producing a balanced and fair report on progress during these unprecedented times.

On the one hand, it seems only fair to expect a significantly lower level of progress over the last two years because of the pandemic, than if the pandemic hadn't happened. On the other hand, it is widely accepted across the country that the national drug-related death rates represent its own challenging Public Health emergency. So, it is also fair to expect, pandemic or no pandemic, that significant focus and efforts should have been made in responding to this emergency. In considering this dilemma we have set out to evaluate what has been possible in other areas of Scotland to help balance our assessment of the level of progress the authorities and services across Dundee have been able to achieve. In this regard we are grateful to several Commission members who have been able to shed light on, and their experience of, pandemic responses and learning across other areas of the UK.

The fundamental observation and question that has exercised our discussions, and to which we will reflect upon in this chapter, has been:

> *'To what extent do we think (given the incredible response to tackling the pandemic from local to national level), that the response to the drug deaths Public Health emergency has been proportionate in Dundee over the last two years when compared to the scale of the challenge?'*

There are undoubtedly lessons that the pandemic has taught (and continues to teach) us, which can and must be applied to tackling the drug deaths emergency. This needs to be viewed as an opportunity to use the learning of the pandemic to break down some of the historic challenges and barriers (such as slow access to drug treatment services), rather than being viewed as an opportunity to criticise a lack of progress with drug deaths. Focusing on the reasons why change is needed and is possible, rather than on the reasons why changes and progress cannot be made, has always been the raison d'être of the Commission.

We want to be clear and unequivocal in our reporting that we are not singling out any individuals or services for criticism. Our thoughts and comments throughout our review have been focused on the 'whole system of care' in Dundee that we have always considered to be not fit-for-purpose. We acknowledge that our first report did single out the Dundee Drug and Alcohol Recovery Service

[DDARS] service for significant commentary. This was purely because: (1) it was the element of the whole system that those we spoke to wanted to talk about; and (2) it has always been the central tenet of the treatment system in Dundee where the vast majority of resources and decision-making powers are based. We have always been clear that the whole system needs to change to allow for a longer-term redistribution of resources and decision-making powers towards a more balanced portfolio of provision within a fully functioning Recovery Oriented System of Care [ROSC]. However, the system is currently what it is, and that is not the fault of any one individual but rather of the historic development of the sector in Dundee over the last two decades or more (and helps to explain why there is such a significant challenge to bring about meaningful change). The DDARS service has been working with extraordinary challenges over the last number of years, and none of our comments and observations about the 'system' are intended to be a criticism of their work or professionalism. The staff within the DDARS service, alongside staff and volunteers from across the whole sector, are overwhelmed and exhausted from the effects of the pandemic, never mind the long-term effects of working in a sector that has experienced such high death rates amongst the population groups they work with. This is something that we have been mindful of and which will require dedicated planning, time, and resource to support the workforce going forward.

We want to express our admiration and grateful thanks to staff and volunteers working across Dundee who have shown (and continue to show) dedication, commitment, and resilience to those they work with in the face of the global pandemic. This commitment has been exemplified by those individuals who have continued to provide crucial face-to-face services and support to some of Dundee's most vulnerable citizens. These efforts have been seen and are truly appreciated. They represent the very best examples of the kindness and compassion that the Commission has envisaged.

3.4 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'.[5] As with our first report, we continue to emphasise 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. The reason for this is to re-emphasise the importance of having a long-term focus and plan for reducing stigma, as well as to highlight the extensive work that is being led by the Scottish Government[6], the Scottish Drug Deaths Taskforce[7] and other organisations across Scotland, such as the Scottish Drugs Forum.[8]

[5] Available at: Microsoft Word - how to write in plain English.doc

[6] Via a current extensive advertising campaign which has received broad Scottish and UK-wide media coverage. Examples include: 'Stop saying junkie' plea to end addiction stigma - BBC News; 'Junkie' Scotland: Adverts aim to end stigma over alcohol and drug problems | HeraldScotland; Scotland seeks to ban words like addict and alcoholic under plan to tackle drugs death crisis (telegraph.co.uk)

[7] stigma-strategy-for-ddtf-final-290720.pdf (drugdeathstaskforce.scot)

[8] Tackling Poverty & Stigma – SDF – Scottish Drugs Forum

We have welcomed the ongoing interest of local and national media in the work of our Commission and have noted and appreciated a continued changing use of reporting language over the full period of the Commission's work. We noted in our first report that at the outset of the Commission the phrase 'shooting galleries' was commonly used in reports, and that by the time we published our first report this phrase had been replaced by more accurate and respectful terms such as 'Drug Consumption Rooms' or 'Safer Injection Sites'. The developments have continued and we wanted to make special mention to an article published in The Courier on 30th November 2021 by Columnist Alistair Heather titled, *'They're not junkies, they're our neighbours – tackling Dundee drug deaths starts with breaking down that barrier.'*[9] We could not have imagined reading this article in the local media when we started our work in 2018. It evidences the important role that journalists have to help challenge and eliminate stigma (which was noted as one of our original recommendations) towards those who experience problems with drugs. To quote Alistair:

> *'So now we have to do our bit. Let's try – just try – to strip ourselves of our defensive language and attitudes around drug users. Let's ditch "junkie" and reduce the stigma. Maybe this can be our contribution to reducing drug deaths and making Dundee a better city for us all.'* (The Courier, 30/11/2021).

We recommend again 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. Several helpful resources are already available to aid this task. We would particularly recommend that the Scottish Drug Forum's *'Moving Beyond 'People-First' Language'* glossary[10] and the online leaflet 'Language Matters', developed by the Network of Alcohol and other Drugs Agencies (NADA) in Australia[11], are promoted at all opportunities across Dundee.

3.5 Terminology

In conducting our discussions and meetings we have been clear that we will not be directly quoting respondents in our report this time around. The reason for this is to protect anonymity given that certain individuals would be potentially identifiable due to their unique roles. However, we have chosen to use a number of quotes from the open-ended survey responses (see **Appendix III** in the **Part 2 – Supporting Evidence** report). In so doing, we have removed any identifiable information from these quotes, or declined the use of a direct quote if this was not possible.

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.

[9] The full article is available at: Dundee drug deaths: They're not junkies, they're our neighbours (thecourier.co.uk)

[10] Available at: Moving-Beyond-People-First-Language.pdf (sdf.org.uk)

[11] Available at: language_matters_-_online_-_final.pdf (nadaweb.azurewebsites.net)

4. WHAT WE HAVE DONE

4.1 Introduction

In contrast to the first phase of our work, where we conducted a significant proportion of our work in public-facing sessions, the majority of our evidence gathering this time around has been conducted in private meetings and interviews. The reason for this change was two-fold. Firstly, holding private sessions enabled individuals and groups to speak openly and honestly with us about their views regarding the extent to which progress (against the Commission's recommendations) has been made in Dundee over the last two years. Secondly, the ongoing restrictions imposed by the pandemic has meant that the majority of our evidence gathering has had to be conducted remotely (virtually)[12] with all core meetings of the Commission itself having to take place using Microsoft Teams.

In the original phase of our work we purposely went to all lengths possible to ensure that anyone who wanted to speak to a member of the Commission were provided with the opportunity to do so. This was possible due to the timescales and resources available at the time (pre-pandemic). Due to the shorter timeframe for our review (6 months in total), this was never going to be an easy option to provide this time around, especially given the challenges of the pandemic. However, we still set out to achieve the same outcome by ensuring that our work was widely advertised across Dundee (with support from the DADP and the Communications Team at Dundee City Council), and also by providing an opportunity for individuals to leave their contact details with us via an online Survey.

4.2 Activity and evidence gathering methods

We have used the following quantitative (data and statistics) and qualitative (expressed views) activities to capture as broad a set of evidence as possible to deliver a balanced and credible review of progress.

We have grouped these activities into the following **twelve** different categories of evidence, as detailed below. In total we have spoken to **167** individuals across these activities as well as receiving **109** survey responses.

No.	Evidence source	Notes
1	Drugs Commission's Review Survey	The purpose of the survey was two-fold: (1) to engage as wide an audience as possible in the Commission's review; (2) to gather views and ratings regarding the three key thematic areas of the Commission's

[12] Although a small number of face-to-face focus groups have been conducted by the facilitator of the Commission from Figure 8 Consultancy.

		review[13]; and (3) to provide individuals with an opportunity to leave contact details for a one-to-one phone call discussion with a member of the Commission. The survey was distributed online and via hardcopy through various networks and was open during September – November 2021. In total, **109** responses to the survey were analysed. Full analysis is provided in **Appendix III** in the **Part 2 – Supporting Evidence** report. An opportunity was provided at the end of the survey for individuals to leave their contact details in order to speak in more detail to a member of the Commission. 26 respondents left their details. All 26 were then contacted by email, but only **five** took up an offer of a phone call.
2	Deeper Dive of Drug Related Death Data	Following on from the Deeper Dive of Drug Related Death Data that was commissioned from the Information Statistics Division at National Services Scotland as part of the Commission's original report, the Deeper Dive of Drug Related Death data was again commissioned (this time from the new Public Health Scotland) 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 and to identify any changes over time. A summary of the key messages of this Deeper Dive is included in **Chapter V**. Our full analysis has been submitted to the Dundee Partnership alongside this report.
3	Service user / family interviews and focus groups	Five focus groups, with a total of **34** 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 October – November 2021.
4	Meetings with Leaders of the Dundee Partnership	During the course of the review, the Chair, Vice-Chair and Facilitator of the Commission met **four times** with the Leaders of the Dundee Partnership Management Group.
5	Staff focus groups	**Ten focus group sessions** were conducted with a total of **55 staff** from across **seven services**. One of

[13] The three key thematic areas are detailed on page 6 of this report.

		the focus groups was conducted with the Third Sector managers forum which is hosted by Dundee Volunteer and Voluntary Action (DVVA).
6	Key stakeholder meetings and interviews	A whole range of key stakeholder meetings and interviews with professionals took place over the course of the review period. A total of **41** individuals inputted into this element of the review.
7	Roundtable Discussion meetings	The first report of the Commission noted that it had not been possible to fully include issues relating to Children and Young people as well as Criminal/Community Justice. As part of the review the Commission agreed that it was necessary to take time to consider these issues more fully, and two roundtable discussion events were set up (late Sept/early Oct 2021). The first discussion focused on Children and Young People's issues and was attended by **seven** managers across relevant services /organisations. The second discussion focused on Criminal/Community Justice issues and was similarly attended by **seven** managers across relevant services/organisations.
8	Evidence submissions from the DADP	Across the lifespan of the Drugs Commission, a wide range of communications (meetings, phone calls and email exchanges) have taken place with the Dundee Alcohol and Drugs Partnership. The Commission met with representatives of the DADP at the end of July 2021 to discuss the DADP Self-Assessment report. The Commission then requested a wide range of documentation and reports from the last two years, and of which have been scrutinised and considered within the findings of this review.
9	Evidence submissions from the Dundee Drug and Alcohol Recovery Service (DDARS)	Across the lifespan of the Drugs Commission, a wide range of communications (meetings, phone calls and email exchanges) have taken place regarding the Dundee Drug and Alcohol Recovery Service (DDARS) in Dundee. In particular, several meetings took place with the Head of Service along with discussions with both Health and Social Work Service Managers. **Ten** staff from DDARS participated in three of the focus group sessions noted in evidence source #5 above. The Commission requested detailed information from DDARS on the services it provides, and DDARS have submitted some detailed responses to the Commission as part of its evidence submissions.

10	North-East Parliamentarians	The Commission were invited to speak with the locally convened cross-party group of parliamentarians who have agreed to meet on a regular basis to review the drug deaths situation in Dundee. The Chair, Vice-Chair and Facilitator of the Commission met with this group of **eight** MSPs/MPs and **two** support staff in September 2021.
11	Scottish Government officials	The Chair and Facilitator of the Commission have met with Scottish Government officials on two occasions during the Commission's review period to consider the progress that Scottish Government has made (and their future plans) in relation to the 'national considerations' made by the Drugs Commission in its first report. The Scottish Government has submitted a formal response to the 'national considerations' which is provided at **Appendix IV** in the **Part 2 – Supporting Evidence** report.
12	Meeting with the MIST (MAT Standards Implementation Support Team) at Public Health Scotland	A bespoke discussion was set-up with the MIST Team from Public Health Scotland in September 2021 to review the progress that Dundee is making towards the implementation of the new Scottish MAT (Medically Assisted Treatment) Standards.[14]

[14] medication-assisted-treatment-mat-standards-scotland-access-choice-support.pdf (www.gov.scot)

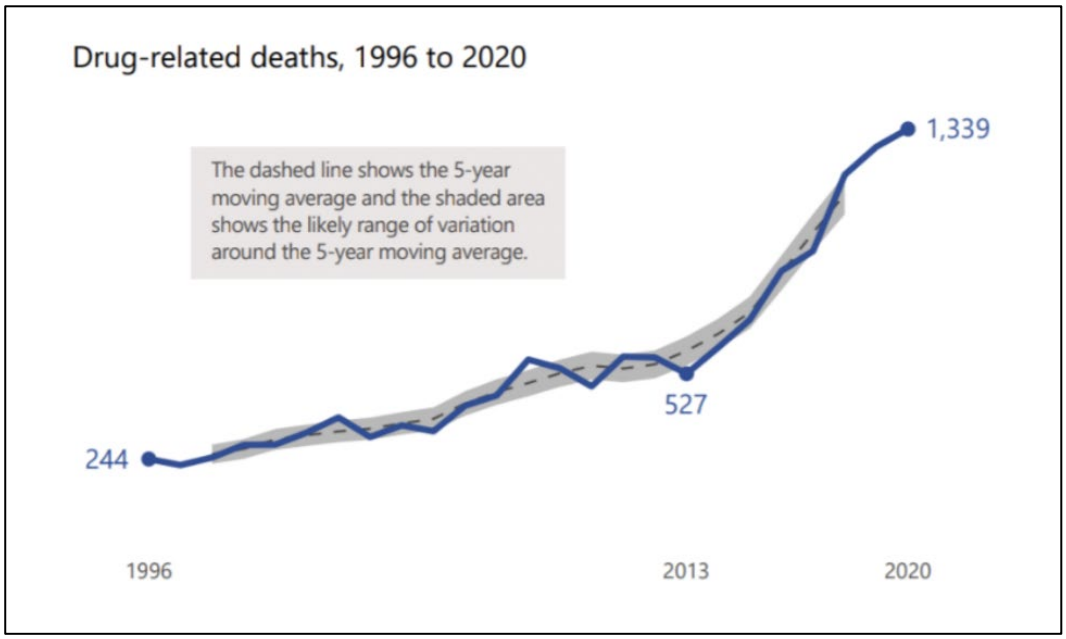
5. DEEPER DIVE OF DRUG RELATED DEATHS DATA

5.1 National context

Without doubt, Scotland continues to experience a crisis in relation to the rapidly increasing numbers of drug-related deaths.

The latest publication of the number of drug-related deaths in Scotland in 2020 by the National Records for Scotland[15] show a 6% increase from the previous year (rising from 1264 to an all-time high of 1,339). Between 2008-2020, the number of drug-related deaths has more than doubled (133% increase from 574 in 2008 to 1,339 in 2020). Over this period a combined total of **10,208** people have died in Scotland from a drug-related death, **533 (5.2%)** of whom have been in Dundee. Dundee, as of 30th June 2020 had an estimated total population of 148,820 which represents **2.7%** of the total Scottish population (5,466,000).[16]

Figure 5.1: Drug-related Deaths in Scotland – 2008-2020



The loss of life, particularly amongst those aged 35-55 years, is such that drug-related deaths are affecting overall life expectancy trends for Scotland[17].

[15] Drug-related Deaths in Scotland in 2020 | National Records of Scotland (nrscotland.gov.uk)

[16] Mid-2020 Population Estimates Scotland | National Records of Scotland (nrscotland.gov.uk)

[17] https://www.scotpho.org.uk/population-dynamics/recent-mortality-trends/

5.2 Local context

Dundee recorded 57 drug-related deaths during 2020 (down from 72 in 2019 and 66 in 2018). Between 2016-2020 Dundee City averages the highest rate of drug-related deaths per 1,000 population of all council areas in Scotland (39.0 deaths per 100,000 population). This figure has risen significantly from the rate of 31.0 deaths per 100,000 population (2014-2018) that we quoted in the first report of the Drugs Commission.

Of note, Glasgow City is not dissimilar to the Dundee City rate. Its rate of drug-related deaths per 100,000 population (2016-2020) is 38.7. The gap has been closed with the number of DRDs in Glasgow City continuing to increase in 2020, whereas the number of DRDs in Dundee City fell during 2020.

5.3 Deeper Dive of data - overview

During the first phase of the Commission we met with and heard evidence from experts at Information Statistics Division (which is now part of the new Public Health Scotland agency) 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).

As part of **Recommendation 12** from our first report which said that the Dundee Partnership should:

> *'Commission a comprehensive independent Health Needs Assessment for people who experience problems with drugs'*, we highlighted that the resulting *'needs assessment should include in its scope further detailed analysis of the 'deeper-dive' of data that has been undertaken'* … and *'further, the Commission recommends that the 'deeper-dive' is repeated (with inclusion of 2017-18 data)'*.

The Dundee Partnership has not been able to deliver the completion of the recommended Health Needs Assessment study in the two years since the Commission reported and no moves were made to repeat the deeper-dive of data. As part of the preparations for our review we requested that Public Health Scotland again be commissioned to conduct this repeat deeper-dive and this was requested by the DADP in June 2021.

The dataset returned by Public Health Scotland was submitted to the DADP on 4th October 2021 and then forwarded to the Dundee Drugs Commission. The Vice-Chair of the Commission (Prof Niamh NicDaeid) 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 by updating the first deeper-dive report through the inclusion of data for 2017-18, which was the latest data provided to the Commission. The full report has been provided to the Dundee Partnership and the DADP alongside this review report.

The Commission retains 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 still requires further testing by further repeating of the 'deeper dive' over several years.

5.4 Deeper Dive of data – key messages

In discussions with Public Health Scotland, who completed the 'deeper dive', the areas that are worthy of consideration and continued exploration are as follows, with those areas that are of particular significance being highlighted in **bold** text:

- When the data are plotted, a visual difference can be seen between the trends in Dundee City versus the rest of Scotland in some of the variables from 2009 until the 2013/14 period and then this reduces up until 2018. The small number of deaths in Dundee means that the trends are more volatile than the rest of Scotland.
- **Since 2009, the percentage of DRDs has been higher for females in Dundee compared to the rest of Scotland with the exception of the three years from 2015 to 2017.**
- The mean age at death of females in Dundee compared to the rest of Scotland is lower (except in 2009).
- There are more DRDs in Dundee in the 25-34 and 35-44 age groups than DRDs in rest of Scotland.
- The proportion of DRDs with SIMD quintile of 1 are higher in Dundee city when compared to DRDs in the population in this SIMD quintile in the rest of Scotland.
- **Since 2015 there has been a steadily increasing trend of DRDs in Dundee amongst those who live on their own.**[18]
- **The percentage of drug related deaths in Dundee City that had been prescribed OST is higher than that in the rest of Scotland and has risen sharply in 2018.**
- In Dundee City there is a higher proportion of recorded DRDs with at least one known psychiatric condition (specifically depression and anxiety) in the 6 months prior to death when compared to the rest of Scotland.
- Dundee City had a higher proportion of DRDs with a known medical condition when compared to the rest of Scotland.
- Dundee City had a higher proportion of post-mortems with the following drugs present when compared to the rest of Scotland: Methadone/EDDP, Anti-depressants, Phenazepam, Etizolam, Gabapentin and Pregabalin.

[18] This has previously been commented on in local Drug Death annual reviews. Improving contact with the socially isolated is a likely benefit of the Outreach work which has been much enhanced since the original Commission report. However, this is an example of how approaches have changed significantly since this 2017 -18 dataset and will therefore require analysis of more recent data to get a fully informed picture.

- **There has been a steady increase in Etizolam and Pregabalin seen in post-mortem samples which are more pronounced in Dundee compared with the rest of Scotland.**

6. WHAT WE HAVE HEARD

6.1 Introduction

We have heard a wide variety of views during the course of our two-year on review. Some individuals and organisations are inclined to be more positive about the depth and pace of change over the last two years. However, this is countered by the majority of individuals and organisations who consider that the depth and pace of change has not been as much as would have been hoped for or expected, even when considering the impact of the Covid-19 pandemic.

A saturation point was reached at an early stage of our fieldwork where we were hearing the same core messages as we heard during the first phase of our work in 2018-2019. In fact, the following paragraph from our first report is wholly representative of what we have heard throughout the course of this review:

> *'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.'*

6.2 Key Messages

In compiling our report we have analysed all the evidence gathered and drawn together the key messages under a series of themed headings, which are presented below. All of these key messages have been used to form the challenging set of recommendations (detailed in **Chapter 7**).

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.

We would also like to highlight that when references are made to Third Sector services, we are making direct reference to the range of services across Dundee who are working directly with those individuals who experience problems with substances, whether directly commissioned or not through the Dundee HSCP. In using the term *Third Sector* we are **not** referring to the whole of the Third Sector in Dundee, which in the main appears to have good working relationships with its statutory service partners.

6.2.1 Leadership

The first recommendation of our 'KCH – Part 1 report' stated:

> *'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.'*

We have sought to assess the extent to which efforts and focus have been placed by the Dundee Partnership on achieving the required standard of leadership as detailed above. We have done this by engaging in regular conversations with the leaders of the Dundee Partnership Management Group, as well as exploring in all our evidence gathering activities whether stakeholders have seen and experienced an improved clarity and standard of leadership around this agenda.

We have heard and observed some positive changes:

- The engagement of senior leaders in our review has been noted as a positive sign that the issues around drug use in Dundee are being taken seriously and are set high on planning agendas across the Dundee Partnership. The leaders stated 'joint' commitment to achieve the desired level of change and their oversight of the documented concerns surrounding the drug treatment service model in Dundee are welcome.
- There is evidence of greater clarity of governance and accountability – particularly the role of the Dundee HSCP.
- There have been positive changes to the role and place of the DADP following a restructuring of the membership, led by the DADP independent Chair. This has led to an improved level of participation in the DADP meetings and workstreams of members. In particular, the involvement of elected members and family members is a significant step in the right direction to achieve the level of independent and objective scrutiny required for any ADP.
- Increased Public Health involvement in the DADP agenda is another positive development compared to two years ago – particularly given the increased Public Health focus on drug issues through the current national strategy. We would also note that the significance of this achievement given the overwhelming pressures placed on Public Health directorates across the country through the Covid-19 pandemic.
- Despite comments that will be made later about the reality of the partnership between statutory and third sector substance use services in Dundee, it is evidence that there remains a genuine desire all round from both the statutory and third sectors to make things better in Dundee.

However, we have heard numerous reports of where further progress is still required in order to achieve the standard of leadership in Dundee that we outlined in our previous report:

- Overall, stakeholders reported that the pace of change is too slow and not in sufficient depth. The sense we are left with is that the positive changes are seen and felt by the majority as *tinkering around the edges* of the fundamental problems, rather than tackling the root causes.

- There is a lack of evidence that the Dundee Partnership has a clear line of sight with clinical leaders of the DDARS, or a plan for how Clinical Leadership is going to address the issue of whole system transformation. This is a challenging and complex issue given the strategic decisions made historically regarding the relationship between GPs and Psychiatrists as to who should lead/manage substance use services. This is made even more challenging and complex when the Commission has been clear that there needs to be a drive towards a productive and effective partnership not just between primary care (GPs) and psychiatry but also embracing the Third Sector as a full partner.
- The pace of change has clearly not been helped by the advent of the Covid-19 pandemic. However, a majority of stakeholders consider that the pandemic is not a sufficient reason for the slow pace of change that people have experienced. Stakeholders are frustrated that the opportunities to break down barriers to access quicker treatment in Dundee as a result of the pandemic have not been learned or run with and a significant number of individuals are reporting that things are in a worse position now (in terms of treatment) than before the pandemic and before the Commission's previous report.
- The area of greatest criticism from stakeholders is in relation to the programme of cultural change that was recommended in the Commission's report (around focusing on Kindness, Compassion and Hope). Stakeholders were almost unanimous in reporting that there has been a lack of evidence of such a focus or programme. Stakeholders were sure that leaders were aware of the need for cultural change and were equally sure that it is on the agenda, but there has been limited visibility of such change and people have certainly not experienced a shift in the culture. This is disappointing for the Commission given our purposeful decision to title our first report *Responding to Drug Use with Kindness, Compassion and Hope*.
- Whilst stakeholders in the main believe that leadership efforts are genuine they do not see or experience the type of distributed leadership envisioned in the Commission's report. This appears to be a particular challenge for NHS Tayside in its leadership approach to Substance Use services.
- Stakeholders are not aware that Dundee has focused on immediately implementing learning from elsewhere.

The first recommendation from our 'KCH – Part 1 report' (as stated above) was clear that *'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.'* From the evidence gathered by the Commission, this test has not yet been passed and will require new efforts to increase the visibility and experience of leadership across the sector.

6.2.2 DADP

We have experienced the DADP to be engaged and committed to the required programme of change for Dundee at a significantly higher level than we experienced in the first phase of our work. The DADP is clearly benefiting from having an independent Chair, although the capacity and ability of the Chair to make progress on so many fronts (given the scale of the challenge) and at the pace that

is being demanded is a potential vulnerability, without increased capacity around him to support the change agenda. This issue is exemplified by the pragmatic decision of the DADP to only focus on the sixteen headline recommendations of the 'KCH – Part 1 report' rather than putting an action plan in place to account for all of the associated findings within the report.

Although stakeholders have welcomed some of the structural changes to the DADP (as mentioned above) they are still unsure as to whether the DADP Board are achieving the level of scrutiny and direction to the sector that is required.

Through our detailed discussions with the DADP we are aware of the ongoing and increasing plans to lead the sector through the changes that are necessary. However, we are equally aware from our broad discussions across all stakeholder groups that most service staff, those with lived experience and family members are unaware of these plans and the overall direction of travel set by the DADP. They are not visible to most stakeholders which leaves individuals questioning the extent to which progress is being made. For example, we found most stakeholders to be unaware of the new (almost £0.5m) investment secured by DADP from the Scottish Government to develop a Test of Change project focused on the Commission's previous recommendation regarding the need for full integration of substance use and mental health services.[19] The opportunity that this Test of Change brings to focus on the co-design and co-production of a new 'whole system of care' can only be realised if everyone is onboard and able to be part of an equal and reciprocal partnership. The danger is that this will become a venture led by the few and imposed upon the many which would be a counterproductive outcome. Stakeholders crave awareness of such significant developments and are disheartened and sceptical as to whether real change will be achieved when they perceive that they are kept out of the loop.

6.2.3 NHS Tayside including the Public Health Directorate

During our first phase of work we were keen to explore how NHS Tayside's Public Health Directorate could solidify and expand its leadership within Dundee's substance use sector, given the clear Public Health focus of the Scottish Government's *Rights, Respect and Recovery* strategy.

We are heartened by the new leadership within this department and would like to commend the significant efforts of the department to prioritise responses to substance use especially during a prolonged period of unique pressures placed upon all Public Health directorates throughout the pandemic.

Over the last two years there is an extensive list of work that NHS Tayside's Public Health Directorate has been leading on, or contributing to, in response to substance use issues across Dundee City, including:

[19] The Commission would like to acknowledge that the period during which we collected our evidence was at a very early stage of the Test of Change, and that during the course of writing our review report the project has made significant progress. This has been led through the appointment of a project manager and has led to increased awareness of the project.

1. NHS Tayside Harm reduction services – advice, commissioning of specialist harm reduction including BBV testing, wound care, overdose prevention, injecting equipment provision, elimination of hepatitis C (delivered by NHS specialist nursing team and third sector commissioned service).
2. Near-Fatal Overdose [NFOD] pathway – NHS Tayside leads the assertive multi-agency outreach pathway to provide support to people following a NFOD.
3. Naloxone (emergency treatment for opioid overdose) – NHS Tayside coordinates and leads on enhancing distribution of naloxone across Tayside. Naloxone programme achievements in Dundee include: supporting Dundee City Council social work employees to be able to carry naloxone and the roll out to Police Scotland in Dundee as part of a national pilot.
4. Drug Death Review Group – NHS Tayside Public Health chairs the Drug Death Review Group, assimilates key themes and makes recommendations for action through the Tayside ADPs. Their annual report is one of the most comprehensive in Scotland (and not all areas currently produce this).
5. NHS Tayside Public Health monitors the trends of NFODs and suspected drug deaths, including review and risk assessment of potential clusters.
6. NHS Tayside is participating in a variety of current research projects, including:
    - 'Cocoon' – a study to encourage re-engagement with services, support hepatitis C elimination and provide holistic review and support to people with substance use through the NHS Tayside Harm Reduction service;
    - Understanding the impact of substance use and needs of people presenting with vascular complications by the NHS Tayside surgical services;
    - NHS Tayside Public Health is supporting the Scottish Government backed drug checking project being led by Stirling University (seeking to implement drug checking services in Dundee, Aberdeen, and Glasgow);
    - NHS Tayside Public Health is supporting work to develop a health psychology intervention following a NFOD to reduce future risk (funded by the Drug Death Taskforce).
7. Dundee was one of the first areas in Scotland to provide COVID-19 testing to people with problem substance use in the community, co-ordinated by Public Health, through NHS Tayside's community testing team and the Harm Reduction Service. This service also supported specialist contact tracing for people with problem substance use.
8. NHS Tayside Public Health organised COVID vaccination outreach clinics in the harm reduction services and hostels/sheltered accommodation in the community.
9. NHS Tayside Public Health is supporting the oversight of the implementation of the MAT (Medication Assisted Treatment) standards through the DADP. These were recently issued

by Scottish Government to enable the consistent delivery of safe, accessible, high quality drug treatment across Scotland.

10. NHS Tayside has designed a holistic service specification for the provision of pharmaceutical care for people with opioid substitution therapy (OST) which will enable pharmacy staff to provide a wide range of health-promoting interventions for people attending for OST, including harm reduction interventions. The aim is to establish community pharmacists as equal partners in care, within the multi-disciplinary team, improving the transfer of care information both ways and aiming to release capacity for the specialist drug treatment services.
11. Establishment of a pain and addiction clinic (many people with substance use also report challenges with chronic pain).
12. NHS Tayside Public Health team is contributing to a multi-agency group chaired by Dundee City Council colleagues, to implement a 'Language Matters' campaign to tackle stigma and the impact of stigmatising language on people who use substances.
13. NHS Tayside Public Health is supporting the development and implementation of the Planet Youth (Icelandic) model in Dundee to enhance preventative approaches.

The one area of disappointment for the Commission is the lack of progress with the recommendation that a comprehensive independent Health Needs Assessment for people who experience problems with drugs in Dundee should be undertaken. We viewed this recommendation as one of the most important and pressing actions following the publication of our first report. Without it being completed, it is difficult to articulate and understand the exact scale of the needs of those who experience problems with drugs in the city, which in turn makes it difficult to plan the scale of response that will be needed to meet those needs. It would be fair to say that a wide variety of information and work has been completed (such as a recent Cocaine Needs Assessment report), and is ongoing, which can help build a fuller picture of needs across the city. However, to date, this has not been brought together into one overarching report which can then be used to make informed commissioning decisions about the type and scale of service provisions that are required. Our hope had been that such a comprehensive needs assessment report would have been available to us at the start of our review. If it had, we would have been able to interrogate in detail whether or not the Dundee Partnership's response to substance use issues in the city has been, and continues to be, proportionate to the scale of the needs that are prevalent.

6.2.4 Mental Health

We have continued to hear the same reports from individuals who use substance use services (and their families) of the immense challenges they face in accessing appropriate mental health support. This was the most significant and consistent message that we heard during the first phase of our work in 2018-2019 and is why we made another of our headline recommendations to be about the need for *'full integration of substance use and mental health services and support'* (Recommendation 13) in the city.

We would like to commend the extensive efforts of the DADP in coordinating planning for a 'whole system of care' test of change project aimed at securing full integration of substance use and mental health services in the city. This ambitious test of change project has received significant funding from the Scottish Government's Drug Deaths Taskforce and will undoubtedly provide significant learning for Dundee as well as for all other areas of Scotland.

We appreciate that this project will take time to get off the ground and become fully embedded within the city.

There is one point that is worth noting which is that very few people were aware of this initiative when we conducted our fieldwork for this review. This is a concern for us, as it would help to instil hope (amongst those with lived experience) that change is happening – and that it is visible to all. The appointment of a project manager for the test of change is a positive step in regard to improving communication around the work, but the DADP should be ensuring that this initiative is well-known across the city and to date we have not found that to be the case.[20]

We are also pleased to note the developments and commitment to opening a Dundee Community Wellbeing Centre (due to open later this year). The Centre will focus on: providing an immediate and compassionate response, 24/7, to anyone who is in distress; achieving callers' safety and stabilisation; and going 'beyond signposting' to bring callers the support they need. We recognised in our first report the critical importance of crisis provision and this Centre will play a significant part in integrating real-time responses to those with multiple and complex needs across the City.

6.2.5 DDARS

The following areas should be viewed in both an organisational (service controlled) and structural (not controlled by service but service responsive) challenges within the Dundee environment.

It is also important to highlight that a number of challenges that DDARS are trying to manage also have a national context and should not be viewed as a specific Dundee issue, these themes include.

- Staff vacancies and recruitment (especially nursing/medical) is a national challenge. Nursing staff have the option to retire with special officer status where RMN's can retire at 55 years with no impact on pension. This is a known issue across all treatment areas and Dundee is experiencing challenges in this area. This is further exacerbated by the difficult working environment and the primarily specialist model of provision as well as the wider options for nurses to have a choice in where they wish to work. We do note that the DDARS service has reviewed grades in an attempt to enhance recruitment potential.
- Addiction psychiatry led treatment models risk lending themselves to provision that focusses on medical and prescribing interventions and can struggle to promote innovative approaches – especially around the place of recovery, wider governance of a service user population at every

[20] During the course of writing up our findings, we have been made aware that Healthcare Improvement Scotland have been engaging with over 60 people who have experience of mental health issues through the Healthy Minds network, which includes people with experience of substance use. This is part of an ongoing process to aid co-production, including re substance use and mental health.

level of severity and complexity, and the appropriate place for the provision of effective Residential Rehabilitation options. This model as embedded in Dundee is historically 'risk averse' and prescription orientated, including the extensive use of psychotropic medications beyond the expected Opioid Substitution Therapy [OST] / Opioid Replacement Therapy [ORT] requirements. This has resulted in a service profile across the geography that individuals are required to fit into rather than services being person centred and reflecting the population's needs.

We do not need to comment in length upon the DDARS service given that the majority of what we have heard from stakeholders is consistent with the findings from the first phase of our work.

Stakeholders in the main are not convinced that this service has moved forward at pace and to anywhere near the extent that it needs to, or should have, even when accounting for the impact of the pandemic.

Stakeholders are also not confident that the leadership of the service is sufficiently committed to embrace the change that has been called for by the Commission. The majority perception is that *nothing has changed* in the last two years. Overall, this is a harsh view given that the Commission has observed and heard about extensive efforts within the service to move forward. The core issue is that these efforts are not visible most of the time to the wider sector and that the strategies being used by the service appear to be *more of the same*. For example, the focus is on continuing efforts to try and recruit more staff to solve capacity issues even though staff retention and recruitment is acknowledged by the service to be a critical challenge. The capacity problem needs to be looked at in a different way and should focus on increasing capacity by progressing those individuals who are at the lower, more stable end of their medical treatment, so that they can be case managed within the commissioned Third Sector services – who are well placed and willing to help. The primary interpretation and reason we can evidence for why this strategy is not vigorously pursued is a continued lack of commitment to partnership, trust with, and respect of, the expertise of the Third Sector services across the City who work with individuals who experience problems with substances. This situation also speaks to the continued challenges of integrated and partnership working as well as poor communication. The sense amongst stakeholders is that this service is not integrated properly and fully between its constituent (health and social care) parts, never mind with its wider Third Sector partners.

We provided the service with opportunities to engage with the Commission in our review. Ten members of staff chose to participate across three focus group sessions, and three members of the management team participated in some of our other meetings/discussions. On the one hand this suggests that the evidence that we've heard from the service is limited in nature and potentially not representative of the whole service, but on the other hand, we are keen to stress that this does not in any shape or form invalidate the views that have been shared with us by those who chose to engage.

The staff who have engaged spoke honestly about the challenges that the service faces in a similar way to staff from all other services talk about their own. DDARS staff are clearly exhausted and overwhelmed at times by the effects of the ongoing pandemic and the significant capacity challenges that have ensued during the pandemic period, which have been exacerbated by an increase in staff

vacancies. There is a clear desire amongst the DDARS staff we spoke to to move towards a clear community-facing service.

The appearance and perception is that the (drug) service still appears to be an opiate prescription-focussed service and hasn't adapted to changing drug use patterns across the city and the broader system to address all needs that is required. We have not been presented with any detailed thinking as to how the service considers it needs to adapt to the recent *Cocaine Needs Assessment* study conducted by the local Public Health Directorate or any detailed plans on how to address, for instance, the high incidence of illicit benzodiazepine use across the city.

Stakeholders hold a majority view that an individual presenting to DDARS has to *fit with the service*, rather than the service accommodating the individual.

It is disappointing that lead DDARS Clinicians have been unable to meet with the Commission during the course of our review and that our request for evidence has had to be completed via email exchanges with the Dundee HSCP. This has left the Commission potentially unsighted on important developments within the service but also simply not being able to assess whether the service has the correct blend and level of leadership expertise, capability, and connectedness to drive the service towards the transformational change that is needed. For example, there is a lack of clarity from written responses as to the extent to which same-day prescribing has happened in the period between the Commission's 'KCH report' being launched (October 2019) and the start of the pandemic (March 2020). We are uncertain as to whether there is a good news story to tell about any early gains that the service made in response to the Commission's recommendations or whether the efforts have just not produced the results that were needed. Without being able to scrutinise this any further, the only thing we are able to say is that given the service has confirmed that same-day prescribing has not happened since the start of the pandemic, then this is a matter that needs resolving urgently.

Stakeholders have commented that there were some early improvements following the Commission's report when DDARS started to co-locate some of its nursing staff within Third sector agencies. This was viewed as a positive step in the right direction and had the benefit of improving communication between staff (which benefited individuals receiving treatment) as well as improving relationships and trust between the services. However, the onset of the pandemic led to these arrangements being reversed in order to ensure maintenance of essential services, and Third Sector agencies were left with uncertainty as to whether these arrangements would be reinstated or expanded.[21]

We were also advised that there were some positive changes to prescribing arrangements during the first Covid-19 lockdown. However, these positives have in the main been lost. Priority should be given to reinstating these arrangements, irrespective of any Covid-19 restrictions.

One of the key areas that we highlighted in our first review was the absence of shared care arrangements with primary care services. Although we were unconvinced in the early part of our

[21] At the time of writing our report, we have received information and reassurances to indicate that similar arrangements are now being stepped back up, including the appointment of three Non-medical Prescribing nurses within the Children and Families Service.

review as to whether sufficient progress had been made in the two years since our first report, we have (during the course of our review period), been presented with more extensive and detailed plans that demonstrate good progress by DDARS and the Dundee HSCP in building shared care capacity within and outwith the service. The plans also lay down a clear roadmap for further developments in the years to come. We recognise that this area is not an easy one to make quick progress on and welcome the leadership commitment shown to tackle this problem and make demonstrable progress. Establishing robust shared care arrangements has to be a core part of the solution to the severe capacity challenges facing DDARS but is not a quick-fix solution, so continued attention, determination, and commitment will need to be applied over the long-term. With the plans that we have seen there is a real opportunity to move things forward with this shared care model to make changes in Dundee to a degree that has not been achieved before.

The service is at an early stage of aligning itself to implement the Medication Assisted Treatment [MAT] standards[22] but the current plan does not appear to be ambitious, robust, and time-bound in nature. We are aware that the Dundee Partnership are receiving support from the MAT standards Implementation Support Team [MIST] at Public Health Scotland, as are all other areas of Scotland. Nonetheless, this area remains a serious concern for the Commission given the distance between what we've heard during our review and the drive from the Scottish Government to fully implement the MAT standards by 1st April 2022. We consider the MAT standards to be a *game-changer* in terms of drawing together a lot of the strands of the Commission's previous recommendations and would urge the Dundee Partnership to regularly review the local implementation plan in relation to the pace and visibility of change and progress.

6.2.6 Lived and living experience (individuals and/or family members affected by their own or someone else's substance use)

We utilised a range of methods to gather the views of those with lived and living experience of problematic substance use, including survey returns, one-to-one discussions, and focus groups.

There are some apparent contradictions between the survey return responses from those with lived and living experience, and the evidence gathered by the Commission through the variety of discussions held with individuals and groups across the six-month review period. In the main, the survey returns (see **Appendix III** in the **Part 2 – Supporting Evidence** report) indicate that just over half of respondents feel that there has been at least partial progress made by the Dundee Partnership in relation to the Commission's original recommendations. However, it became clear, very quickly, in all our discussions with individuals and groups that those we spoke to described exactly the same issues that we heard about, and referenced, extensively during our first phase of work – which regrettably provided a tangible sense of déjà vu for us. We reached a point of 'saturation' quickly in

[22] The Scottish Government's Drug Deaths Taskforce was set up in September 2019 and prioritised the introduction of standards for Medication Assisted Treatment (MAT) to help reduce deaths, and other harms, and to promote recovery. The standards provide a framework to ensure that MAT is sufficiently safe, effective, acceptable, accessible and person-centred to enable people to benefit from treatment for as long as they need. Medication Assisted Treatment (MAT) standards: access, choice, support - gov.scot (www.gov.scot)

terms of the key messages – all of which focused on a sense for the majority that *very little (if anything) has changed* in the last two years in relation to their experiences of drug treatment.[23] The changes that people did speak about most were related to the negative impact of the pandemic (such as: not being able to see their drug treatment keyworkers; isolation; lack of mental health support; etc.).

Our explanation for the apparent contradiction is that although everyone in the individual and group discussions started talking in more positive terms about progress made, once these views were explored in more detail the honest view that *very little (if anything) has changed* became highly tangible. This is a reflection of the strength of using qualitative (in-person) methods as opposed to survey techniques.

It was noticeable that family members and carers were overwhelmingly of the view that *nothing has changed* in the last two years regarding their experiences of engaging with the DDARS service. For those individuals currently accessing DDARS the picture was a little mixed, where a small number did speak of positive experiences (albeit these experiences were always related to the support provided by individual workers rather than the DDARS service as a whole).

There was consensus throughout all our discussions with individuals and family members that any response over the last two years with regard to kindness, compassion and hope has neither been visible nor felt.

6.2.7 Third Sector (Substance Use) Services

During the course of our first phase of work, we reported that one of the areas of greatest concern for us concerned the role of Third Sector services engaged in work around substance use in Dundee.[24] In particular, this concern focused on the Third Sector's relationship with the DDARS (formerly known as ISMS) statutory service.

We reported the following aspects that concerned us most (see 'KCH – Part 1 report'[25]):

- The structure of funding for drug treatment has created an unequal 'playing field' between statutory and Third Sector services in Dundee, which *'makes it difficult for the third sector to engage equally and results in concerns about 'biting the hand that feeds them' by speaking honestly'* (see 'KCH – Part 1 report', page 41).

[23] The vast majority of those individuals who spoke to the Commission during the review were currently engaged in drug treatment with the DDARS service.

[24] The specialist Third Sector substance use services in Dundee are core funded by the public sector. Contracts are awarded and have remained in place for a number of years. Unlike most other local authorities, Dundee City Council/Dundee HSCP do not recommission or re-tender annually for these services. The substantive difference is that The Third Sector services are monitored routinely through contract arrangements and meetings whereas Public Sector services are not. Statutory services have also bid for short term funding to support change: such as the model to develop Shared Care. Specialist statutory services are asked to provide regular updates to the ADP and for ADP funded projects, will report through the ADPs Commissioning Group as this work develops. Monthly meetings with all substance use services have been instigated by the DADP, which are mainly represented by Third Sector services, where there are detailed reports from ADP meetings.

[25] Responding to Drug Use with Kindness, Compassion and Hope Report (dundeecity.gov.uk)

- Due to a system of unequal power and control in decision making ('them and us'), there had been a breakdown in relationships and loss of trust between the statutory DDARS service and its Third Sector partners, *'to the point where third sector services have chosen not to speak honestly in meetings for fear that their services will be decommissioned'* (see 'KCH – Part 1 report', page 41).

The key considerations that we made to address these concerns can be found under Recommendation 4 of the 'KCH – Part 1 report' (page 52):

> *'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.'*

In terms of restructuring of the funding arrangements for drug treatment in Dundee we specifically stated under Recommendation 4 that:

> *'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.'*

We are disappointed that the Dundee Partnership nor the DADP have made significant progress in moving towards a singular joined-up commissioning plan. Having said that, we also noted in our first report that *'this is a situation that the Dundee Partnership cannot change by itself but will need to escalate to Scottish Government to find a solution'* ('KCH – Part 1 report', page 53). We are therefore mindful of the response provided by Scottish Government (see **Appendix IV**, response 2) to the national consideration that we made about funding for substance use services, which states:

> *'The Partnership Delivery Framework[26] was agreed with COSLA and published in July 2019 by the Scottish Government. It sets out the partnership arrangements needed to reduce the use of and harms from alcohol and drugs.*
>
> *In terms of financial arrangements, the Framework notes that investment in the delivery of outcomes will come from a range of sources, including the Local Authority, Health Board, and the Integration Authority, as well as outside of the public sector. Arrangements must ensure that the ADP is able to:*
>
> - *Establish a shared understanding of the total investment of resources in prevention of harm and reducing inequalities from alcohol and drugs across the local system.*
> - *Make effective decisions to invest in the delivery of these outcomes.*
> - *Ensure there is scrutiny over investments in third sector and public sector to deliver outcomes.*

[26] Alcohol and Drug Partnerships: delivery framework - gov.scot (www.gov.scot)

In July 2021 COSLA and the Scottish Government agreed a further set of recommendations to support the implementation of the Partnership Delivery Framework. This includes that as a part of improving ADP governance the IJB Chief Finance Officer (CFO) must provide assurance regarding funding and require service underspends to be reinvested or carried forward into the ADP strategy. A national working group has been established to deliver on these recommendations chaired by Christine Lafferty, IJB Chief Officer, Renfrewshire.'

From a wide range of consultations conducted through our review it is evident that the Third Sector still feel that there is a vastly 'unequal playing field' when it comes to available funding. A significant focus over the last two years has been placed on the Third Sector being encouraged to apply for short-term (12-24 month) funding pots, which have mainly been made available by the Scottish Government (and administered by the CORRA Foundation) through its recent increased investment in drug services. On the one hand this funding has been welcomed in that it has allowed new Third Sector initiatives across Dundee to be set-up. On the other hand, the Third Sector has been vocal in the challenge that such short-term funding has provided for them, in terms of: (1) the significant time that is required to put multiple applications together (often at short-notice) and which has been to the detriment of time being taken away from existing responsibilities/tasks; (2) the challenge of recruiting staff into short-term posts; (3) uncertainty as to longer-term sustainability of new services developed through such short-term funding; and (4) the focus being taken away from any long-term redistribution of core funding towards the Third Sector which could (and should) come from moving towards a singular joined-up commissioning plan, as we previously recommended.

In terms of the 'them and us' culture between the DDARS statutory service and the Third Sector and the breakdown in relationships and loss of trust that we reported on two years ago, there have been some indications of improvements.[27] However, these are generally noted as having been in the early days following the launch of the Commission's 'KCH report' in October 2019 and the start of the pandemic. In particular, we heard about improvements in relationships and communications when DDARS started to co-locate staff within Third Sector services to meet and work with individuals alongside the Third Sector services. This contrasts to the current challenges of communication where we've received numerous reports from Third Sector agencies of trying to phone DDARS to speak to the keyworkers of the individuals that the Third Sector are working with, only to be required to leave a message with reception staff and then not getting a call back from the keyworker. The pandemic put paid to the early gains of co-location, but the learning from them must not be lost, and we welcome the plans of the Dundee Partnership to reinstate and expand these arrangements as Covid-related restrictions are eased. That said, the overwhelming view currently among the Third Sector is that things have taken a backward step since the start of the pandemic, and for some this situation feels even worse than it was two years ago.

[27] The DADPs Self-Assessment report and work conducted by Healthcare Improvement Scotland also confirm evidence of improved joint working between Statutory and Third Sector services in response to the Covid-19 pandemic.

We have concluded that many Third Sector voices are still restrained from speaking honestly for fear of the perceived consequences of so doing. To counter this, we had previously recommended under Recommendation 4 of our report that:

> *'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'[28] 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.'*

We are of the opinion that neither the Dundee Partnership or the DADP have made the necessary progress in regard to creating the 'right conditions' for this change in culture and partnership working. We have noted the efforts of the DADP in committing to and conducting a comprehensive self-assessment (consultation) exercise in preparation for the Commission reconvening. However, we have noted that the findings and conclusions of the self-assessment exercise (in relation to the role and place of the Third Sector) are far more positive than our findings. Our conclusion is that the Third Sector did not feel safe enough to be as honest with the DADP as they felt able to be with the Commission. An example would be how Third Sector partners have spoken to the Commission about how they will try and be positive and forward thinking with the DADP and its other partners without being brutally honest about how they are still feeling. The direct threat of this situation, that we have witnessed over the nearly four years existence of the Commission, is how difficult it will be for the DADP to get to a point (without independent scrutiny) where it can be confident that this culture has changed given: (1) the DADP's self-assessment report reflecting a more positive picture than the reality which we have evidenced; and (2) how we have heard multiple times during the course of our review from those in statutory services that they believe this situation has improved when the reality is somewhat different. The obvious observation for us is that if the Dundee Partnership and the DADP believe the situation has changed and is now healthy, then there is little incentive to do more to create the 'right conditions' that we have urged for.

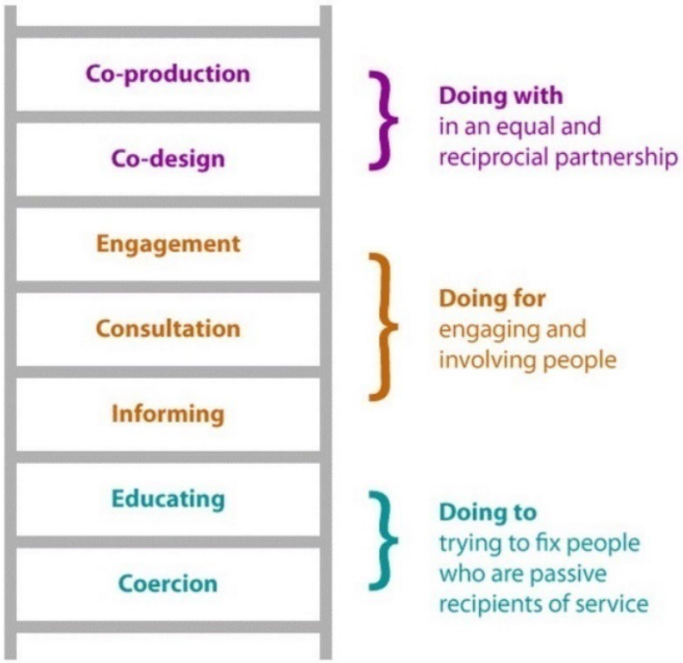
It is a matter of disappointment to us that the above-mentioned finding (i.e. '*A report should be presented to the Dundee Partnership within six months to enable action to be taken. The report should be focused on how the '17 elements of Recovery-Oriented Systems of Care and Services' should be embedded and evolved in a future system design.*) has not been actioned. Our belief was, and still remains, that this situation reflects one of the fundamental problems and challenges to turning around the drug death situation in Dundee and making the most of the extensive network of Third Sector (specialist and non-specialist substance use) services and supports across the city – the list of which makes impressive reading.

This ongoing situation will require increased genuine and extensive efforts over the long-term. Developing a clear plan towards establishing an equal and reciprocal partnership between all partners, rather than focusing on the involvement and engagement of the Third Sector as led by

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

statutory partners has to be prioritised. This may well require external facilitation and support, and that is something we will come back to in our conclusions and recommendations. We would highlight the diagram below to help visualise the change we are looking to see from 'doing for' (i.e. engaging and involving) towards 'doing with' (i.e. in an equal and reciprocal partnership).

Figure 6.1: Moving towards co-production and co-design



6.2.8 Pharmacy

As part of our two-year on review we held a bespoke meeting with three managers from the DDARS pharmacy service and from Community Pharmacy to review progress against Recommendation 11 from our first report, which stated:

> *'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.'*

As a response to the Commission's recommendation, the Lead Pharmacist in Tayside (for Controlled Drugs, Substance Use, Justice Healthcare and Out of hours) prepared a paper titled *'Community Pharmacy Services for People Receiving Substance Use Treatment'* which was published in April 2021. The details of this paper provided the focus for our discussions and review of progress and challenges over the last two years.

The Pharmacy Managers explained the background involved in negotiations with the pharmacy contractors' group and the work that had been undertaken to develop an agreed new service specification that would support delivery of Recommendation 11. The aim of this proposed new pharmacy framework is noted as being to *"reduce the harms associated with drug use and support*

people towards treatment and stabilisation, creating a recovery enabling environment by providing tailored clinical and social support". We were pleased to note that there is a clearly defined plan for the first year of implementation.

Unlike other health boards, all community pharmacies in Tayside participate in the locally negotiated OST supervised self-administration scheme. All locally negotiated pharmacy contracts are negotiated on a board wide basis and in Tayside cover three ADP areas (Angus, Dundee, and Perth & Kinross).

The Pharmacy Managers noted that the pharmacy contractors' representative group have been fully involved in the design of the proposed inclusive pharmacy care model. The anticipated implementation date is January 2022. We want to acknowledge that negotiating and agreeing local contracts is often a long difficult process and the pharmacists who initiated and completed the process are to be congratulated on reaching an agreed position.

There was recognition that many of the problems highlighted in our original report still exist and that, in our evidence gathering, we have continued to receive reports of pharmacy concerns and complaints. Following a wide-ranging discussion with the Pharmacy Managers there was an acceptance that there had not, as yet, been any major changes in the way community pharmacy services have been delivered since 2019. Having said this, we do want to note general improvements in partnership working with support to pharmacies from the third sector as well as positive links to the Green Health Partnership.[29]

There appears to be an emerging problem with planned and unplanned closures of pharmacies due to locum shortages. This is a problem replicated across Scotland and local responses need to be investigated to minimise harm to OST patients. Due to frequent, often daily, attendances at pharmacies, this group of patients is the most adversely affected by any short notice closure.

We want to highlight that a distinction needs to be made between the pharmacists employed within DDARS and the staff within the 92 independent community pharmacies. The treatment services pharmacists have been involved in developing and delivering a number of positive and innovative interventions, including:

- the introduction of a NFOD pathway involving all relevant partners that has served as an example of good practice for other areas of Scotland; and
- the introduction of online web training and support to the pain and addictions clinic.

It is our view that the existing professional support resource available to community pharmacies is insufficient to provide the level of support, training, incident resolution and ongoing monitoring required to fully implement the new service specification and deliver cultural change. None of the current pharmacy professional support staff have a full-time remit for Alcohol and Drug Services. We were genuinely surprised by how little dedicated pharmacy support there is for community pharmacies across Dundee/Tayside (i.e. between the four current staff members the total equates to just under two FTE employees). Historically. the *Right Medicine* report (Strategy for Pharmaceutical

[29] Dundee's Green Health Prescription is a new pathway to make the most out of Dundee's nature-based activities in greenspaces as a health-promoting resource. Further information available at: Dundee Green Health Partnership | Dundee City Council

Care in Scotland, 2002) recommended that each Health Board should have a pharmacist employed as a specialist advisor in pharmaceutical aspects of drug use. NHS Tayside was one of the first Health Boards to employ a full-time pharmacist in this board-wide advisory role. However, the specific remit has been eroded over time and the post holder now has significant other areas of responsibility, leaving only 0.4WTE of the post dedicated to substance use.

Based on a pro rata comparison of the number of pharmacies, Injecting Equipment Provision [IEP] sites and the alcohol and drug caseload, with the position in Greater Glasgow and Clyde, we estimate that a minimum of 1.5 WTE additional professional posts are required to fully deliver on the aspirations of the new contract.

6.2.9 Criminal/Community Justice

In our first phase of work we noted:

> *'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.'* (See 'KCH – Part 1 report', page 24).

One of the key areas that we noted as not having received sufficient attention by the Commission was the role of criminal justice services and matters of availability of drugs across Dundee and law enforcement of drugs.

At an early stage we decided that this was an area that we wanted to allocate some focus to in our review process and agreed that we would set-up a half-day Roundtable (virtual) discussion session with key criminal and community justice partners/stakeholders. A session was held with seven leaders/managers from across the sector on 4th October 2021.

The Roundtable discussion noted a number of achievements over the last two years, including:

- Dundee Community Justice Services being an active member of the daily Dundee NFOD pathway call.
- An increase in post-custody support and improvements in partnership working.
- The early release from custody scheme instigated as a result of the Covid-19 pandemic and developments in 'virtual' care.
- The Covid-19 pandemic has provided the opportunity to challenge some of the things that have been unchanged for a long time.

The Roundtable discussion also noted a number of ongoing challenges that require further attention and support, including:

- Capacity issues in relation to screening of adult at risk referrals.[30]
- A lack of support for those who are moved out of community justice services.
- Community and criminal justice services are not set-up to accommodate the role of mental health in those use experience problems with substance use.
- A lack of resources to properly focus on underlying trauma, where far more time is needed than the simple offer of a prescription.
- Significant increases in the 'remand' prisoner population.
- Ongoing stigma around this population that is often exacerbated by the media contributing to the negative narrative evidence in public opinion.

The evidence from the Roundtable discussion session has also been combined with evidence gathered from a range of further one-to-one discussions with key stakeholders to provide a focus on what can be done differently or better going forward, the key points of which are:

- **Prevention** - including through a better multi-disciplinary focus on transitions from childhood to adulthood for vulnerable young people, noting that the prison population consists of a high number of males in their mid-20's despite very low numbers at HMP Polmont.
- **Public Health** - balancing a legalistic approach to Fiscal and Sheriff decision-making on prosecution and sentencing with one which is more Public Health informed and more sympathetic to inequalities experienced by this group, typically from birth.
- **Community capacity** - targeting shared partnership capacity in ways which recognises the barriers faced by this population, including in relation to pro-active engagement and appointment times.
- **Enforcement** - recognising that prescriptive approaches towards enforcement of community alternatives can be counter-productive and contribute towards the revolving door syndrome.
- **Silo working** - linking the justice agenda more strongly with the ADP agenda and reviewing ringfenced funding streams to allow them to be used more flexibly and creatively.[31]
- **Prisons** - adapting support to reflect both the changing type and extent of substance use and being pro-active and brave about early release to help manage numbers.

[30] It was noted that a lot of individuals suffering a DRD stop seeing services shortly before their death. The volume of adult at risk concerns being submitted and assessed in Dundee is much greater than other partnerships across Scotland, with the vast majority originating from Police Scotland. The Adult Support and Protection Committee is overseeing improvements in the way that adult at risk concerns are screened and responded to, including follow-up responses to people who do not meet the statutory 3-point test for adult protection intervention but who may benefit from support in relation to risks and vulnerabilities, including disengagement with services.

[31] The officer supporting the Community Safety and Justice agenda is now part of the integrated Protecting People Strategic Support Team which is supporting improved connections with DADP business, the DADP Lead Officer and the independent DADP Chair.

- **Learning from work with children** - applying the GIRFEC principles[32] to work with adults, in ways already promoted by the Independent Review of Adult Social Care.

6.2.10 Children and Young People

Another of the key areas that we noted as not having received sufficient attention by the Commission in our first phase of work was the impact of drug use upon children and young people affected by their own use or that of family members/significant others and the role of substance use services in Child Protection case conferences.

Again, it was decided at an early stage of our review that this was an area that we wanted to allocate some focus to in our review process. We agreed that we would set-up a second half-day Roundtable (virtual) discussion session with key stakeholders from across the children and young people's sector in Dundee. A session was held with seven leaders/managers on 28th September 2021.

The Roundtable discussion, supplemented by evidence submitted to the Commission following the meeting, noted a number of achievements over the last two years, including:

- Improved partnership working and information sharing between DDARS and children/young people's services, mainly due to the embedding of DDARs locality nurses within children's services.
- Increased follow up with people and better linkages with both individuals and other agencies.
- Increased focus on the impact of trauma and a change in terminologies and how people are discussed.

In our first phase of work we reported concerns about the lack of engagement of DDARS with Child Protection Case Conferences:

> *'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* [now known as DDARS] *staff attended just one of these conferences and provided a report to a further three conferences overall providing recorded input for four children.'* (See 'KCH – Part 1 report', page 710.

Upon requesting an updated picture for the period from 1st April 2020 to 31st July 2021 we have been informed that a total of twenty (20) Child Protection Case conferences took place where substance use was a concern. Seventeen (17) of these went ahead with three (3) being deferred (none of which were deferred due to DDARS non-attendance). At these Case Conferences (some were for multiple children), there was someone in attendance from DDARS at ten (10), and reports were provided for a further thirteen (13). Some had both a DDARS worker present plus a report, some had one or the other. Only three (3) had neither.

[32] Getting it right for every child (GIRFEC) - gov.scot (www.gov.scot)

We have been informed that, in the main, the senior officers chairing the Case Conferences did not feel there was a major impact on decision making for the conferences where there was no DDARS staff in attendance or where no report was provided, which suggests that up to date information was able to be shared by the professionals in attendance. On one occasion, the senior officer felt it may have been useful to have another professional's recommendation to inform decision making. Also, on one occasion, the senior officer noted that by having someone present from DDARS it was very helpful in terms of management of risk.

This picture represents a significant improvement in substance use services attendance and input into protection processes. These improvements need to be maintained and improved further going forward.

We would also like to make special reference to the work undertaken to develop the Youth in Iceland model (now called Planet Youth) across Dundee which was highlighted in the Commission's first report as a model of prevention that would be worth exploring. Survey work has now been completed in pilot secondary schools, with findings expected imminently. This is a significant proposal with potentially profound impacts if the Icelandic findings are replicated in Dundee. It must be stressed though that it has taken Iceland 20 years to realise the exceptional results it is now reporting and Dundee must therefore continue to invest in this approach over the long-term and not just the short-term.

6.2.11 Gendered Approaches

Our first report included clear recommendations to ensure that the needs of women affected by drug use are assessed and addressed via the adoption of gender-mainstreaming and gender-sensitive approaches to service planning. DADP has also noted in its Strategic Plan that developing a gendered approach is also required by the Public Bodies Gender Equality Duty, and as such it is a statutory responsibility.

Around the time that our first report was launched, research was also commissioned to look at the needs of women in Dundee. It was funded by the Scottish Government Challenge Fund, with the funding secured by Dundee Women's Aid. An oversight group was set up, which included representatives from Dundee Women's Aid, Dundee Voluntary Action, Dundee Health and Social Care Partnership (DDARS), and Dundee City Council Housing Services.

In summary, this research project provided evidence suggesting that vulnerable women in Dundee experiencing a range of complex issues are not receiving the services they need to support recovery.

Barriers highlighted by women with lived experience included:

- being stigmatised and therefore not receiving appropriate care;
- being subjected to dangerous situations while vulnerable; and
- facing barriers of 'conditionality'.

Women reported that their accounts were often not believed by staff, or that staff were reluctant to work with them once they had opened up and told their full stories. This makes it difficult to maintain engagement with the support available. Specific issues were highlighted around accessing mental health support when also experiencing Gender-Based Violence and / or substance use issues and being placed in mixed sex accommodation.

A Gendered Service Group was developed to lead the development of the gendered approach. It reports to the ADP Implementation Group and to the Violence Against Women Partnership. A key element of the work focuses on the development of the Gendered Services Project Manager post which is funded through the National Challenge Fund and is based within the Protecting People Team.

The research and work that has been prioritised around developing gendered approaches in Dundee is applauded. It's an area that will require continued investment and innovation over the long-term to ensure expertise is built up and embedded across all services and professional practice.

6.2.12 Drug Checking

DADP is working towards the establishment of a point of care drug checking service provision in collaboration with other partners. This project would provide an analytical service to identify potential substances and in so doing, enable accurate and bespoke harm reduction information to be delivered to service users in real time during consultations. This is a welcome and significant development for Dundee with potential learning for the whole of Scotland.

7. OUR CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

As an independent Commission, in collating and analysing the significant amount of evidence (both written and verbal) that has been gathered over the last few months, we have again taken our time to reflect upon, and attempt to balance, the wide variety of views presented. In doing so, we have met virtually as a whole Commission on four occasions since our review started at the end of June 2021, with a further substantial layer of smaller meetings involving different sub-groups of the Commission and a whole swathe of email discussions and requests for information from commissioners and service providers. We have also met on several occasions throughout the review period with the Dundee Partnership leaders (Dundee City Council Chief Executive, NHS Tayside Chief Executive, and the Dundee HSCP Chief Officer) to discuss progress and secure their input into the review process. They have always emphasised their commitment to prioritise the drug deaths situation in Dundee. Their time and input has proved helpful and has been welcomed by the Commission.

From our detailed discussions with the Dundee Partnership leaders we are aware that there are detailed plans being shaped, which appear to resonate with the thinking of the Commission (as outlined in this review). This has generated confidence within the Commission, which was formerly lacking, that the Dundee Partnership has the necessary commitment to, and enthusiasm for, the next phase of the journey to combat the drug death emergency in the city. To date, however, the Dundee Partnership plans are not shaped into a sufficiently comprehensive strategy and subsequent action plan that covers the entirety of recommendations and associated findings outlined in our first report. There is also no evidence of a robust communication strategy that would need to accompany the strategy and action plan to ensure firstly that it is visible and secondly that it results in improvements that are experienced (felt) by those affected by problematic substance use across Dundee.

The recommendations that we outline later in this chapter are once again aimed at the Dundee Partnership, which has always shown tremendous courage to open up the issue of drug use in Dundee to independent (and public) scrutiny. In our first report we made a number of statements regarding the nature and scale of the challenge that we considered the Dundee Partnership to have in front of them. These are matters that we have been scrutinising within our review of progress, and which we will again comment on throughout this section of the report. The pertinent statements are:

- We were clear in our first report that the recommendations we delivered to the Dundee Partnership were going to be: 'Challenging to implement and would 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''.
- We were also clear that we would be looking for: '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.'

- Finally, we were also clear 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' were also offered and presented to Scottish Government.[33]

Our final comment in this section of our report is to note that the political interest and support for the Commission has continued to be as significant as it has from the outset. Of particular note:

- The new Drugs Policy Minister for the Scottish Government requested to meet with the Commission back at the start of February 2021 to be briefed upon the first phase of the Commission's work and to understand the plans for the Commission's review. The Minister noted that she would like to meet with the Commission again once the review report has been published.
- The Commission's first report was presented to the Scottish Government's Drug Deaths Taskforce in January 2020 and the Taskforce has indicated that they would like to be briefed upon the findings of the review once it has been published.
- Local MSPs and MPs have continued to engage in conversations with the Commission. We had an opportunity to meet in September 2021 with the recently convened committee of local parliamentarians that has been set-up to keep a watching brief on the drug deaths situation in Dundee. Similarly, this committee is also keen to meet with the Commission once the review report has been published.

7.2 The extent to which progress has been made in relation to the Dundee Drugs Commission's 2019 recommendations

Following the publication of the Commission's first report, the Dundee Partnership and the DADP launched its *Action Plan for Change* (see **Appendix V** in the **Part 2 Supporting Evidence Report**). This plan has been kept under review and was formally updated in February 2021. The plan helps to demonstrate evidence that concurs with our view that genuine and extensive efforts have been made by the Dundee Partnership, the DADP and local services over the last two years in response to the Commission's recommendations.

However, we have noted that the *Action Plan for Change* has focused its attention only on the sixteen headline recommendations of the Commission's report and hasn't explicitly taken account of the significant number of other findings that sit underneath each of the headline recommendations. The position of the DADP is that it has not been possible, due to capacity and resource, for all these associated findings to be covered in detail, and therefore a pragmatic approach was taken to focus on the headline recommendations. The DADP view has therefore been that they should be assessed against overall progress made towards the headline recommendations of the Commission rather than whether each of the associated findings has been accounted for. The problem for the

[33] As part of our review we have spoken to Scottish Government officials regarding the national considerations that we made in our first report, and we have received a written response from them on the plans that Scottish Government have been working on (and continue to work on) in relation to the points raised by the Commission. This response is presented in the **Part 2 - Supporting Evidence Report** at **Appendix IV**.

Commission though, is that the associated findings were purposely designed to be a significant part of the roadmap towards meeting each of the headline recommendations and they should not have been put to one side. Having said that, we do recognise and appreciate that the whole suite of recommendations that were laid out in our report was ambitious and we note that the DADP has not had sufficient capacity or resource to fully respond to the whole picture. We consider this to be the first indication that the overall response to the drug deaths situation in Dundee has not been proportionate and that the scale of the challenge for Dundee (as for other areas across Scotland) has been (unintentionally) underestimated.

We would like to highlight three (of various) examples that demonstrate our thinking.

1. Advocacy

We made the following statement in our first report:

> *'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.... **Resources should be redirected** into rebalancing the sector to support more community-based provision.'*

On the face of it, the DADP has made significant progress in responding to this recommendation, in that there is now some advocacy provision in place which wasn't previously. However, this has only been made possible by making a successful bid for short-term funding from Scottish Government, rather than redirecting resources from core funding streams (as indicated above) to ensure that advocacy is built into the long-term portfolio of service provision, rather than having to bounce from one funding application to another. This is an indication that the DADP has not been able to move to a joint commissioning approach of the whole substance use budget, as we recommended previously[34]. Without this it will be impossible to redistribute resources over the long-term away from the predominance on medical treatment towards mainstreaming a balanced portfolio of services within a fully functioning ROSC. This must include advocacy provision alongside peer-led, mutual aid groups as well as recovery communities for those with lived and living experience as well as affected family members and loved ones.

2. Assertive Outreach

We would also place on record we have a similar observation, as above for advocacy provision, in respect of the recommendation we made regarding the place that assertive outreach needs to take within the portfolio of service responses in Dundee:

> *'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.*

[34] Also recommended in the 'Defining and Improving Prevention and Recovery through better Substance Misuse Outcomes' (2016) study, which was commissioned by the DADP.

Assertive outreach needs to be positioned as a fundamental ingredient of both the transition plans and the longer-term system redesign.'

Although we warmly welcome and applaud the work of local Third Sector services in developing and expanding assertive outreach programmes that are linked into the excellent Dundee Non-Fatal Overdose pathway, we also note that said services have had to compete for funding from short-term and fixed funding programmes via the Scottish Government rather than being mainstreamed (integrated) into the core funding programmes of the DADP. This leaves assertive outreach in a potentially vulnerable position in the long-term as and when the short-term additional funding available just now disappears.

3. Residential Rehabilitation

We also made the following statement in our first report:

'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)*'[35].

During the course of our review we were presented with a paper that was submitted to DADP which presented a detailed and encouraging response to how rehabilitation (both community and residential options) would be developed for Dundee citizens. However, the conclusion of this paper was that the work would primarily be managed and developed through the Local Authority's Social Work department with significant funding being directed to recruiting new social work staff. So, again, on the face of it, this was a good news story in terms of the development of community and residential options. However, because our recommendation was not considered (i.e. where a 'dedicated budget held by the Third Sector' was our recommendation, rather than through the existing Social Work route) we are not convinced that the speed of accessing rehabilitation options will be improved. Towards the end of our review, we were made aware that the DADP is now reviewing this situation with a view to the Third Sector fully managing the resource (both staff and budget), which is a welcome step. This has been a clear example of the pitfalls for the DADP in focusing purely on the headline recommendations in our previous report and not working through the detail contained in all the associated findings.

In preparation for the Commission's Review, the Dundee ADP conducted a comprehensive self-assessment exercise (see **Appendix VI** in the **Part 2 Supporting Evidence Report**). This was a helpful and welcome starting place for the Commission to start its review – and is a strikingly different approach than we encountered from the DADP when we started our work in 2018. This is without a doubt a positive sign of the new leadership of the DADP and the evolution it is going through. We also welcome that the DADP has committed to repeating this kind of self-assessment at regular future intervals as part of a plan for continual improvement. From reviewing the ADP Self-Assessment it is clear that the ADP consider themselves, in the main, to have made *reasonable* progress over the

[35] https://www.firstforfife.co.uk/residential-rehabilitation

last two years against most (twelve) of the sixteen headline recommendations from the Commission's report – although they do note that they have only made *partial* progress in relation to recommendations 2, 3, 10 and 12.[36]

Through the course of our review we have noted **genuine and extensive efforts** to make positive changes in response to the Commission's recommendations from all key partners and stakeholders over the last two years. This is not in question. In particular, we would like to note a number of areas of significant progress and improvements:

- We can see and evidence some significant early gains following the launch of the Commission's report in relation to some of our core concerns around the speed of access to, and initiation on, medical treatment. We are aware that these gains were associated with the development of drop-in clinics as well as the co-location of some nursing staff within Third Sector partner agencies. Although these early gains have been curtailed since the start of the pandemic (due to the necessary social distancing regulations being put in place), they demonstrated clear benefits at the time. The utilisation of drop-in clinic approaches and co-location of staff are matters we will come back to later in this chapter.
- We wholeheartedly welcome the establishment and commitment to a daily NFOD multi-agency telephone call and expansion of connected assertive outreach services. The evidence we have received indicates this as being a significant development in the efforts to prevent drug related deaths in Dundee – and has received attention from across Scotland as an innovative response.[37]
- We have noted, and welcome, the efforts to expand OST treatment options, especially in relation to DDARS inclusion in a UK long-acting buprenorphine trial, where it is the only Scottish service to have been included in the trial.
- Despite our comments about the inadequate funding arrangements, we are encouraged by the commissioning of some advocacy provision for those who need or are currently engaged in drug treatment in Dundee. This provision must be protected and expanded (as part of the core provision of services) going forward.
- We have been impressed with the significant attention to and developments in gendered approaches (co-ordinated through the setting up of a Gendered Services Group Action Plan).
- We are heartened by the significantly improved engagement of DDARS with Child Protection Case Conferences and partnership working arrangements with children's services.

[36] 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 10: *'Involvement of primary care and shared care models.'* Recommendation 12: *'Commission a comprehensive independent Health Needs Assessment for people who experience problems with drugs.'*

[37] The only comment we would make is that although efforts have been made to evaluation the NFOD Multi-Agency pathway work, the evaluation that was conducted (via the University of Dundee) only took evidence from those actively engaged in running the NFOD daily meetings (rather than a broader set of stakeholders) and is therefore likely to have a bias in the positive findings of the evaluation.

- We want to highlight the extensive amount of work and commitment that has been invested in securing a significant award of new funding from Scottish Government for implementing a 'whole system Test of Change project', which we note is a direct response to our previous Recommendation 13 (i.e. full integration of substance use and mental health services and support). The only disappointment for us is that most stakeholders were unaware of the plans for this Test of Change project which indicates that an improved communication plan is urgently required around these developments.
- We want to pay special mention to the efforts to restructure the ADP, led by the new independent Chair. We recognise that this is not an easy endeavour and one that will take time for the benefits of the restructuring to be visible and felt across the sector. We are encouraged by the direction of travel despite the distance that is still to be journeyed.
- We welcome the work of the ADP Resilient Communities group around challenging stigma. In particular, we would mention the short animation[38] developed via this group, which aims to raise awareness of the impact of language on people who experience substance use challenges. We are aware that a full campaign launch and communication strategy is due to take place in the first part of 2022.
- We have been impressed with NHS Tayside Public Health's ability to increase its capacity and input into the local agenda (especially given the overwhelming pressures on Public Health during the Covid-19 pandemic).
- Finally, we would make special mention to the commitment that has been provided by the Senior Leadership of Dundee Partnership to meeting regularly with our Chair and Vice-Chair during the review period. This has reassured us that substance use issues are high on their agendas and that ongoing commitment has been provided to responding to the findings and recommendations of the Commission's review.

Although all of these positive developments, along with the genuine and extensive efforts that have been made, are noted, and welcomed, we would urge caution in drawing the conclusion that these changes will provide the required results to reduce (and ultimately eradicate) drug-related deaths across the City. We would also note that a lot of the positive changes noted above have not been visible or experienced (felt) by those who use local services or their family members and loved ones. This is a matter for urgent consideration, and needs addressing, if our local communities are going to have the hope that things are improving and will continue to improve over time.

Our concern remains that these changes, whilst undoubtedly bringing improvements to the situation, are not in themselves tackling the fundamental, systemic issues that we reported on in our first report. We do not consider the current overarching strategic planning to be as comprehensive, innovative, or evolved as we would have hoped for by this point. We believe this is because the scale and gravity of the challenge has been (unintentionally) underestimated and sufficient resources (time, expertise and budgetary) have not been applied to the Dundee Partnership's response.

[38] Available at: www.dundeehealth.co.uk/stigma

Overall, we believe that the DADP has been over-generous in their self-assessment of progress to this point. However, we have also noted that the depth and tone of comments that were reported to the DADP through the self-assessment exercise were not as critical or upfront as the weight of comments made to the Commission throughout our review. Our sense is that stakeholders felt able to be more honest and upfront with the Commission than when being asked similar questions by the DADP, which to a large extent is understandable given the independent (and confidential) nature of the Commission.

7.3 The extent to which progress has been made in the last two years with kindness, compassion and hope being visible in Dundee for those affected by their own (or someone else's) drug use

The title of the Commission's first report, focusing on *'Kindness, Compassion and Hope'* was a purposeful reflection of the plea that we heard consistently from those with lived and living experience of (their own or someone else's) problematic drug use that the culture surrounding drug treatment in Dundee needed to change. So, with that in mind we have focused our review not just on changes to systems and processes in service delivery but equally on whether any changes in culture have been visible and experienced (felt) by those who need to connect with services and supports.

We have always acknowledged that the desired culture change is a long-term journey. Our expectation of the level of change after two years (and taking account of the pandemic) was therefore less optimistic than our expectation for positive system and process changes. Our expectation would have been to see a clear, visible, and experienced (felt) culture change at senior leadership and management levels along with the green shoots of change at the service delivery level. Our roadmap for the Dundee Partnership that was designed to kickstart the cultural change journey, was detailed in the final paragraph of our first report:

> *'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.'*

We also made an explicit statement that:

> *'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.'*

Whilst we have seen or heard little evidence to indicate that either of the above recommendations have been progressed in the way we had envisaged, we are aware that Third Sector services have led

the way in focusing on the values of kindness and compassion. This is a start. However, a concerted effort must now be made to develop a culture based on kindness, compassion, and hope across all services.

For this reason, we have purposely discussed and agreed as a Commission that the title of our review report should be ***'Time for Kindness, Compassion and Hope: The Need for Action Two Years On.'*** Whatever action is taken from here on needs to be based on a comprehensive communication strategy so that it can be visible and experienced (felt) by all.

7.4 What more needs to be done across Dundee to substantially reduce the high number of drug-related deaths? What should the next steps be? How confident can the Commission be that this issue is being treated with the correct and proportionate response?

There was a consensus amongst Commission members regarding what the next steps should be. These focus in the main around many of the same issues that we presented to the Dundee Partnership two years ago. We were consistently hearing the same comments and issues being raised as they were previously with a sense that *not a lot* or *nothing* has changed. A notable number of respondents, especially family members, felt that things are now worse than they were two years ago. We appreciate that these are the experiences of those we have spoken too, but we also want to balance that with the evidence that we've seen of positive changes. It is a shame that these positive changes have not been experienced (felt) by many of those who need the change the most. Again, this emphasises the urgent need for improved communication and visibility of the various plans being rolled out by the Dundee Partnership and the DADP. The critical issues and substantive points that the majority of respondents wanted to talk to us about this time around focused on:

- An over-reliance on and a power-imbalance within a centralised, overly bureaucratic medical model of drug treatment in Dundee (as reported in our first report).
- An unequal and non-reciprocal playing field between the DDARS service and its Third Sector (Substance Use) Partners. The Third Sector, in the main, is still fearful of the consequences of speaking up within what it perceives as an imbalanced partnership.
- A strong perception that there is a continued lack of treatment options and a continued adherence to a service-led culture within the DDARS service.
- The need for those who are seeking help for substance use problems to be afforded **time** from all services so that they can work together in a fully functioning partnership for the benefit of the individual.

In addition to these points, and taking the impact of the pandemic into account, respondents in the review identified the significant pressures that have been upon staff across all services and organisations during the pandemic and how *exhausted* the sector is (as commented earlier).

In respect of whether the response to the Commission's recommendations is being treated with the correct and proportionate response, our overarching conclusion is that it's not. We believe that the scale of the challenge to turn the situation around hasn't been fully appreciated and that the

conventional methods we have noted as being adopted by Dundee to try and change the situation have not produced the required results at this point. We therefore believe that it is time for a more focused approach to be taken, which may require external support and expertise. As we have mentioned on several occasions, the efforts of those in leadership across this agenda (at all levels) have been both genuine and extensive. However, we believe that it is now time to acknowledge that the level of expertise required to turn around such a challenging Public Health emergency is not fully present within existing resources in Dundee and that a request will need to be made to Scottish Government for help.

7.5 What needs to be done now and why?

In answering this question the Commission has taken the time to apply 'Theory of Change' frameworks and principles to the inherent problems that we've outlined. In particular we have been informed through our experience of Contribution Analysis, which has allowed Commission members to have the space and time to consider and test out underlying assumptions around the need for change, as well as taking account of a wide variety of external factors.

The emphasis of Contribution Analysis is on outcomes rather than just accounting for what programme(s) deliver and produce (although inputs, activities and outputs are part of the process). The conceptual development and application of Contribution Analysis has been influenced by individuals such as John Mayne[39] and Steve Montague[40] who have described the process as 'results-based management' involving the gathering of a range of forms of evidence (or 'evaluative evidence') to tell the 'performance story' about how programmes have contributed to outcomes in the short-term, medium-term, and long-term.

Contribution Analysis is therefore a theory-informed evaluation method, appropriate to the review of complex, multi-level programmes of work where direct causal attributions are not possible.

Theoretically, Mayne[41] proposes that it is reasonable to conclude that the programme(s) is/are contributing to/influencing the desired outcomes if:

- There is a reasoned theory of change for the programme.
- The activities of the programme were implemented as planned.
- The theory of change (or key elements) is (are) supported and confirmed by evidence.
- The sequence of expected results has been realised and the theory of change has not been disproved.

[39] Mayne, J. Contribution analysis: An approach to exploring cause and effect, Institutional Learning and Change Initiative Brief 16, http://www.cgiar-ilac.org/files/publications/briefs/ILAC_Brief16_Contribution_Analysis.pdf

[40] Montague S. Practical (Progress) Measurement and (Impact) Evaluation for Initiatives in Complex Environments. Performance Management Network: Performance Management Network; 2011.

[41] Mayne, J. (2010) Contribution Analysis: Addressing Cause and Effect. In: R. Schwartz, K. Forss, and M. Marra (Eds.), *Evaluating the complex*. New Brunswick: Transaction Publishers.

- Other influencing factors (contextual/external) have been assessed and accounted for and either shown not to have made a significant contribution, or their relative role has been recognised.

Through being informed in this manner, we have outlined a potential starting point for the Dundee Partnership, which we have visualised in a graphic Logic Model[42] (see **Figure 7.1** below and subsequent further commentary). By adopting, testing out, and refining the Logic Model the Dundee Partnership will enter into an evaluation journey to help demonstrate over time what 'contribution' their response to the drug death situation makes to improving outcomes. We have included this within our recommendations below to ensure that evidence will be provided over time to answer the critical question of 'How will everyone know that the efforts and changes made by the Dundee Partnership are contributing to real, tangible, and improved outcomes?'

[42] 'A logic model is a graphic which represents the theory of how an intervention produces its outcomes. It represents, in a simplified way, a hypothesis or 'theory of change' about how an intervention works. Process evaluations test and refine the hypothesis or 'theory of change' of the intervention represented in the logic model.' Creating a logic model for an intervention: evaluation in health and wellbeing - GOV.UK (www.gov.uk)

Figure 7.1: Logic Model

CONTEXT: Dundee continues to experience the highest population rate of drug-related deaths in Scotland. The extensive and genuine efforts made to stem and (ultimately) reverse the drug-death rates in the city have not gone far enough, deep enough or fast enough, even when considering the impact of Covid-19. NHS Substance Use Services within the total provision of the city are severely challenged in configuration and capacity. They cannot spend the necessary time with individuals to fully support their needs; it is out of balance with other services that have key contributions to make in offering support and treatment options. Service users and their families have seen transient changes but no sustained improvement to the range and quality of interventions that they need and deserve.

RATIONALE: The damaging consequences of chaotic substance use (combined with other challenges such as poor mental health) can be reduced and mitigated through radical reform (at all levels) of Dundee's leadership and strategy for support to people with drug problems. There is a need to focus on its commitment to equal and reciprocal partnership and shared purpose around medically assisted treatment. This must include the deconstruction of Dundee's historic centralised and overly bureaucratic medical model for drug treatment as well as a co-produced and co-designed 'whole system' model of care (for the whole protecting people agenda, not just drugs specific). By so doing, the desired transformational change can be realised.

INPUTS
What is needed?

- Collaborative, authentic, visible, and distributed leadership based on kindness, compassion, and hope.
- A new integrated 'whole system' model of care structured around an equal and reciprocal partnership with primary care, the third sector and whole families (for the whole protecting people agenda, not just drugs).
- Expertise in change management.
- Increased expertise and resource to expand primary care and pharmacy input.
- Joint commissioning of whole substance use budget.

ACTIVITIES

What has to be done?

- Increased and priority focus on visible and experienced cultural change.
- Completion of Health Needs Assessment as an immediate priority with subsequent development of a new ADP Strategic Plan for 2022-25.
- Co-produced and co-designed reconfiguration of the partnership between DDARS, all Third Sector partners, and those who use services (and their families) to be overseen and managed by the setting-up of an externally sourced Prog Mngt Board.
- Closure of Constitution House and sourcing of a smaller medical base(s) for Clinicians.
- Application of learning and planning lessons from Covid pandemic to dealing with drug deaths emergency.
- Embedding of 'whole family approaches' across all services which embrace the valuable role of family members and recognise the needs of all children within the family.

Who will be influenced?

- Those who use services
- Those with lived and/or living experience
- Family members/carers
- Partnership agencies
- Community organisations
- Dundee ADP
- Dundee Partnership
- Members of the Public
- Local media
- Scottish Government

OUTCOMES

What will be gained?

1 Evidence of improved quality and effectiveness of treatment.
2 Fewer individuals in DDARS (thus improving capacity) and shorter times for individuals between start of treatment and discharge.
3 Improved communication and collaboration between all partner agencies.
4 Improved retention of staff.
5 Rebuilding of trust and respect between statutory and third sector partners.
6 Improved governance and accountability.
7 Improved transparency and visibility of decision-making from the ADP.
8 Ability to meet the MAT standards.

What will be different?

1 Increased Primary Care capacity around substance use.
2 Agreement of contractual arrangements for GPs around prescribing input.
3 Equal and reciprocal partnership between professionals and those who require services in relation to treatment/support decision-making.
4 A truly level 'playing field' between statutory and third sector.
5 More individuals being moved on from DDARS and being managed in the Third Sector and Primary Care.

IMPACT
What difference will this make?

- Reduced drug-related deaths and increased life expectancy.
- Improved health outcomes.
- Reduced costs to society and increased contributions to society.
- Improved relationships and family lives.
- Improved relationships between all partners.

ASSUMPTIONS

- All partners commit to DDARS entering an equal and reciprocal partnership with both primary care and the third sector'.
- It is accepted that Dundee does not have sufficient expertise to turn the drug death crisis around within current resources.
- There is a strong commitment (strategically) to ensure change takes place.
- Increasing staffing numbers within DDARS is the wrong way to tackle the capacity challenge.
- There are more than sufficient third sector/community support services to help all those who need it.
- A deconstruction of the centralised model will provide proper allocations of time that individuals need alongside the key treatment decision-making processes (in the same moment and space).
- A focus on trauma informed care will deliver better support to service users and improve engagement with services.
- With the right support (at the right time), people can enter into and sustain recovery.

EXTERNAL FACTORS

- The level playing field for the Third Sector (discussed in Recommendation 4 from the original report) has not been achieved and is still the greatest stumbling block to the significant changes that are required.
- Requirements placed upon Dundee by Scottish Government.
- The national funding model for drug and alcohol and linked sectors.

7.5.1 Context

Dundee continues to experience the highest population rate of drug-related deaths in Scotland[43]. Taking in to account the encouraging drop in numbers of deaths in 2020 (a single year), the number and rate of loss of life remains at a very high level by any comparison. The evidence gathered by the Commission in its two-year on review (of progress against its 'KCH – Part 1 report') indicates that the extensive and genuine efforts to make the necessary changes across Dundee to stem and (ultimately) reverse the excessive drug-death rates in the city have not gone far enough, deep enough or fast enough, even when considering the impact of the Covid-19 pandemic. The scale of the challenge cannot be overstated and must not be underestimated, against the backdrop of high levels of poverty and deprivation in the city. Those struggling with problematic substance use have spoken consistently, and at length, about the need for kindness, compassion, love, respect and critically **time** from support/treatment services and staff. This is where the fundamental problem lies within the current Dundee Treatment Services Model. The main treatment service (DDARS), which holds the bulk of the power and decision-making ability in relation to a person's treatment regime, cannot spend the necessary time with individuals to fully support their needs. It is out of balance with and separate from (rather than fully integrated and co-located), the broad range of other services and community organisations across the city that have key contributions to make in offering general and specific support, problem-solving, and treatment options. NHS Substance Use services (as a core part of DDARS), within the total provision of the city, are severely challenged in configuration and capacity. As such, those who use services and their families have reported seeing transient changes[44] but no sustained improvement to the range and quality of interventions that they need.

7.5.2 Rationale

The Commission's firm belief continues to be that the damaging consequences of chaotic substance use (combined with other challenges such as poor mental health) can be reduced and mitigated through radical reform of Dundee's leadership and strategy for support to people with drug problems. There is a need to focus on its commitment to equal and reciprocal partnership and shared purpose around medically assisted treatment. This must include the deconstruction of Dundee's historic centralised medical model for drug treatment as well as a co-produced and co-designed 'whole system' model of care. By so doing, the desired transformational change can be realised. This deconstruction of the centralised model will create the conditions whereby a chain-reaction of positive events will naturally follow, such as:

- Improvements in trust and respect between staff from different disciplines due to multi-agency working arrangements.

[43] Despite a recent decrease in DRDs in Dundee during 2020, the five-year rolling average deaths rate (for 2016-2020) for Dundee City is still the highest in Scotland, standing at 39.0 per 100,000 population. Glasgow City is nearly on a par with Dundee City at 38.7 deaths per 100,000 population with Inverclyde at 34.0. For comparison, all other areas of Scotland are between 6.7 and 27.2 per 100,000.

[44] Most reports of these 'transient changes' relate to the five-month period from the launch of the Dundee Commission's report in October 2019 through to the start of the Covid-19 pandemic in March 2020.

- Improvements in communication and information flow due to co-location of staff.
- Improvements in staff retention and optimism which are currently severely challenged.
- Quicker pathways for individuals into and through services that will generate stronger and improved recovery outcomes for the city.

Current leadership efforts are centred around tackling capacity by increasing staffing levels within the DDARS service.[45] However, this is tackling the problem of capacity in the wrong way. There is now a need for external support and expertise to manage a transformation change plan around the provision of substance use services in Dundee. This radical change needs to centre on the transition of the DDARS service from a service based out of Constitution House to a service that embeds its staff within those organisations and agencies that it needs to partner with (Third Sector, Pharmacies, GP surgeries, Community Organisations).

7.5.3 What is needed? (Inputs)

- Collective, authentic, visible, and distributed leadership based on the core values of kindness, compassion, and hope.
- A new integrated 'whole system' model of care. Proper allocations of time needs to be provided alongside the key treatment decision-making processes in the same moment and space. This can only be achieved by agreeing and establishing an **equal and reciprocal** partnership with both primary care and the third sector (see Recommendation 8 from the original Dundee Commission report). The level playing field for the Third Sector (discussed in Recommendation 4 from the original report) has not been achieved and is still the greatest stumbling block to the significant changes that are required.
- Expertise in change management.
- Increased expertise and resource to expand primary care and pharmacy input.
- Joint commissioning of whole substance use budget.
- A clear Partnership statement presenting the plan for the transition of DDARS to a fully integrated/co-located model (including the closure of Constitution House and transition of frontline staff into the premises of third sector partners and other organisations).
- Clear definitions of thresholds for access to DDARS with the transfer of lower-level, stable patients to third sector organisations (which will require additional funding for existing third sector contracts).

[45] There are two key sides to the capacity challenge. The first is around developing Shared Care approaches with Primary Care. In this respect good progress is being made by DDARS and Dundee HSCP, as detailed in **Section 6.25 (pg 28)**, towards a long-term plan f new arrangements. The other side to the capacity challenge is the one which DDARS is struggling with most. It is where they struggle to discharge individuals on low-level OST, who are more stable, to their Third Sector partners. The current solution being applied to this challenge is to try and recruit more nurses for the service (at a time when staff retention and recruitment in the service is a significant obstacle), rather than working with the extensive capacity within the Third Sector locally to help.

- Development of a 5-year plan for the DADP to achieve a sustainable and balanced portfolio of core-funded work that requires the pooling of all resources into a Joint Commissioning Plan.
- Improved visibility and transparency of funding arrangements and service contracts, as well as DADP decision-making. This will require a comprehensive and monitored communication strategy and plan to ensure the required changes are both visible and experienced (felt).

7.5.4 What has to be done and who will be influenced? (Activities)

- There has to be an increased and priority focus on visible and experienced cultural change – focused on the values of Kindness, Compassion and Hope.
- The completion of a comprehensive Health Needs Assessment as recommended in the 'KCH – Part 1 report' (Recommendation 12) has to be viewed as a critical action and immediate priority. Completion of the Needs Assessment should then inform the subsequent development of a new ADP Strategic Plan for 2022-25.
- All efforts need to be given to co-producing and co-designing a reconfiguration of the partnership between DDARS, all Third Sector partners, and those who use services (and their families). This must be overseen using external support and expertise to manage a transformation change plan.
- The closure of Constitution House needs to happen at the earliest opportunity (and within a maximum timeframe of 12 months). Dundee Health and Social Care Partnership should source more appropriate and smaller medical base(s) for DDARS Clinicians.
- The Dundee Partnership should convene a working group to identify and apply the significant learning and planning lessons from the Covid-19 pandemic to dealing with the drug deaths emergency.
- 'Whole family approaches' need to be embedded across all services which embrace the valuable role of family members and recognise the needs of all children within the family.

7.5.5 What will be gained and what will be different? (Outcomes)

What will be gained?

- Evidence of improved quality and effectiveness of treatment.
- Fewer individuals in DDARS (thus improving capacity) and shorter times for individuals between start of treatment and discharge.
- Improved communication and collaboration between all partner agencies.
- Improved retention of staff.
- Rebuilding of trust and respect between statutory and third sector partners.
- Improved governance and accountability.

- Improved transparency and visibility of decision-making from the ADP.
- Ability to meet the MAT standards.

What will be different?

- Increased Primary Care capacity around substance use.
- Agreement of contractual arrangements for GPs around prescribing input.
- Equal and reciprocal partnership between professionals and those who require services in relation to treatment/support decision-making.
- A truly level 'playing field' between statutory and third sector.
- More individuals being moved on from DDARS and being managed in the Third Sector and Primary Care (once they are established with an agreed support & treatment plan).

7.5.6 Ultimately, what difference will this make? (Impact/measurable outcomes)

- Reduced drug-related deaths and increased life expectancy.
- Improved health outcomes.
- Reduced costs to society and increased contributions to society.
- Improved relationships and family lives.
- Improved relationships between all service partners.

7.5.7 Risks and Assumptions

The underpinning assumptions (and associated risks) for the Logic Model are identified as follows. These should provide a starting place for discussions within the Dundee Partnership in regard to responding to the recommendations contained within this report.

- The Dundee Partnership (and all its constituent partners) visibly commit to DDARS entering an equal and reciprocal partnership (rather than just involving and engaging) with both primary care and the third sector.
- It is accepted that Dundee does not have sufficient expertise to turn the drug death crisis around within current resources.
- There is a strong commitment (strategically) to ensure change takes place.
- Increasing staffing numbers within DDARS is the wrong way to tackle the capacity challenge and efforts will be focused on (1) changing culture to support staff retention; and (2) transfer of lower-level stable patients to the Third Sector.
- There are more than sufficient third sector/community support services to help all those who need it.

- A deconstruction of the centralised model will provide proper allocations of time that individuals need alongside the key treatment decision-making processes (in the same moment and space).
- A focus on trauma informed care will deliver better support to service users and improve engagement with services. A focus on trauma and recovery can only be delivered effectively across the whole Dundee Partnership. So, whilst our review report understandably focuses on the DADP, consideration needs to be given to how the DADP sits as part of a whole system of care across the protecting people landscape.
- With the right support (at the right time), people can enter into and sustain recovery.
- All drug deaths are preventable.

7.5.8 External Factors

- The level playing field for the Third Sector (discussed in Recommendation 4 from the original report) has not been achieved and is still the greatest stumbling block to the significant changes that are required.
- There are significant requirements placed upon the Dundee Partnership by Scottish Government for wholesale change across this agenda. The recommendations of this report need to work alongside and complement the Scottish Government's direction and agenda.

7.6 Recommendations

Through our rapid review, we have facilitated and witnessed significant and far-reaching discussions concerning the nature and extent of the current and continued challenges faced and, most importantly, on what more needs to be done to further improve the situation in Dundee. 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 continued high number of drug-related deaths in the city.

The following are our set of **twelve (12)** recommendations that we believe are within the abilities of the Dundee Partnership to progress. As with our first report we do believe that for all the stated changes to be made successfully, then there are some matters that are outside the gift of the Dundee Partnership to progress, and which will require support and decision-making from the Scottish Government in particular. As noted above, the Scottish Government have provided feedback on their progress and thinking against the eight national considerations that the Commission presented them with two years ago. Instead of updating these national considerations in this report we now believe that it is down to the Dundee Partnership to further its dialogue with the Scottish Government in relation to the support they will require going forward. As a Commission we will look forward to sharing the conclusions of our review with the Drugs Policy Minister, the Drug Deaths Taskforce, and the committee of local (North-East) parliamentarians once our report has been published.

In terms of the suggested timescales for action, we do believe that the focus needs to be on planning for the next five (5) years, and although we reference some specific timelines within the following recommendations, we would expect the Dundee Partnership to identify appropriate timescales when prioritising and developing their future strategy and resultant action plan.

Recommendation 1: The Dundee Partnership needs to update and expand its 'Action Plan for Change'. This must include an acknowledgement that all the recommendations and associated findings from the Commission's first report are still valid and need to be accounted for and encompassed within the updated plan.[46] The response to all recommendations and findings (including those from both Commission reports), should be subject to some form of independent scrutiny to assess more accurately the progress that has been made. This would result in a more realistic assessment of the rate of progress and how much remains to be implemented further.

Recommendation 2: In light of the Commission's Review finding that the scale of the drug deaths emergency challenge in Dundee has been (unintentionally) underestimated, the Dundee Partnership needs to refocus its efforts and upscale its response in order to speed up the pace of change. The starting point for this is to seek expert help to design a plan for leadership (at all levels of leadership across the Dundee drug treatment sector) that identifies learning and mitigation strategies from the Covid-19 pandemic which could be applied to tackle the drug death emergency in Dundee (and Scotland[47]).

Recommendation 3: The DADP should commit to the co-production and co-design of a Recovery Oriented System of Care (ROSC) for Dundee. The DADP and its partners should assess the extent to which the key elements of Recovery-Oriented Systems of Care and Services'[48] are in place and jointly work to address any identified deficiencies. This work should include addressing any lack of shared understanding of Recovery Orientated Systems of Care or where current approaches and activities will diminish the chances of a ROSC being comprehensively delivered.

Recommendation 4: The Dundee Partnership is once again challenged and recommended to co-design (with all partners) and instigate a 'year of kindness and compassion' and must ensure that this is communicated widely, with a commitment to it being visible and

[46] For the avoidance of doubt, the Commission has already submitted to the DADP a list of all the recommendations from our first report that need to be accounted for.

[47] We believe that Scottish Government should support this recommendation in order to utilise the developed leadership plan across all areas of Scotland.

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

experienced (felt) across the whole City. Additionally, all core and funded services should be tasked by the DADP with developing a plan for combating stigma and discrimination based on the core values of kindness, compassion, and hope. Each plan should be co-produced and co-designed in an 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. The need for organisational development support should be assessed and offered in order to enable all services to engage with this recommendation in a genuine and meaningful manner.

Recommendation 5: Joint commissioning of the whole substance use budget is required to ensure that a balanced portfolio of services and support is provided across the city. This will be the 'game changer' if funding is to be redistributed over the long-term to a better and improved balance between investment in prevention, treatment, and recovery provisions. The Dundee Partnership needs to demonstrate, vocalise and make visible its commitment to achieving the joint commissioning of the whole substance use budget, focusing on why this change is needed and the things that it can change and commit to – rather than focusing on the challenges that would stop this change happening.[49] The first step to achieving a better balance to the portfolio of services in Dundee, which at the same time will provide improved outcomes and protection for individuals accessing services, should be to independently assess the need and scale of advocacy and assertive outreach provision for the City. The DADP should then subsequently enter into negotiations with all DADP partners to agree a plan for redistributing core resources to ensure that these provisions receive ongoing funding, and no longer have to compete for funding from short-term funding pots.

Recommendation 6: The Dundee Partnership needs to prioritise as a matter of urgency a plan for conducting a strategic independent Health Needs Assessment for the population of Dundee who have drug problems, that we recommended as a priority in our first report. It should be a global piece of work, synthesising the portfolio of items that are already in place with the changing picture, the wider context of people experiencing multiple deprivation and co-occurring illness especially where needs are distinct for Dundee and actions are possible locally. Without this it is impossible to reliably evidence the actual service need across Dundee, which then compromises the ability of the DADP to ensure the correct balance of provisions are prioritised and funded.

[49] We have noted the response of the Scottish Government to the national considerations that we made in our first report and that ongoing work is being taken forward in relation to the implementation of the Partnership Delivery Framework. We will be stressing the importance of this issue with the Scottish Government's Drugs Minister when we present our findings in due course.

Recommendation 7: The DADP needs to revise and update its Strategic Plan to take account of the full findings of the Commission's review. The DADP is advised to title the new Strategic Plan 'Responding to Drug Use with Kindness, Compassion and Hope' to ensure that the correct focus is applied to the strategy development. It should also include a strong workforce plan aimed at supporting the substance use workforce to respond effectively to the Commission's recommendations (as well as the continued impact of the Covid-19 pandemic).

Recommendation 8: The DADP should commit to repeating the Deeper Dive of Drug Related Death data (commissioned from Public Health Scotland) to track the changes in trends over time and should partner with an independent organisation (such as a university with appropriate capabilities) to interrogate the Deeper Dive data. This interrogation of the data should also incorporate learning from the 6-weekly meeting of the Tayside Drug Death Review Group, which completes a detailed, multi-agency review of Dundee Drug Deaths data (including relevant risk vulnerabilities). The DADP should also explore the provision (and resourcing) of Public Health drug checking within Dundee with external partners with appropriate capabilities to enable agile and rapid planning around drug use, and develop, harm reduction strategies and capabilities.

Recommendation 9: The DADP needs to develop an advanced communications strategy to ensure that transparency and visibility of its work and decision-making (including financial decision-making and planning) is significantly improved. This includes investment in keeping an updated website which hosts key documents (for example: DADP minutes and agendas; Strategy documents; Action Plans; and details of commissioning decisions and financial expenditure).

Recommendation 10: The Partnership needs to commit to closing Constitution House in the shortest possible timeframe (and definitely within the next 12 months). DDARS staff need to be transitioned out of Constitution House with arrangements agreed with Third Sector partners, community pharmacies and primary care to host nursing and social work staff in multi-agency teams. Careful consideration needs to be given to the oversight and assurance that will be required to facilitate a smooth transition, taking into account the impact on both those individuals using the service and the DDARS staff team. This transition will only be successful if the long-standing relationship difficulties experienced by Third Sector services with DDARS are reset, with trust and respect being demonstrated by all parties. We recommend that independent specialist facilitation support is provided to enable all services to improve communication and working relationships.

Recommendation 11: The Dundee Partnership needs to further develop and strengthen its relationship with the third sector. This needs careful attention to create the culture where the

Third Sector feel safe to speak up and contribute to the equal and reciprocal partnership that we believe would make a seismic change in the culture across Dundee drug services. The test of progress in this regard will be the extent to which Statutory services are able to move away from only 'involving' the Third Sector in its plans towards a service culture where both Statutory and Third Sector services work hand-in-hand with those with lived experience and family members to co-produce and co-design future services.

Recommendation 12: The Dundee Partnership needs to fully support the implementation of the new community pharmacy contract and SLA. The level of professional support that will be required to effectively implement and provide ongoing support and monitoring for the proposed new community pharmacy contract will need to be kept under regular review and additional resources allocated as necessary. Consideration should be given to the engagement of Pharmacist Independent Prescribers (PIPs) as part of a multi-disciplinary DDARS prescribing workforce. A communications strategy needs to be developed with all pharmacies to highlight their responsibilities for patients with OST supervised and instalment prescriptions and the associated risks that planned or unplanned emergency closures can cause. All individual contingency plans should include alternative dispensing /prescribing arrangements for OST patients.

7.7 Concluding thoughts

We do firmly believe that if the above recommendations are accepted, agreed, and enacted then the situation in Dundee will improve at the quickest possible pace. We are also adamant that current expertise and resource within the existing Dundee system is not sufficient and that Scottish Government will need to work closely with the Dundee Partnership to secure the necessary expertise and resource to supplement and enhance existing efforts and leadership. Upon publication of this report, we will make these representations ourselves to the Scottish Government's Drugs Policy Minister in support of Dundee as we are convinced that the lessons that will be learned in Dundee can be used in full measure to affect similar improvements across all other areas of Scotland (in support of the national mission to reduce drug related deaths).

Finally, we want to stress the need to view the challenge ahead through the lens that *drug-related deaths are preventable*. This core assumption must be visible at all times and should underpin all strategy and planning in order to ensure that appropriate responses are found and implemented.