

# 2019

## **Responding to Drug Use with Kindness, Compassion and Hope**

**A report from the Dundee Drugs Commission**

**PART THREE – SUPPORTING EVIDENCE – FIELDWORK**

**Presented to the Dundee Partnership**

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**NOTE:** Simon Little was a member of the Drugs Commission until January 2019 when he resigned his position to take up the role of independent Chair for the Dundee Alcohol and Drugs Partnership.

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## Reports

This **Part 3** report is the second of two 'Supporting Evidence' Appendix reports of the Dundee Drugs Commission, and provides records of the thirteen 'fieldwork' evidence gathering activities (**Appendices X – XXII**) conducted by the Commission during its tenure. The other 'Supporting Evidence' Appendix report provides the nine background and contextual evidence documents (**Appendices I – IX**) produced by the Commission. These two documents document the evidence to support the findings and recommendations in the Commission's main 'Part 1' report.

## Disclaimer

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

It is not the intention of this report to cast aspersions on any individual, but rather to help identify where systems and services aren't working as they should in order to help identify realistic and workable solutions.

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

## Acknowledgments

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

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

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





## APPENDIX X: SOURCES OF EVIDENCE

A wide variety of quantitative (data and statistics) and qualitative (expressed views) activities have been used to capture as broad and balanced set of evidence as possible over the last year. In total, we have grouped these activities into eighteen different categories of evidence, as detailed below. The following table identifies the key messages of the study and which of the sixteen activities have contributed to those key messages. The relative strength of each key message is also identified using a traffic light system.

No.	Evidence source	Notes	Appendix
1	Initial Call for Evidence	An initial call for evidence was distributed through various networks across Dundee during May 2018. The call for evidence consisted of three key questions, focused on understanding how the work of professionals across Dundee in supporting those who have problematic drug use can make a positive difference to their outcomes. In total <b>39</b> responses were received.	<b>Appendix XI</b>
2	Deeper Dive of Drug Related Death data	Following discussions with and a presentation to the Commission by Lesley Graham (Clinical Lead for Alcohol, Drugs and Health in Justice Settings, ISD Consultant Team) and Lee Barnsdale (Principal Information Analyst [Drugs], ISD) a formal request was made to ISD for provision of a 'Deeper Dive' of Drug-related Death data to compare a set of key parameters between Dundee and the rest of Scotland. The aim was to identify if there are any particular factors of significant relevance to Dundee in relation to DRDs, compared to other areas of Scotland.	<b>Appendix XII</b>
3	Public Evidence Sessions	Over the course of the last year, the Drugs Commission has held <b>six</b> public evidence sessions where a range of experts were invited to either present to the Commission or discuss certain topics as part of a panel-based question and answer session with the Commission.	<b>Appendix XIII</b>

4	Service user / family focus groups	Seven focus groups, with a total of 60 participants, were conducted by Figure 8 Consultancy with a range of groups with people experiencing drug problems and family/carers support groups across Dundee between June – August 2018	<b>Appendix XIV</b>
5	Service visits	A range of visits to third sector service in Dundee were undertaken by groups of Commission members on 14 <sup>th</sup> November 2018. In total, <b>six</b> services were visited, with an opportunity for Commission members to meet with staff and service users or family members.	<b>Appendix XV</b>
6	Written submissions from the Integrated Substance Misuse Service	<p>Across the lifespan of the Drugs Commission, a wide range of communications (meetings, phone calls and email exchanges) have taken place with management from the Integrated Substance Misuse Service (ISMS) in Dundee. The Commission requested detailed information from ISMS on the services it provides, and ISMS have submitted some detailed documents to the Commission as part of its evidence submissions, with the key documents being:</p> <ol style="list-style-type: none"> <li>1. Provision of a 'factsheet' from ISMS</li> <li>2. Written response from ISMS to questions posed by the Commission</li> <li>3. Written submission to the Drug Commission's Final Call for Evidence</li> <li>4. Analysis of the Deeper Dive of DRD Data commissioned from ISD (Dundee v's Rest of Scotland)</li> </ol> <p>Full details are provided in <b>Appendix VIII</b> in the Supporting Evidence document. A further four packs of detailed information were provided to the Commission in relation to: (1) Clinical Guidelines; (2) Service Redesign Plans; (3) Performance and Governance; and (4) Carers.</p>	<b>Appendix XVI</b>
7	Staff focus groups (ISMS)	Three focus groups were conducted with a total of <b>16</b> staff at ISMS during March 2019.	<b>Appendix XVII</b>

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

		needed to prioritise in timeframe allocated (one year). There were four consistent themes that were identified, over and above any others: Drug-Related Deaths; Leadership; Mental Health; and Treatment.	
12	Final Call for Evidence	A final call for evidence was distributed online and via hardcopy through various networks across during March-April 2019. There were <b>112</b> responses to the survey, although most only completed demographic information. There were a total of <b>39</b> respondents who provided answers to the key questions posed – a mixture of individual and corporate responses.	<b>Appendix XXII</b>

## APPENDIX XI: INITIAL CALL FOR EVIDENCE – THEMATIC ANALYSIS

### Introduction

An initial call for evidence was distributed through various networks across Dundee during May 2018. The call for evidence consisted of the following three key questions, focused on understanding how the work of professionals across Dundee in supporting those who have problematic drug use can make a positive difference to their outcomes.

- 1. What are the challenges and barriers we face in Dundee to developing opportunities for supporting people experiencing drug problems and their families?**
- 2. What examples are there of support and treatment improving the lives of people experiencing drug problems and their families in Dundee?**
- 3. We would also like to know what issues you think (and why) the Commission needs to investigate and report on?**

In total, there were **thirty-nine (39)** responses to the survey, although some respondents chose not to answer the key open-ended questions, or the respondent noted that they had nothing to say regarding the key questions. Furthermore, some respondents chose to provide general responses rather than answering the specific questions posed. These 'general' responses have been analysed to see if elements relate to the questions above.

Three members of the Figure 8 Consultancy team have separately analysed the responses for the purpose of identifying consistent (key) themes. All responses were then entered into text analysis software which allowed for coding of responses to be completed by two members of the team.

Themes have been identified as a consistent (key) message where a minimum of one in four (25%) of respondents referred to the theme.

A summary of all consistent messages noted, with example quotes, is provided below, under each question heading.

### **What are the challenges and barriers we face in Dundee to developing opportunities for supporting those who have problematic drug use and their families?**

In total there were **30** responses to this question. The key themes identified in the analysis of survey responses are as follows and are presented from the highest number of responses first and descending thereafter.

#### Concerns Over Current Substitute Prescribing/ ORT Practices

A challenge cited by **21 (70%)** respondents related to concerns over current substitute prescribing/ opiate replacement therapy (ORT). The place of ORT in an individual's treatment journey was a pressing issue:

*'Methadone or nothing.'*

*'ORT – becomes central to treatment packages rather than one facet of them.'*

Current waiting times was also a point of concern for several respondents:

*'Folk wait a perilously long time to get into Opiate Replacement Therapy (ORT) when they express desire, motivation and need to get off drugs.'*

*'Waiting times into treatment too long ... services should be accessible when clients are ready and wanting treatment.'*

*'Time taken to access treatment, some 12 weeks and the steps service users have to take before accessing treatment to evidence need and motivation.'*

*'The waiting times for getting access to treatment programmes is too long and can be a barrier to women getting the support / treatment at the times they need it, meaning that many women we work with have to prostitute themselves in order to be able to get by in the intervening time.'*

Other relevant comments include:

*'The reliance and 'domination' of the clinical and prescribing medical model and practice guidelines.'*

*'Too many 'hoops' to jump before you can access treatment, the process is difficult for people who at times are living chaotic life styles.'*

#### A Lack of Joined up Working

One challenge stated by **17** (56.7%) respondents was a lack of joined up working, which appears to inhibit individuals receiving adequate care. The comments below demonstrate that respondents' beliefs:

*'Working between services needs to improve. Still a sense of silo working.'*

*'Lack of partnership working – lack of trust – competition for resources.'*

*'There does not seem to be a joined-up approach from drug services.'*

*'Lack of consistent joined up working by agencies to assist service user from re-entering substance misuse cycle.'*

*'Lack of integrated working between addiction, mental health and criminal justice.'*

#### Co-occurring Mental Health Issues

Mental health was a theme mentioned by **16** (53.3%) respondents. From the comments below it appears that lack of access to mental health support is a pressing barrier:

*'People with co-existing issues / problems struggle to access a good level of support.'*

*'Mental health support is poor - people with substance misuse issues struggles to get access to mental health support particularly for trauma/ bereavement/ abuse.'*

*'There appears to be a barrier to drug users accessing mental health services.'*

*'Individuals with dual diagnosis of substance use and mental health problems (which again is a large proportion of individuals looking for help) are not getting the right supports. Turned away from mental health teams (if they can even get a referral submitted) as there is a*

*substance misuse problem and not enough resources/staff in substance misuse to support mental health problems. Large proportion of individuals self-medicating to deal with ongoing issues which are not being addressed.'*

*'One of the main barriers consistently cited is the lack of access to mental health services for people with problematic drug use.'*

Furthermore, the comments below provide accounts of the barriers individuals face when it comes to receiving mental health support if they have a co-occurring substance issue:

*'Drugs v's mental health – client is left with no treatment/ counselling due to ongoing drug use or passed from pillar to post between services with no progress.'*

*'If a person has problem drug (or alcohol) use, it appears that they are not entitled to mental health care. We frequently see people who have mental health problems as well as a problem with addiction (85% of the folk who attend our service). Sometimes mental problems can become acute. [Staff] at Carseview have refused to even see/assess folk when we have phoned about a serious problem. We have been advised to call the Police.'*

*'Accessing mental health support is difficult. If the mental health problems are identified after the drug misuse, then access to services appears to be through the Treatment service not the person's GP.'*

### Stigma Towards People Experiencing Drug Problems

Stigma towards people experiencing drug problems was a theme stated by **16** (53.3%) respondents. General stigma was cited by several respondents:

*'Stigma is a significant issue in Dundee.'*

*'There is so much stigma attached to service users who struggle with addictions. More needs to be done to make the public aware of the impact that this has and further ostracising them and their family only serves to exacerbate the problem.'*

*'Wider public attitudes and discrimination toward drug users.'*

The apparent stigma individuals receive from services was also mentioned:

*'Service re-enforcing stigma.'*

*'General stigma / discrimination towards clients, this has been observed whilst working in [named services] and within doctors' surgeries.'*

Furthermore, stigma within the chemist space (where people receive Opiate Replacement Therapy) is another challenge / barrier to developing opportunities for supporting people experiencing drug problems and their families:

*'Parents have voiced that the daily trip to the chemist (sometimes with their children) is shaming, labelling and disempowering.'*

*'Stigma and stigmatising systems for treatment delivery (methadone prescribing in community pharmacies).'*

*'The address for drug treatment services and the dispensing chemists are well known and as such attaches a stigma to the people using the service and also leads to a danger for women trying to avoid violent partners/ex partners as they know what chemist to go and wait at.'*

The role of the media was also highlighted with respondents indicating that media portrayal of substance use issues has a role to play in stigmatisation this vulnerable group:

*'The stigma experienced by those with problematic drug use and their families is a barrier, and this can be exacerbated by adverse media coverage of the issue.'*

*'Sensationalist local media reporting.'*

#### Poor Communication Between Services and Barriers to Information Sharing

Poor communication between services was stated by **14** (46.7%) respondents as a challenge / barrier:

*'It is very difficult to establish any communication with staff in the Integrated Substance Misuse Service (ISMS). We are seeing the same folk, although we may see them up to 3+ times per week. Yet when there are problems, we are not welcome to make any contribution, even when their patient requests this. We are probably the most significant 'protective factor' that some folk have, and yet we are effectively frozen out. We may in some instances be equivalent to their lead professional. Yet our resource is ignored, wasted.'*

*'All services need to communicate much quicker and freely (with consent).'*

*'Lack of communication between services especially prison and community.'*

*'Repetition and duplication of personal stories still occurs, highlighting the lack in communication between services.'*

Another aspect of communication relates to information sharing practices, with several respondents commenting that this is impacting on the level of care an individual can receive:

*'It can be very difficult obtaining information from substance misuse services in a timely manner and this can lead to delays in this information being shared within reports, meetings and also the worker involved with the children reacting to information, well after the concern (i.e. parent producing positive samples) was first noted by substance misuse workers.'*

*'The lack of proactive information sharing with regard to risk and the lack of immediacy with which ISMS share information.'*

*'People seem to fall through the net. Information is not being shared between services that would help to support clients.'*

#### Lack of Treatment Options Available (including lack of rehab/detox facilities)

This theme was stated by **14** (46.7%) respondents. A recurring theme in terms of the challenges and barriers faced in Dundee to developing opportunities for supporting people experiencing drug problems and their families appears to be a lack of rehabilitation facilities:



*'There is no facility in Dundee for residential drug detox. While it may not be a problem for folk to have to go to Perth, there are huge risks upon return to Dundee. It can be up to three weeks before a follow-up appointment – how can that work?'*

*'Dundee needs a dedicated residential rehabilitation facility where person-centred, truly holistic care can be provided in a safe environment. Cost is always cited as the reason for not providing this. Yet the costs of eviction, homelessness, ORT, being 'parked' on Methadone for years cannot surely be any less than giving folk a real hope and structure to enable them to move forward towards recovery.'*

*'No Rehab or detox facility locally.'*

*'Lack of meaningful rehabilitation/re-integration opportunities for those with a history of problematic drug use and associated criminalised behaviour.'*

Other relevant comments in terms of treatment options relate to lack of choice for individuals seeking support:

*'Often windows of opportunity are created which need to be responded to quickly. There is no service which can do this.'*

*'A lack of choice for service users over treatment options or worker.'*

#### Drug Treatment Services and Treatment Practices

Concerns over quality of drug treatment services and perceived punitive treatment practices was a theme stated by **13** (43.3%) respondents:

*'Treatment programmes – have tended to focus on a medicalised model of treatment rather than on a person-centred support (of which a treatment should be part of). Such an approach has meant that many of these vulnerable women haven't been able to build trusting relationships with staff in these services. Many women using our service have come to us because their methadone programme has been suspended.'*

*'Maintaining people in treatment is very important and whilst we accept that we are working with people perhaps more toward the complex and chaotic end of the spectrum of drug misuse this is an area we believe could be improved. People are suspended from their prescription with no apparent notice. They are not offered a rapid reassessment and usually have to go back to the beginning of the treatment cycle again e.g. filling drug diaries etc. This can take 12 weeks. The harm reduction advice is variable. Other agencies are not given prior warning. If someone misses three dispenses in a row, then they are automatically suspended from their prescription and are required to return to the beginning of the treatment cycle.'*

The issue of individuals apparently having to travel outside Dundee for treatment was also highlighted as a challenge:

*'We have experience of folk having to travel right across the city to reach the pharmacy where ORT is administered, and the ridiculous situation of people being forced to attend a pharmacy*

*in Perth on a daily basis, because there is no pharmacy that will or can take them in Dundee, they are told. People who have addictions are being punished for seeking help.'*

*'We have heard of some service users having to travel to Perth to receive their methadone because they have been "struck off" in Dundee.'*

For some respondents, inflexibility within services appears to be a pressing issue as demonstrated below:

*'There seems to be an 'impenetrable jungle' to get through at this very vulnerable stage. All the onus is on the patient to tick all the right boxes and meet very specific criteria. Failure at any point to achieve enough 'ticks' results in pretty summary dismissal from that service, leaving our folk knowing that they have 'failed yet again'; it makes them feel that they matter no longer – case closed.'*

*'There is also a lack of flexibility in the current treatment model. A worker cited one example of how a client's failure to produce a drugs diary meant that she would be denied treatment.'*

The appointments system individuals must adhere to was also cited as a barrier:

*'On occasions service users are expected to attend appointments daily usually at different times each day. Many of the service users are experiencing chaotic lives it would be helpful if the appointments were at least the same time every day.'*

*'Service users also attend appointments and are told that it has been cancelled because the worker is absent.'*

*'The appointments system involves letters usually. If the system says the letter went out, then the service user received the letter whether they did or did not. This can lead to missed appointments and could result in the loss of their prescription. However, service users also receive letters and attend their appointment to be told that there was no appointment for them that day. One service user received four letters for separate appointments in one week.'*

#### Workforce Issues (staff attitudes, culture, values, mistrust, etc.)

Workforce issues was a theme stated by **11** (36.7%) respondents, with staffing issues raised:

*'The attitude of some staff is not enabling. It would appear that the default position is that all service users are lying. There is also a perception held by service users that the treatment service has all the power and control over decisions.'*

*'Women have also told us of feeling forced into a certain course of action by substance misuse / statutory services (including health) – in terms of the support they are offered. This sense of pressure can be compounded by their sense of lacking control / power in their own lives and also because of the power imbalance (perceived and also real) in a support / treatment relationship.'*

The language used by professionals was also mentioned:

*'Lack of cohesive positive or ambiguous language used by all professionals i.e. use of the word "Junkie" by professionals in informal chat.'*

As seen below, current services' culture and values appear to present a barrier:

*'To improve how drug support services are delivered in Dundee there needs to be work undertaken to develop a new culture across disciplines and professions and hopefully a position of shared vision and values. At present it is my perception that prescribing ORT type drugs is seen as the most importance focus and the "medical model" is the accepted doctrine. This is under the control of the NHS and is, unsurprisingly viewed through a disease model lens.'*

*'Apparent lack of shared vision or values between social work and NHS drug treatment staff.'*

### Family

Family was a theme specified by **11** (36.7%) respondents. A lack of support for family members was stated:

*'Lack of support for families. To paraphrase a recent comment from a mother 'My son needs to recover but so does my family.'"*

*'In terms of the support that is offered to families where there are substance misuse issues, there is a general consensus that it seems to be a 'one size fits all' response.'*

*'Limited time to spend with families due to ongoing pressures - competing time. Family breakdown. Family dysfunction.'*

*'With the continuing drug related deaths, we are not supporting individuals who are continually losing their friends and family recognising the impact this is having on their health and wellbeing.'*

The lack of a family members' involvement in their loved-one's recovery journey was also put forward:

*'Lack of the involvement of families or carers in the individual's recovery.'*

### Trauma Informed Support

A lack of trauma informed support, including identification of, and support for Adverse Childhood Experiences, was a theme stated by **8** (26.7%) respondents:

*'The ability to address underlying issues in a service user's life which may well have a significant impact on their drug use is poor e.g. trauma.'*

*'Lack of support of those who achieve stability to address their trauma and underpinning reasons for use of drugs.'*

*'The core drug service, ISMS, is over stretched and as a result is very much a prescribing service with limits to what therapeutic work can be undertaken with service users. The latter is what service users need to overcome trauma/adverse experiences from early childhood, which is often at the root of substance misuse.'*

*'Courts have a lack of understanding of our clients' issues around trauma and addiction and have too high expectations of change in too short a time frame.'*

Furthermore, the specific needs of women and young people were also identified:

*'We need to consider the specific needs of women who have problematic substance misuse and also the additional risks they face, particularly of gender-based violence and abuse, including prostitution, sexual violence and domestic abuse. Additionally, many women with substance misuse issues have experienced many forms of childhood abuse.'*

*'The young people we work with are significantly impacted on by multi-layered trauma and Adverse Childhood Experiences. Many of the young people have chaotic substance misusing parents who they have been removed from but who they return to when they leave care. There does not appear to be enough of a focus or priority given to ensuring that young people, particularly care leavers, receive appropriate support to deal with the trauma that impacts on their emotional and mental well-being, their ability to cope which in turn impacts on their employment prospects and how the system helps them.'*

### Housing

Housing was a theme mentioned by **8** (26.7%) respondents. Lack of appropriate housing and recognition of the importance of appropriate housing were key issues as demonstrated below:

*'Housing difficulties; people struggle to move area when they are trying to change their lifestyle and if this is not facilitated it is highly likely they will return to previous behaviours.'*

*'In terms of social housing, people within the substance using population are often in receipt of benefits and therefore cannot afford to live in the sought-after areas in Dundee. This creates an issue in that people from this population are often allocated housing within multi-storey blocks where - more often than not - other people who use substances are also placed. This makes it extremely difficult for those in recovery to move on with their lives in an environment which is free from temptation and supportive. Poor housing opportunities coupled with relapse triggers makes it very difficult to develop opportunities to support people with an addiction.'*

*'Meeting the holistic needs of these women is also very challenging as they are often not able to get access to refuge, appropriate homeless accommodation, mental health services and sexual violence support services because they are deemed too chaotic.'*

*'Having to live in a hostel with other drug users when I'm doing well.'*

### Wider Support Services

A lack of, and poor accessibility to, wider support for clients was stated by **8** (26.7%) respondents as a challenge / barrier faced as demonstrated in the comments below:

*'So much more support is needed.'*

*'Lack of services and resources.'*

*'Lack of awareness of the wider issues affecting substance user's i.e. mental health, homelessness, family, abuse, trauma.'*

## **What examples are there of support and treatment improving the lives of people experiencing drug problems and their families in Dundee?**

**24** responses were received to this question. Generally, there were very few consistent 'specific' examples given through the responses given to this question. The consistent responses identified tended to be grouped around more general themes of:

- more recovery activity in Dundee;
- the evolution of the community hubs;
- development of Peer Support initiatives; and
- an increase in the number of mutual aid groups.

## **We would also like to know what issues you think (and why) the Commission needs to investigate and report on?**

This question received **26** responses and from our analysis of responses given, there appears to be several key themes mentioned consistently by respondents. Analysis of responses under each of these themes has allowed us to develop the following key set of questions:

### **Drug Deaths**

Why does Dundee in particular have such a high rate of drug related deaths and what can be done to reduce the number of deaths as quickly as possible?

### **Stigma**

What can be done to tackle stigma of drug use and people experiencing drug problems – from the public, the press and from some professionals?

### **Treatment Options**

Why is Dundee not offering more treatment options (and frequency of), including: rehabs, detox, low threshold prescribing and other prescribing options - taking into account and learning from other countries/cities?

### **Waiting Times**

How can waiting times for drug treatment services be reduced so that lost opportunities (when individuals are wanting to engage) are lessened?

### **Capacity**

Is there enough capacity in Dundee to work with existing levels of substance misuse? Why are caseload numbers so high?

### **Partnership Working**

What are the barriers preventing better partnership working and a more holistic approach to supporting individuals in Dundee, and how can they be overcome?

## **Mental Health Support**

Why do Mental Health services appear to be unable/unwilling to work with people until they address their substance misuse?

## **Workforce**

Why does there appear to be so much mistrust between services and staff of different services?

## **APPENDIX XII: 'DEEPER DIVE' OF DRUG-RELATED DEATH DATA (DUNDEE V'S REST OF SCOTLAND)**

Following discussions with, and a presentation to, the Commission by Lesley Graham (Clinical Lead for Alcohol, Drugs and Health in Justice Settings, ISD Consultant Team) and Lee Barnsdale (Principal Information Analyst [Drugs], ISD) a formal request was made to ISD for provision of a 'Deeper Dive' of Drug-related Death data to compare a set of key parameters between Dundee and the rest of Scotland. The aim was to identify if there are any particular factors of significant relevance to Dundee in relation to DRDs, compared to other areas of Scotland.

The dataset provided by ISD was submitted to the DADP on 27<sup>th</sup> May 2019 and then forwarded to the Dundee Drugs Commission. A team of statisticians from the Leverhulme Research Centre for Forensic Science agreed to conduct a rapid, independent review of the data to perform an observational analysis. Their report is provided below:

### **Analysis of the Deeper Dive of Drug Related Death Data (Dundee City vs Rest of Scotland)**

Report produced: 14/06/2019:

Analysis conducted and report prepared by: Christian Cole, Emma Comrie, Harry Gray & Joyce Klu.

Data Used: Copy of 'IR2019-00518\_Final\_20190527' spreadsheet

#### Notes on analyses

When reading the following report please be aware of the following. First, the data provided was for drug related deaths (DRDs) from two locations, namely Dundee City and Rest of Scotland for the 2009-16 period. The number of DRDs in Dundee City, both annually and aggregated over the 2009-16 time period is small and this should be taken into consideration when reviewing the report. For example, over the years there are between five and 12 female DRDs in Dundee, thus a difference of one or two due to reporting issues would be noticeable. Second, the analyses conducted were based only on the data provided, no additional information was provided to the analysts. A final note: the analysts do not have training in drugs and drug-related factors.

#### Summary of Key Insights

The following are the main insights from the analysis of the data.

- When the data are plotted, a visual difference can be seen between the trends in Dundee City versus Rest of Scotland in some of the variables from 2009 until 2013/14 period and then this reduces up until 2016. Note: this is only for a short period of time and the small number of deaths in Dundee means that the trends are more volatile than Rest of Scotland. The following are examples:

- Mean age at death (see Table 4b analysis);
- Percentage of DRDs living alone (see Table 6a analysis);
- Percentage of DRDs prescribed OST at time of death (see Table 8a analysis);
- Percentage in contact/not in contact with drug service (Table 11 analysis);
- Percentage with known overdose (Table 12 analysis); and
- Percentage of deaths with alcohol problem (Table 13 analysis).
- In Dundee City there is a higher proportion of the recorded DRDs with a known psychiatric condition when compared to Rest of Scotland (see Figure 25).
  - Relatedly, there is a higher proportion of DRDs with associated recently prescribed anti-depressants and anti-psychotics (Table 20a).
- There are more DRDs in Dundee in the 25-34 and 35-44 age groups than DRDs in Rest of Scotland (Figure 4).
- Females make up a higher percentage of DRDs in Dundee City when compared to the percentage of female deaths in Rest of Scotland (Figure 3).
- The proportion of DRDs in the lowest SIMD quintile in Dundee City are higher than the rest of Scotland (Figure 8).
- Dundee city had higher proportion of DRDs with a known medical condition when compared to Rest of Scotland (Figure 22).
- Dundee City had a higher proportion of post mortems with the following drugs present when compared to Rest of Scotland: Methadone/EDDP, Anti-depressants, Phenazepam, Etizolam, Gabapentin and Pregabalin (Table 16a analysis).
- Dundee City had the following drugs implicated in DRDs more often than the rest of Scotland: Diazepam, Methadone/EDDP, Phenazepam, Etizolam, Pregabalin, Alprazolam, and All Other Drugs (Table 17b analysis).



### Table 1 Analysis:

Table 1: Number & % of Deaths by Suicide<sup>1</sup> by DRD Location; 2009-16 aggregate.<sup>2</sup>

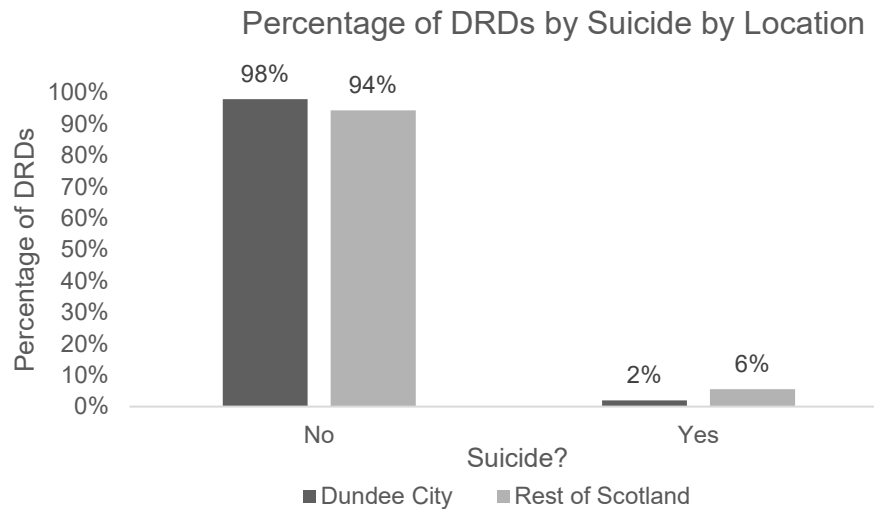


Figure 1: In both areas, Dundee City and Rest of Scotland, suicide accounts for only a small percentage of the drug related deaths. In the 2009-16 period, the aggregate percentage number of DRDs by suicide in Dundee City is 2.0%, which is less than half than that recorded in Rest of Scotland (5.6%).

From Figure 1, the percentage of death by suicide is low for Dundee City compared to the rest of Scotland.

### Table 2 Analysis:

Table 2: Number & % of DRDs by DRD Location; 2009-16.<sup>3</sup>

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<sup>1</sup> Deaths by suicide are excluded from the analyses presented in the remainder of this workbook.

<sup>2</sup> Note: table number, title and footnote are taken from the data provided.

<sup>3</sup> Note: table number and title are taken from the data provided.

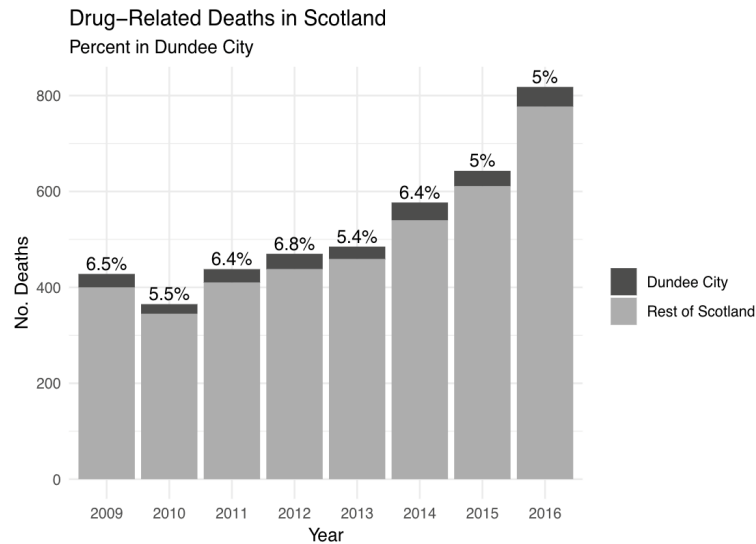


Figure 2: On average, between 2009 and 2016, Dundee City's DRDs account for approximately 5.8% of the total DRDs in Scotland. From 2009 to 2016, there is only a small fluctuation in the percentage, varying between a minimum of 5% and a maximum of 6.8%. In Scotland as a whole, DRDs have increased 91.1% since 2009.

Based on Figure 2, the number of drug deaths recorded in both Dundee and the Rest of Scotland are rising although the proportion in Dundee is marginally dropping.

#### Table 3 Analysis:

Table 3: Number & % of DRDs by Sex; 2009-16.<sup>4</sup>

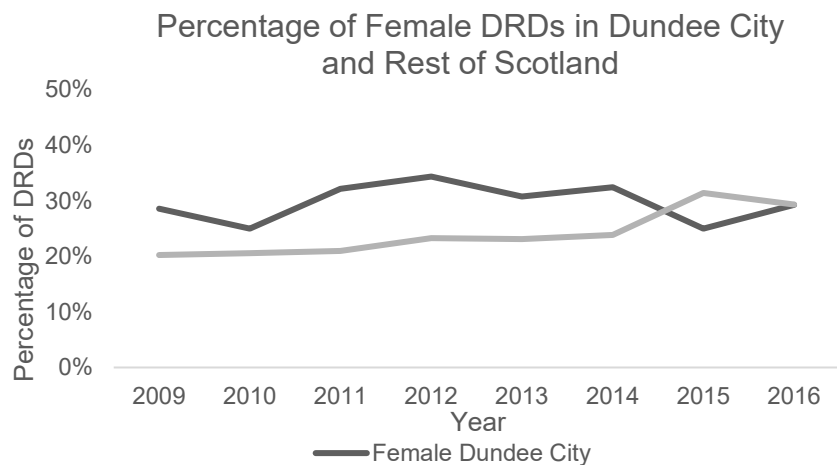


Figure 3: Over the 2009-16 time period, the average percentage of drug related deaths that are female for Dundee City and Rest of Scotland are 29.9% and 25.0%, respectively. This shows that: (1) in both areas there is a higher percentage of male than female DRDs, (2) that there are more female DRDs in Dundee than seen in the Rest of Scotland, and (3) only in 2015 is the percentage of female deaths lower in Dundee City when compared to Rest of Scotland. Note: only female percentages are shown as male percentages can be inferred based on the female percentages.

<sup>4</sup> Note: table number and title are taken from the data provided.

From Figure 3, the percentage of DRDs is higher for females in Dundee compared to the rest of Scotland over the years except for 2015 where it is lower and 2016 where they are the same.

#### Table 4a Analysis:

Table 4a: Number & % of DRDs by Age Group and DRD Location; 2009-16 aggregate.<sup>5</sup>

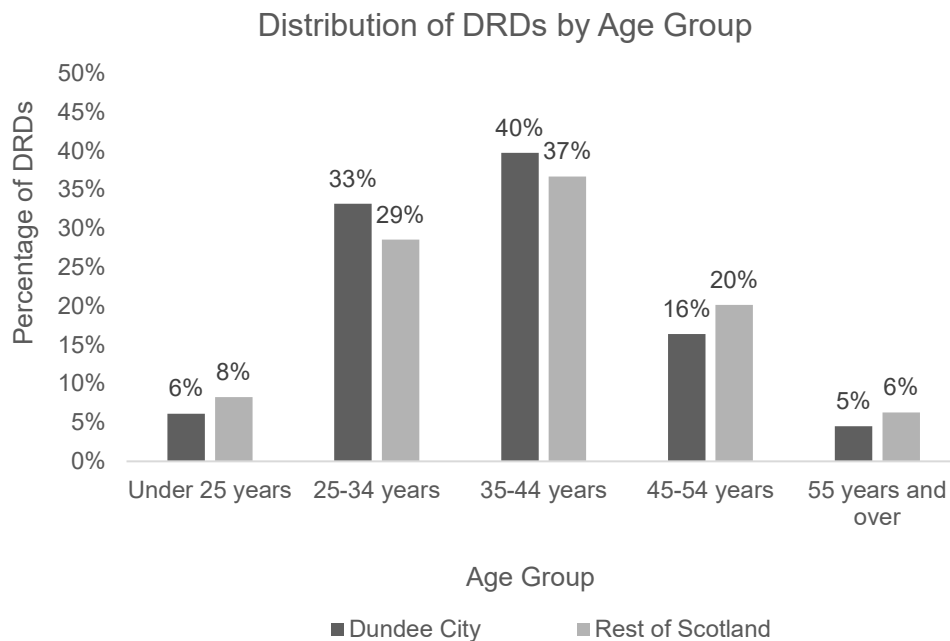


Figure 4: In both locations, Dundee City and Rest of Scotland, higher percentages of DRDs are in the 25-34 year old and 35-44 year old age categories. When comparing the two areas, Dundee City has a higher percentage of deaths in the 25-34 and 35-44 year old age categories than the Rest of Scotland and has lower percentages in the remaining categories (under 25, 45-54 and 55 and over).

From Figure 4, both Dundee City and Rest of Scotland have higher percentages of DRDs in the 25-34 year old and 35-44 year old age categories. When comparing the two areas, Dundee City has a higher percentage of deaths in the 25-34 and 35-44 year old age categories than the Rest of Scotland and has lower percentages in the remaining categories (under 25, 45-54 and 55 and over).

#### Table 4b Analysis:

Table 4b: Number & Mean Age at Death by Sex and DRD Location; 2009-16.<sup>6</sup>

<sup>5</sup> Note: table number and title are taken from the data provided.

<sup>6</sup> Note: table number and title are taken from the data provided.

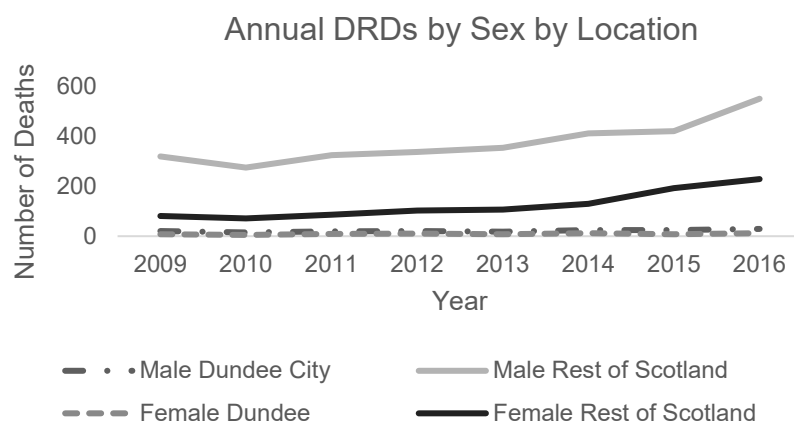


Figure 5: In Rest of Scotland, there is an upward trend in the number of DRDs recorded each year for both males and females, with males DRDs having a sharp increase between 2015 and 2016.



Figure 6: In Dundee City, there is a slight upward trend in the number of deaths per year for both males and females.

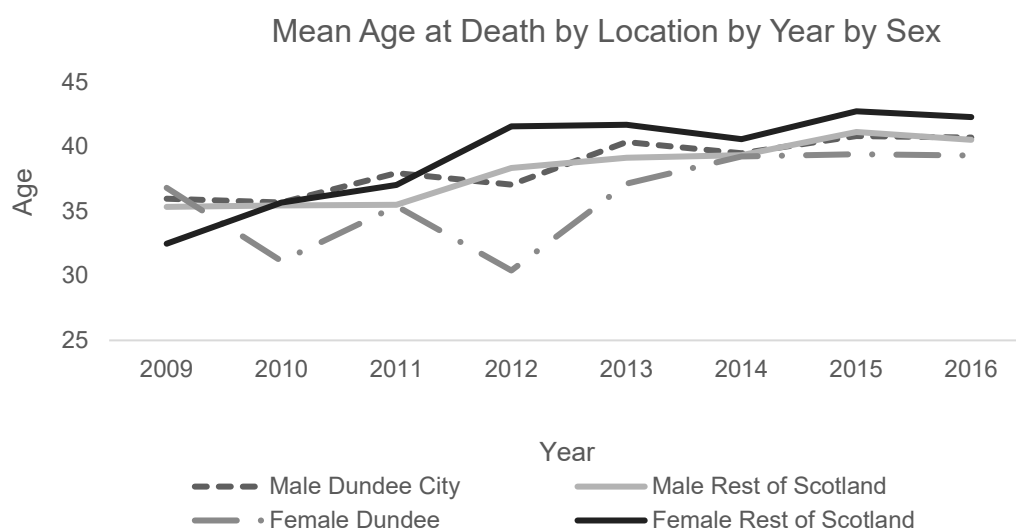


Figure 7: General increasing trend in the mean age of DRDs for the two locations and by sex during the 2009-16 period. The mean female age of Dundee DRDs oscillates over time, particularly in the 2009-2013 period, then steadying over the 2014-16 period. Comparing the age of deaths of females in Dundee to the rest of Scotland, the age of death is younger (except 2009). Mean age of male deaths in both locations are similar over the time period.

From Figure 7, a general increasing trend in mean age is observed for DRDs over the 2009-16 period. Mean female age of Dundee DRDs oscillates over time, particularly in the 2009-2013 period, and the following 2014-16 is approximately steady. Comparing the mean age of death of females in Dundee to the rest of Scotland, the mean age of death is younger (except 2009). The mean age of male deaths in both locations are similar over the time period.

Table 5 Analysis:

Table 5: Number & % of DRDs by SIMD Quintile and DRD Location; 2009-16 aggregate.<sup>7</sup>

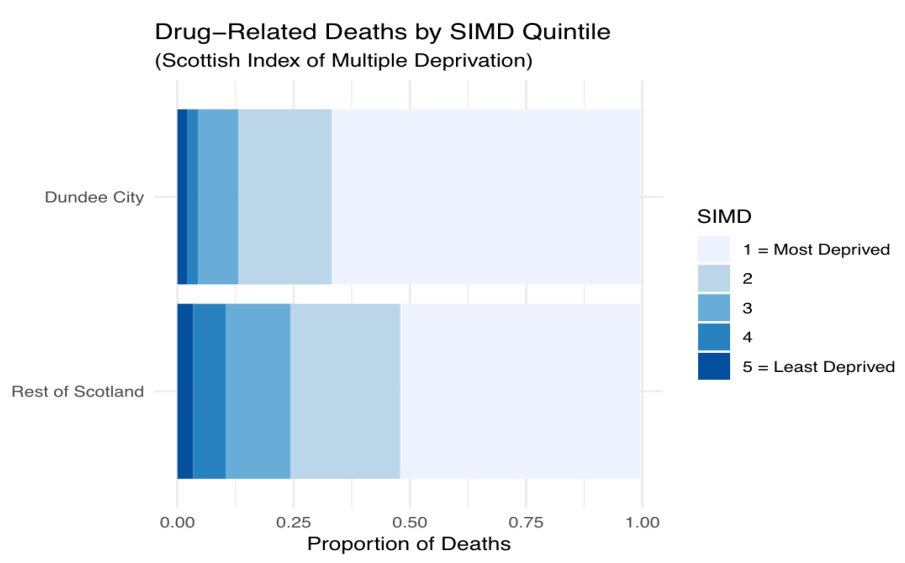


Figure 8: The distribution of DRDs across the five SIMD Quintiles within each location are similar, namely there is a higher percentage DRDs belonging to the lowest SIMD Quintile and a decreasing percentage as the quintile increases to 5. Dundee City, however, has a higher percentage of deaths (66%) with a SIMD Quintile of 1, the lowest level of deprivation, when compared to the rest of Scotland (52%).

From Figure 8, the distribution of DRDs across the five SIMD Quintiles within each location are similar, namely there is a higher percentage DRDs belonging to the lowest SIMD Quintile and a decreasing percentage as the quintile increases to 5.

Table 6a Analysis:

Table 6a: Number & % of DRDs Living Alone<sup>8</sup>; 2009-16.<sup>9</sup>

<sup>7</sup> Note: table number and title are taken from the data provided.

<sup>8</sup> This category is derived from the multiple response 'Living with whom' variable within the NDRDD dataset. 'Living alone' indicates that the individual who died lived alone all or part of the time in the period immediately prior to their death (i.e. that 'lives alone' was one of the responses provided).

<sup>9</sup> Note: table number, title and footnote are taken from the data provided.

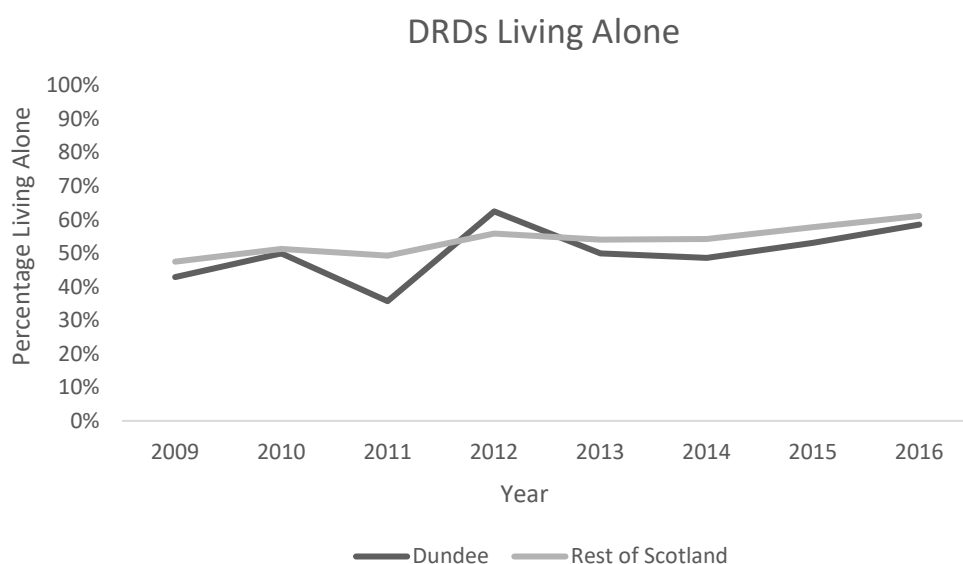


Figure 9: The percentage of DRDs living alone is lower in Dundee City than the Rest of Scotland except in 2012.

#### Table 6b Analysis:

Table 6b: Number & % of DRDs Living Alone Only<sup>10</sup>; 2009-16.<sup>11</sup>

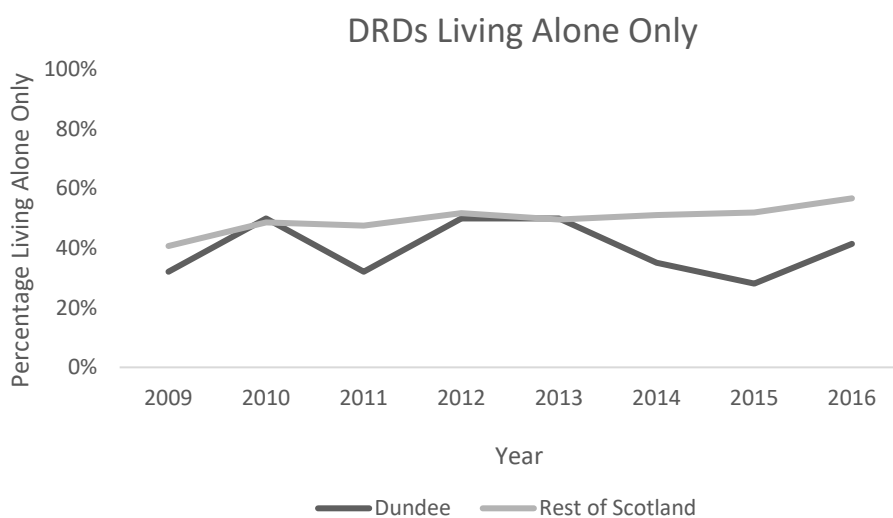


Figure 10: General increasing trend in the Rest of Scotland. Variation in the percentage of DRDs living alone only over the 2009-16 time period.

<sup>10</sup> This category is derived from the multiple response 'Living with whom' variable within the NDRDD dataset. 'Living alone' indicates that the individual who died lived alone all of the time in the period immediately prior to their death (i.e. that 'lives alone' was the only response provided).

<sup>11</sup> Note: table number, title and footnote are taken from the data provided.

### Table 7a Analysis:

Table 7a: Number & % of DRDs with Children under 16 years; 2009-16.<sup>12</sup>

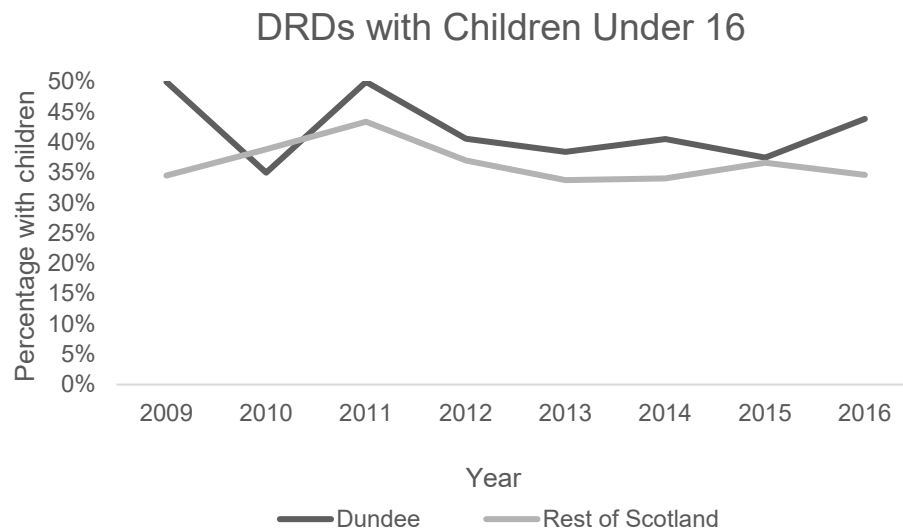


Figure 11: Dundee has a higher recorded percentage of DRDs with children under 16 than Rest of Scotland.

### Table 7b Analysis:

Table 7b: Number & % of DRDs with Children under 16 years living at home by DRD Location; 2009-16 aggregate.<sup>13</sup>

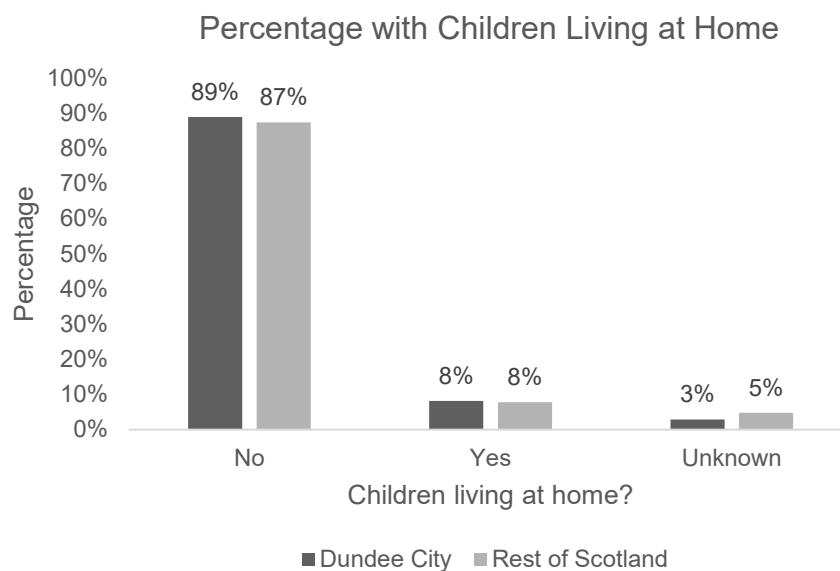


Figure 12: Similar distribution of DRDs with and without children living at home in the two areas.

<sup>12</sup> Note: table number and title are taken from the data provided.

<sup>13</sup> Note: table number and title are taken from the data provided.

### Table 8a Analysis:

Table 8a: Number & % of DRDs prescribed OST at time of death; 2009-16.<sup>14</sup>

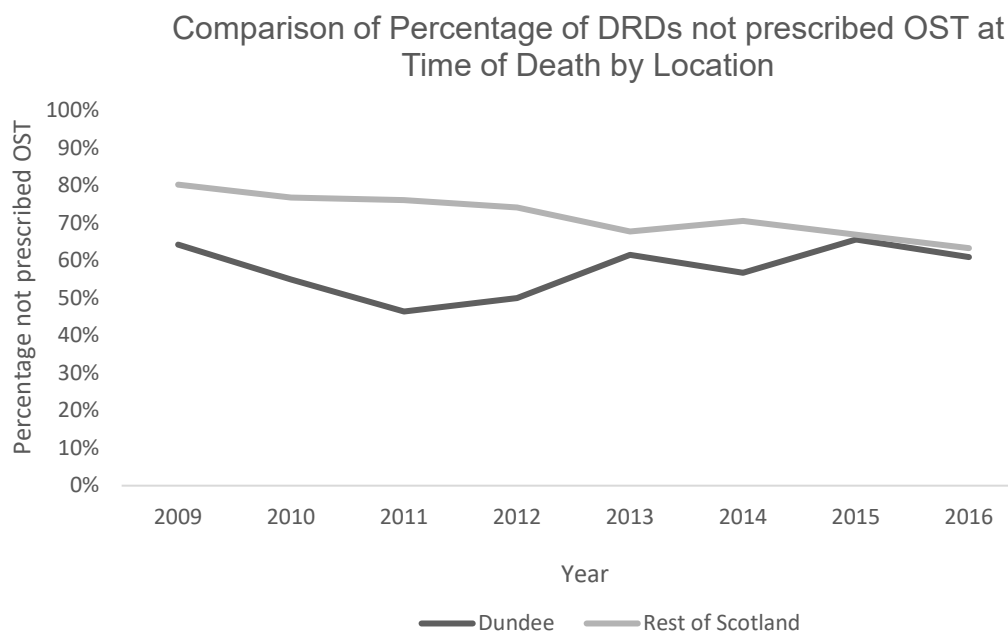


Figure 13: In the 2009-16 period, the percentage of drug related deaths in Dundee City that had not been prescribed OST is lower than that in the Rest of Scotland. Note: percentage prescribed OST is not shown as can be inferred from the chart – in the time period there is a higher percentage of DRDs in Dundee prescribed an OST at time of death when compared to the Rest of Scotland. Differences in the percentage prescribed OST are seen between 2009 and 2014 but in 2015 and 2016 the percentages are similar. Note: there is an “unknown” category with small percentages for the rest of Scotland data which has not been shown.

In Figure 13, the percentage of drug related deaths in Dundee City that had not been prescribed OST is lower than that in the Rest of Scotland. Alternatively, in the time period there is a higher percentage of DRDs in Dundee prescribed an OST at time of death when compared to the Rest of Scotland.

### Table 8b Analysis:

Table 8b: Number & % of DRDs by OST prescription type<sup>15</sup> and DRD Location; 2009-16 aggregate.

<sup>16</sup>

<sup>14</sup> Note: table number and title are taken from the data provided.

<sup>15</sup> Individuals not prescribed an OST at the time of death are excluded.

<sup>16</sup> Note: table number, title and footnote are taken from the data provided.



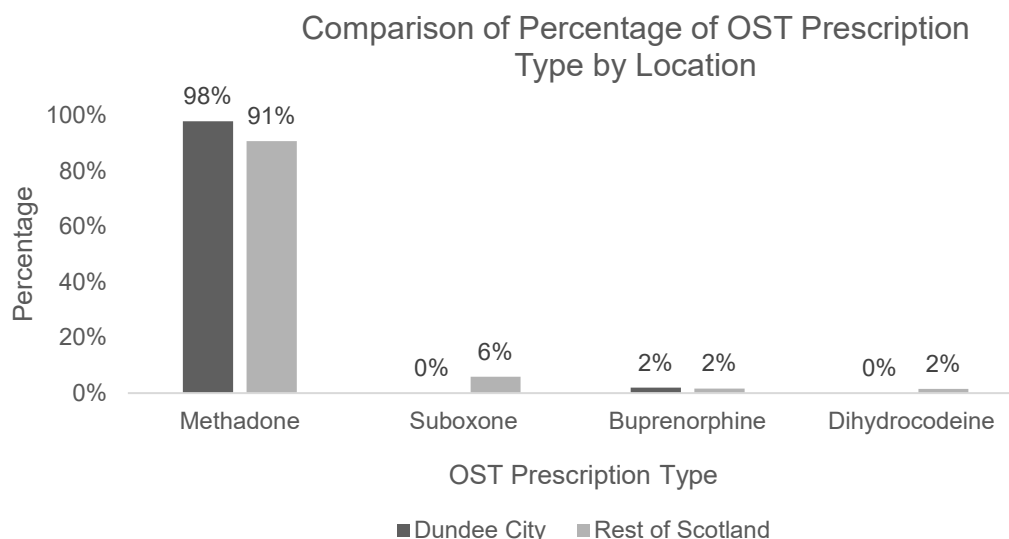


Figure 14: A comparison of the OST prescriptions show that, as a percentage, in both Dundee City and the Rest of Scotland, Methadone is the most frequently prescribed OST. There are three other prescribed OSTs - Suboxone, Buprenorphine and Dihydrocodeine which make up much smaller percentages. In Dundee City, Methadone is prescribed in 98.1% of prescriptions, higher than in the Rest of Scotland (90.9%). Suboxone has not been prescribed in Dundee City (0%), which is less than in the Rest of Scotland where it accounts for 5.9% of the prescriptions.

In Figure 14, a comparison of the OST prescriptions show that, as a percentage, in both Dundee City and the Rest of Scotland, Methadone is the most frequently prescribed OST. There are three other prescribed OSTs - Suboxone, Buprenorphine and Dihydrocodeine which make up much smaller percentages. In Dundee City, Methadone is prescribed in 98.1% of prescriptions, higher than in the Rest of Scotland (90.9%). Suboxone has not been prescribed in Dundee City (0%), which is less than in the Rest of Scotland where it accounts for 5.9% of the prescriptions.

#### Table 9 Analysis:

Table 9: Number & % of DRDs by Length of OST prescription<sup>17</sup> and DRD Location; 2009-16 aggregate.<sup>18</sup>

<sup>17</sup> Individuals not prescribed an OST at the time of death are excluded.

<sup>18</sup> Note: table number, title and footnote are taken from the data provided.

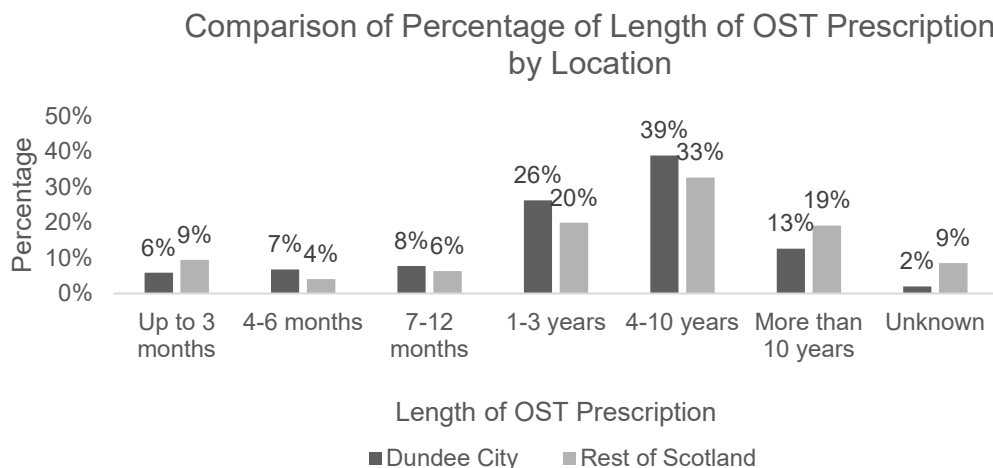


Figure 15: Note: when reading the chart, the categories are of different interval lengths. The categories with the highest percentage lengths of OST prescription for both locations are 4-10 years followed by 1-3 years. In both of these categories, the Dundee City percentage is higher than the Rest of Scotland.

In Figure 15, the categories with the highest percentage lengths of OST prescription for both locations are 4-10 years followed by 1-3 years. In both of these categories, the Dundee City percentage is higher than the Rest of Scotland.

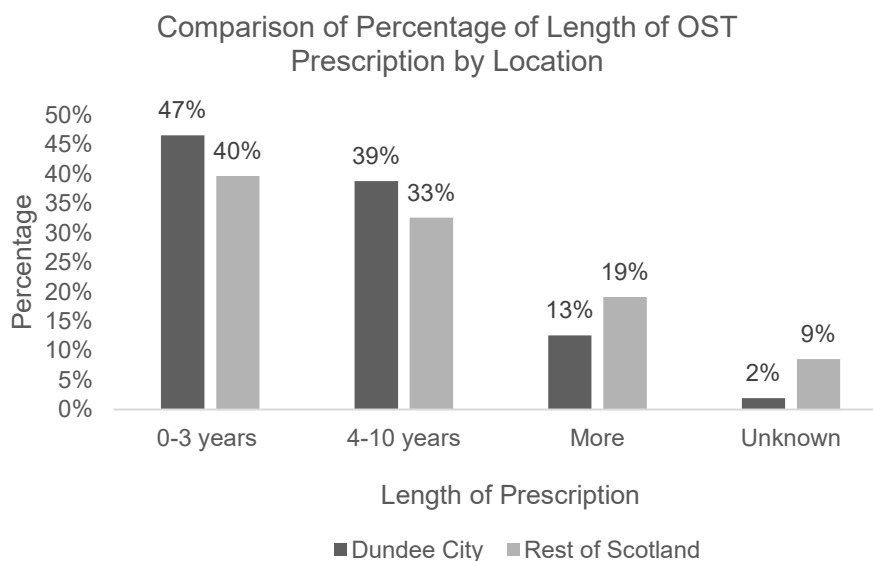


Figure 16: Same as above, with the following categories grouped together - up to 3 months, 4-6 months, 7-12 months and 1-3 years. In both Dundee City and Rest of Scotland, the highest percentage of DRDs are in the 0-3 year category.

#### Table 10 Analysis:

Table 10: Number & % of DRDs by OST dosage (methadone/buprenorphine only) and DRD Location; 2009-16 aggregate.<sup>19</sup>

<sup>19</sup> Note: table number and title are taken from the data provided.

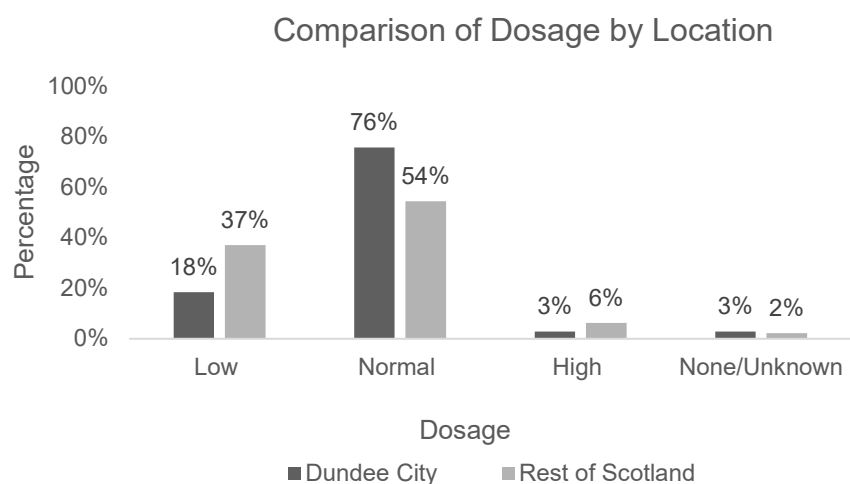


Figure 17: Note: Low = (M: <60 mg, B: <12 mg); Normal = (M: 60-120 mg, B: 12-16 mg); and High = (M: >120 mg, B: >16 mg). The figure shows that the highest percentage of deaths in both areas have a 'normal' level of opioid substitution treatment (OST) dosage. Dundee City has a fewer DRDs in the 'Low' dosage of OST than the rest of Scotland.

#### Table 11 Analysis:

Table 11: Number & % of DRDs in contact with drug treatment service at time of death; 2009-16.<sup>20</sup>

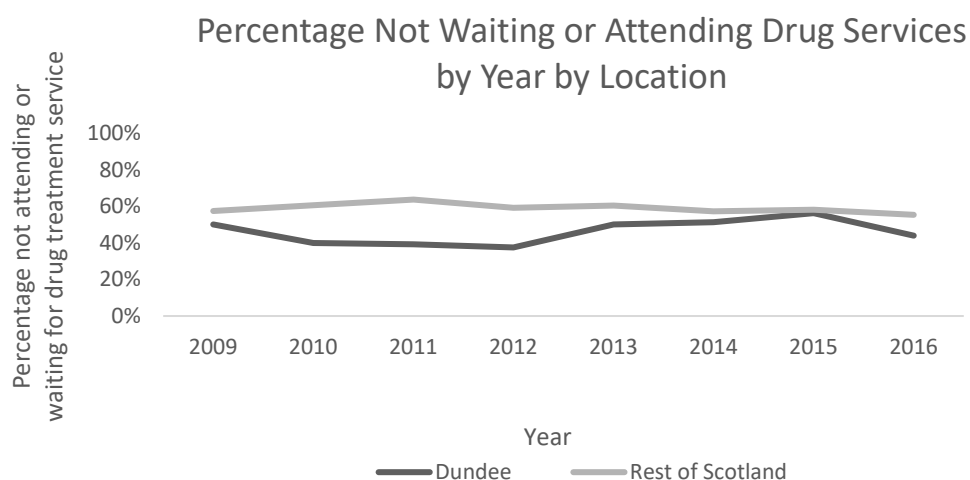


Figure 18: Note: the percentages of those either waiting or attending a drug service is not shown but can be inferred from the chart above. In the 2009-16 time period, the percentage of DRDs not in contact with drug treatment services at time of death is generally flat for both locations. When comparing Dundee City to Rest of Scotland, the percentage not attending or waiting for drug treatment services is lower than the Rest of Scotland. Of DRDs in Dundee City there is a higher percentage who are attending or waiting to attend a drug treatment service than not attending. In Rest of Scotland, there is a lower percentage of DRDs who are attending or waiting to attend a drug treatment service at time of death. This means that of the DRDs in Dundee, there is a higher percentage of people who are attending or in contact with the drug treatment services.

<sup>20</sup> Note: table number and title are taken from the data provided.

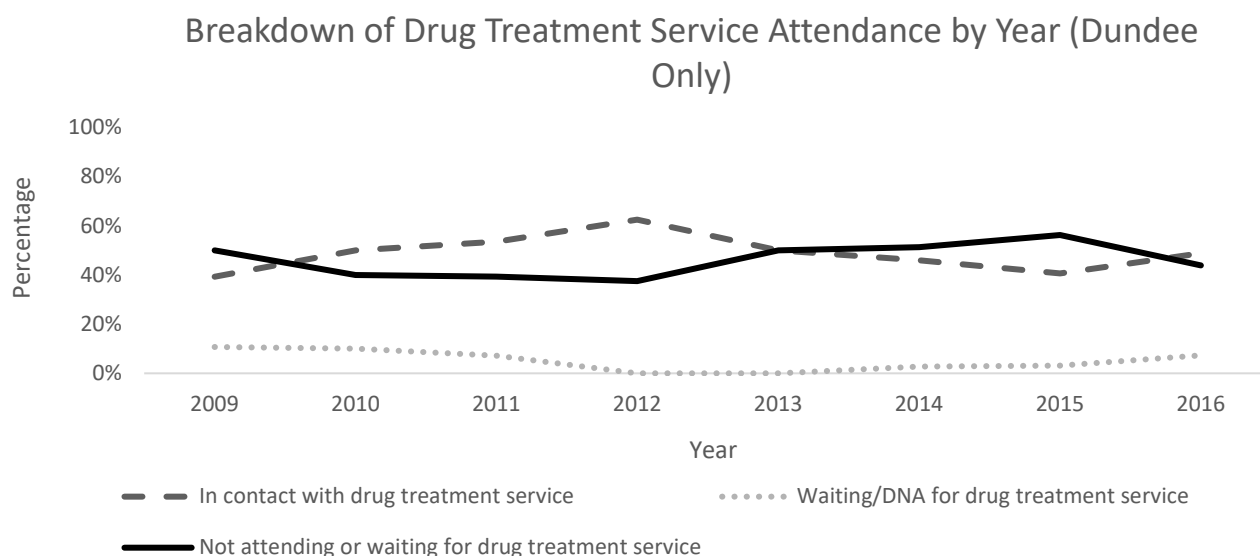


Figure 19: Breakdown of DRDs by relationship with drug services by year for Dundee's DRDs only showing: (1) the percentage of DRDs in contact with drug treatment services peaked in 2012 at 62.5%, and (2) in 2012 and 2013 no individual was waiting/DNA for drug treatment service. (DNA: did not attend).

#### Table 12 Analysis:

Table 12: Number & % of DRDs with known overdose prior to death; 2009-16.<sup>21</sup>

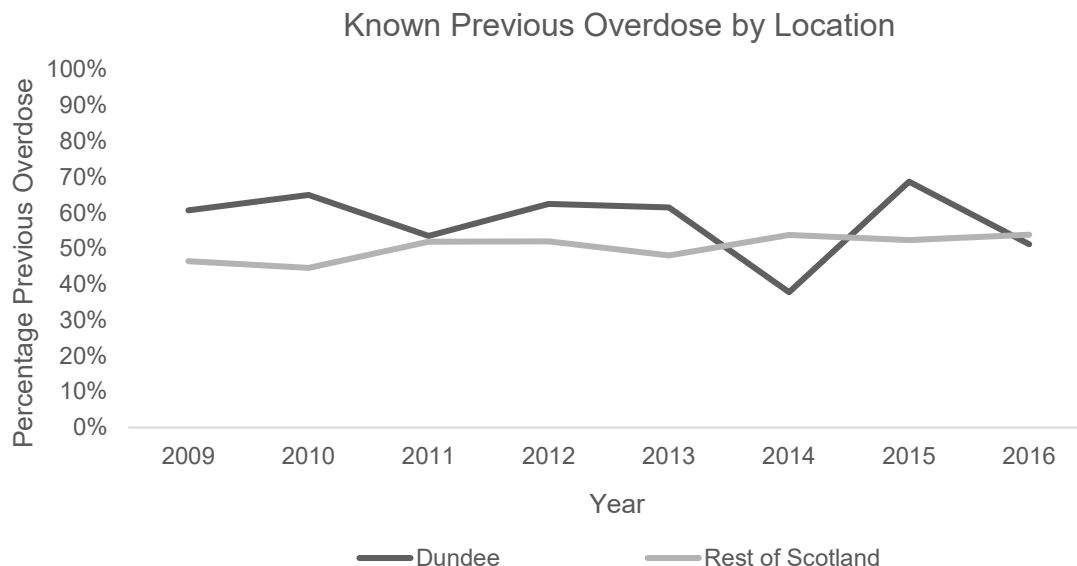


Figure 20: Note the percentage of "No known overdose" is not shown but can be inferred. Between 2009 and 2013, the percentage of deaths with a known previous overdose is higher in Dundee City than the Rest of Scotland. In 2010, there is a difference of 20.36% between the deaths in Dundee with a known overdose and those in the Rest of Scotland. There is a sharp decrease in 2014, where the percentage in Dundee City is lower than the Rest of Scotland. In 2016, the percentages are similar.

<sup>21</sup> Note: table number and title are taken from the data provided.

### Table 13 Analysis:

Table 13: Number & % of DRDs with known problem alcohol use<sup>22</sup> recorded prior to death; 2009-16.<sup>23</sup>

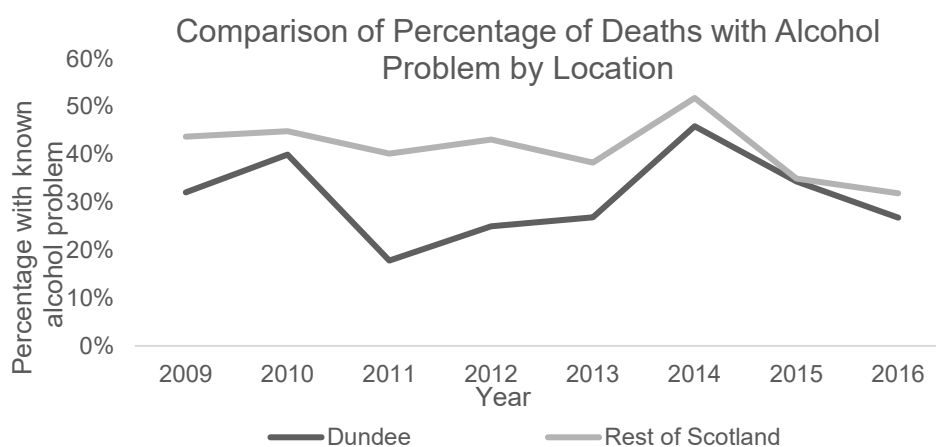


Figure 21: Note: percentage of DRDs with no alcohol problem recorded is not shown but can be inferred from chart. In the period between 2009-16, the percentage of deaths with a known alcohol problem is lower in Dundee than in the Rest of Scotland.

### Table 14 Analysis:

Table 14: Number & % of DRDs with recent medical condition<sup>24</sup> recorded prior to death; 2009-16 aggregate.<sup>25</sup>

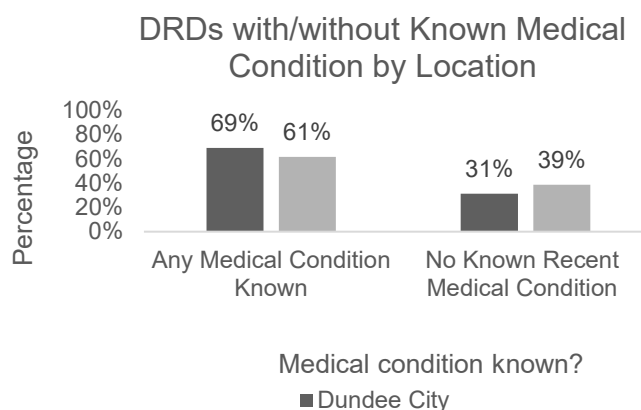


Figure 22: Of DRDs, there is a higher percentage with a known medical condition recorded prior to death in Dundee compared to Rest of Scotland, 68.9% as opposed to 61.5%.

<sup>22</sup> Categorisation based on evidence of recent (within 6 months of death) problem alcohol use within the psychiatric condition, medical condition, mental health, contact with non-drug treatment services and recent alcohol treatment variables of the NDRDD dataset.

<sup>23</sup> Note: table number, title and footnote are taken from the data provided.

<sup>24</sup> The denominator for the individual condition categories is the 'Any Medical condition' category. Multiple conditions can be entered. Therefore, the sum of the individual condition categories is greater than the number shown in the 'Any Medical condition' category.

<sup>25</sup> Note: table number, title and footnote are taken from the data provided.

From Figure 22, Dundee has higher percentage with a known medical condition recorded prior to death compared to the Rest of Scotland.

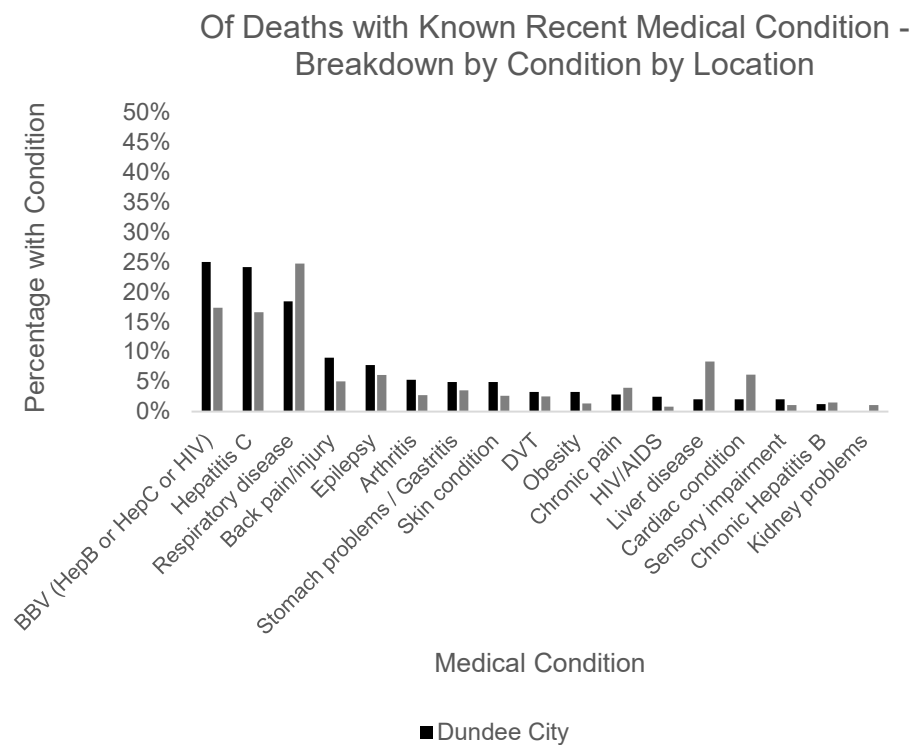


Figure 23: Note: some conditions are represented more than once, for example Hepatitis C appears alone and as part of BBV. Of those deaths with at least a known medical condition, the breakdown of conditions show that BBV is the highest percentage in Dundee City, whereas in the Rest of Scotland Respiratory disease is the highest percentage.

Figure 23 shows that of those deaths with at least one known medical condition, the breakdown of conditions show that BBV is the highest percentage in Dundee City, whereas in the Rest of Scotland Respiratory disease is the highest percentage.

Table 15 Analysis:

Table 15: Number & % of DRDs with recent psychiatric condition<sup>26</sup> recorded prior to death; 2009-16 aggregate.<sup>27</sup>

<sup>26</sup> The denominator for the individual condition categories is the 'Any Psychiatric condition' category. Multiple conditions can be entered. Therefore, the sum of the individual condition categories is greater than the number shown in the 'Any Medical condition' category.

<sup>27</sup> Note: table number, title and footnote are taken from the data provided.

### Comparison of Deaths by Known/No Known Psychiatric Condition in 6 Months Prior to Death by Location

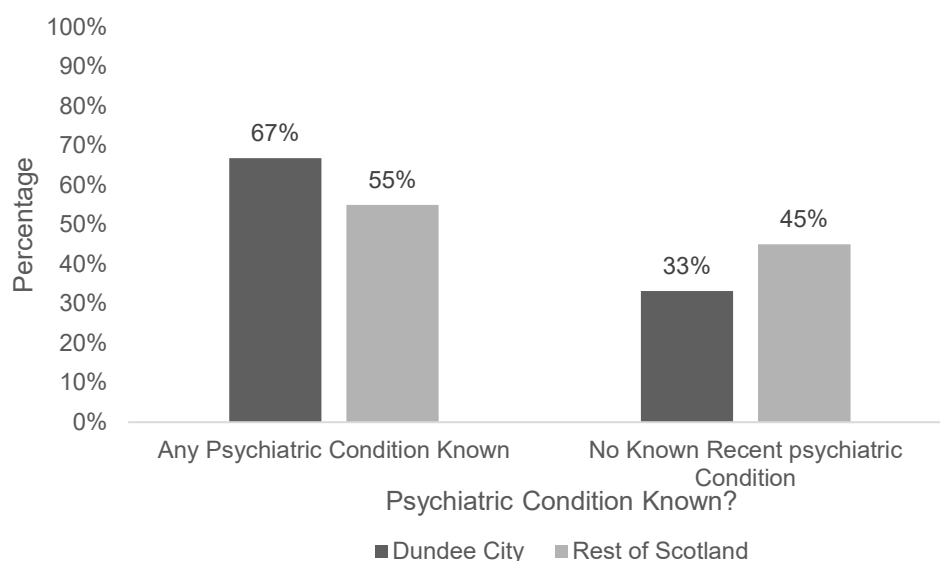


Figure 24: Dundee City has a higher percentage of deaths with at least one known psychiatric condition in the 6 months prior to death of 66.8% compared to 54.9% in the Rest of Scotland.

Figure 24 shows that Dundee City has a higher percentage of deaths with at least one known psychiatric condition in the 6 months prior to death of 66.8% compared to 54.9% in the Rest of Scotland.

### Of DRDs with a Psychiatric Condition, Percentages of Psychiatric Condition in the 6 Months Prior to Death

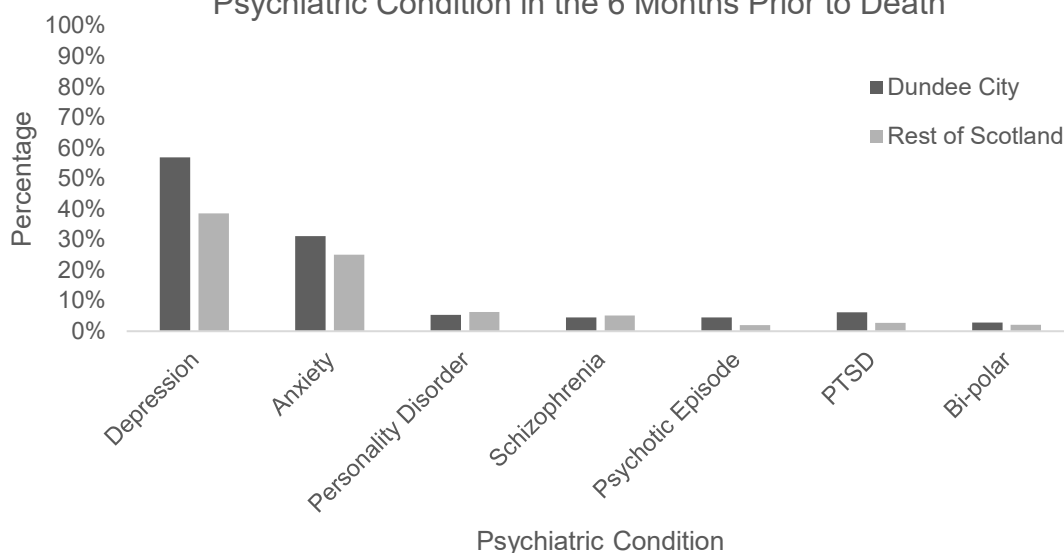


Figure 25: Note that a person can have multiple conditions. Chart only shows data from those with at least one psychiatric condition in the 6 months prior to death. Depression and anxiety accounts for the largest percentages in both Dundee City and Rest of Scotland.

In Figure 25, depression and anxiety accounts for the largest percentages in both Dundee City and Rest of Scotland. Dundee City has 18.4% more DRDs diagnosed with depression and 6.1% more with anxiety than the Rest of Scotland.

Table 16a Analysis:

Table 16a: Number & % of DRDs with drugs present at post mortem<sup>28</sup>; 2009-16 aggregate<sup>29</sup>

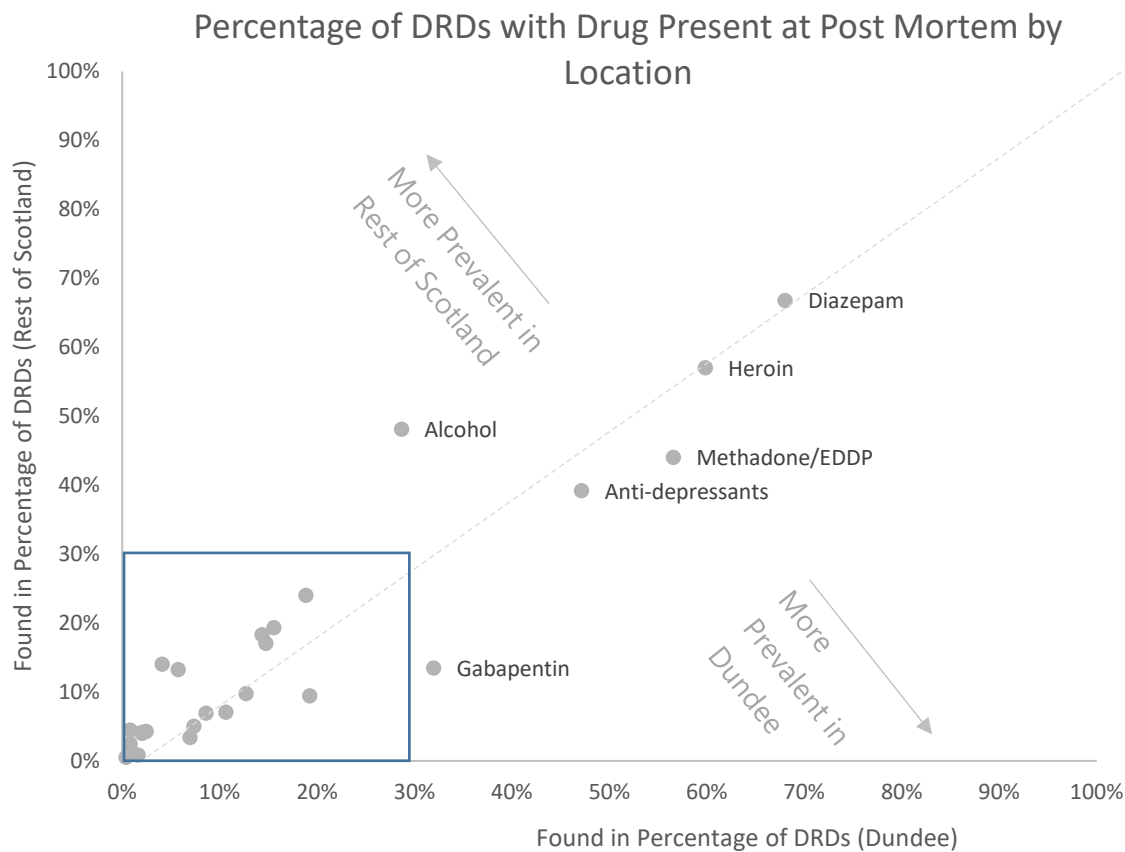


Figure 26: A comparison of the percentage of DRDs with drug present at post mortem. Drugs with percentages less than 30% are shown in more detail in the following plot. Note: drugs lying below the diagonal line, such as Methadone/EDDP, are those which are found in a higher percentage of DRDs in Dundee City when compared to Rest of Scotland. Those lying above the diagonal line, such as alcohol, are those found in a lower percentage of DRDs in Dundee City when compared to Rest of Scotland.

<sup>28</sup> Multiple drugs may be found at post mortem. Therefore, the sum of the individual drug categories is greater than the total.

<sup>29</sup> Note: table number, title and footnote are taken from the data provided.



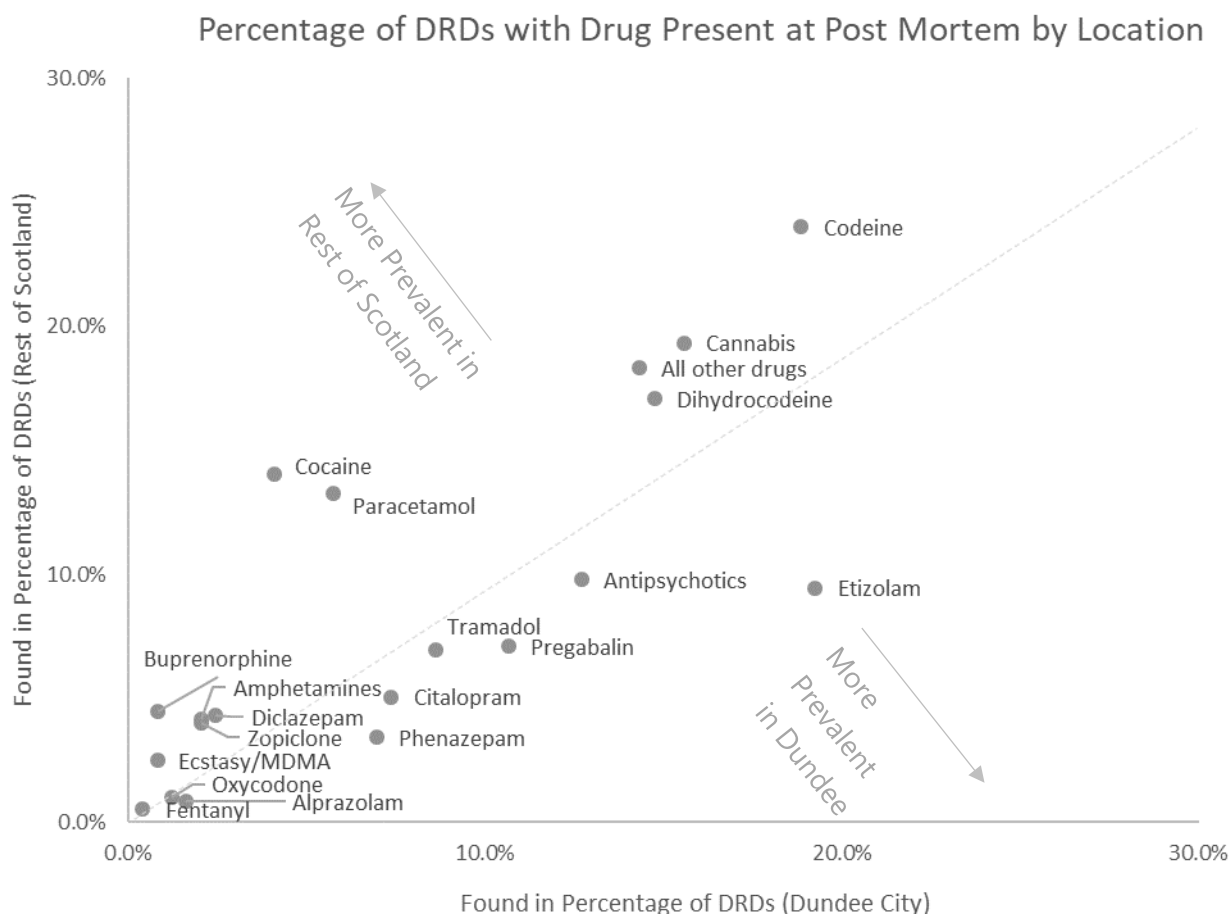


Figure 27: Same as previous figure with a more detailed view of the drugs found in up to 30% of DRDs.

Figure 26 and Figure 27 shows a comparison of the percentage of DRDs with drug present at post mortem. Note, drugs lying below the diagonal line, such as Methadone/EDDP, are those which are found in a higher percentage of DRDs in Dundee City when compared to Rest of Scotland. Those lying above the diagonal line, such as alcohol, are those found in a lower percentage of DRDs in Dundee City when compared to Rest of Scotland. It is noticeable that the drugs Methadone/EDDP, Anti-depressants, Phenazepam, Etizolam, Gabapentin and Pregabalin are more prevalent in Dundee City DRDs as compared to the rest of Scotland.

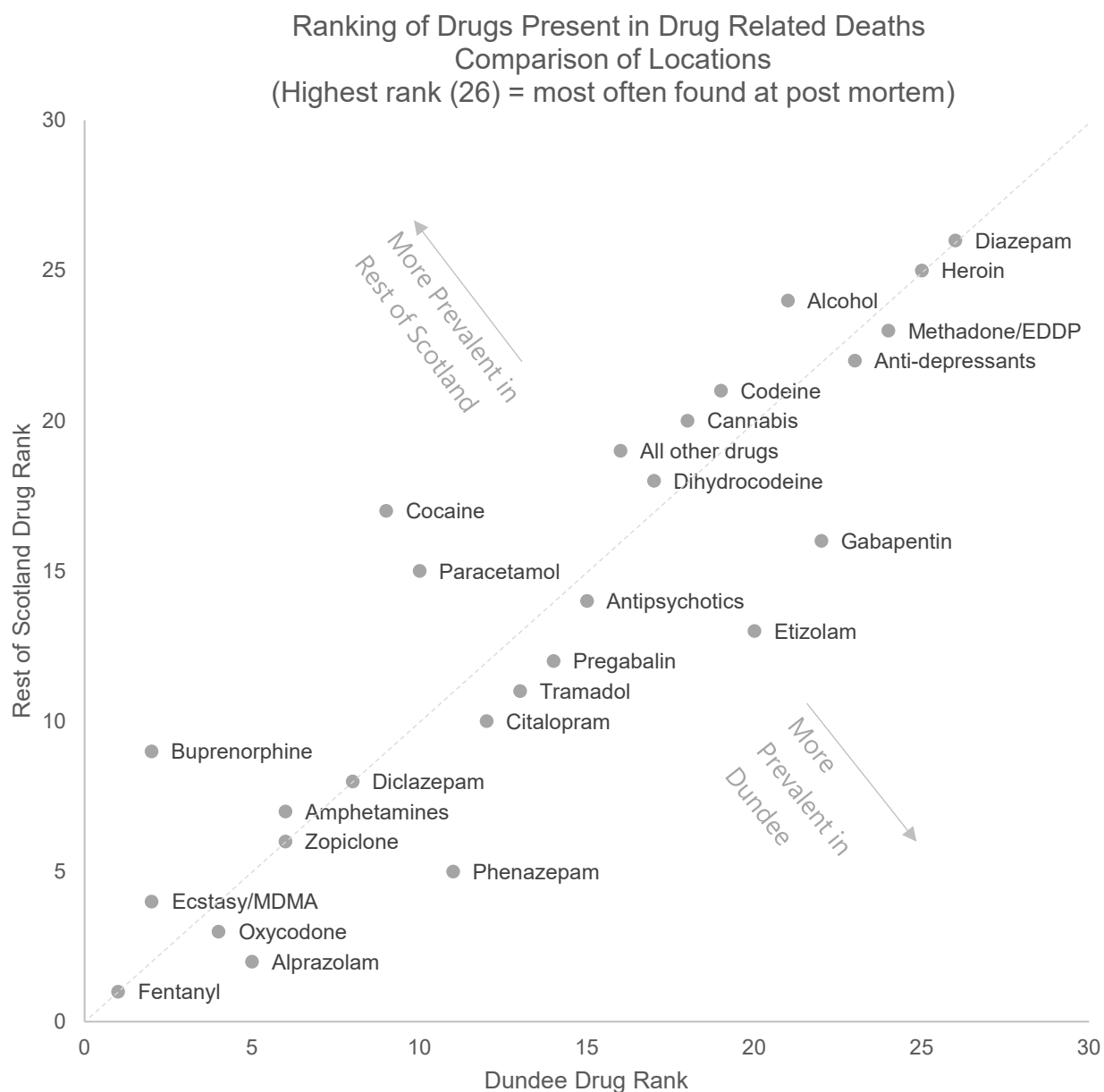
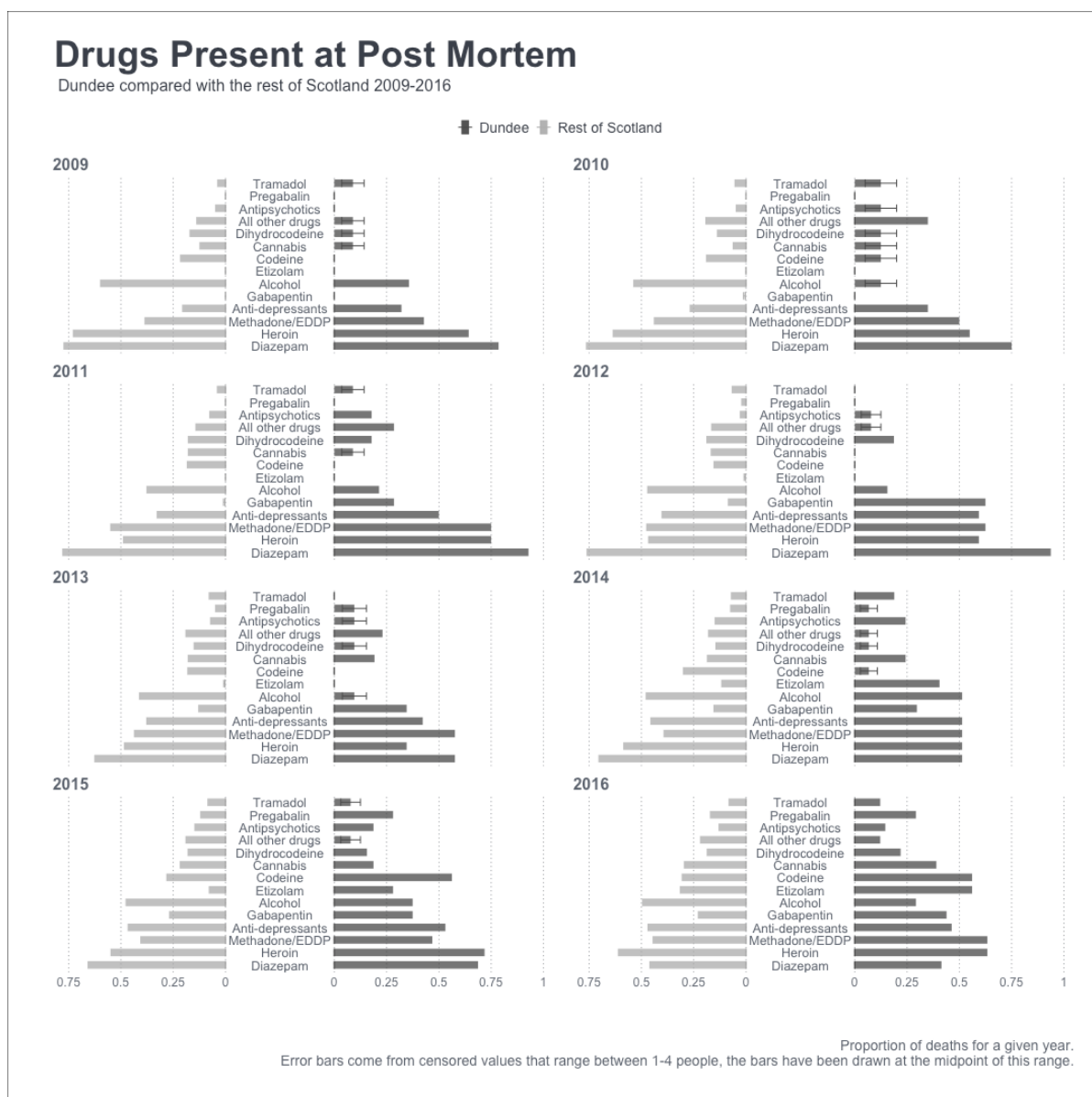


Figure 28: Drugs have been ranked in terms of the frequency seen at post mortem. Drugs with a high rank, e.g. 26, like Diazepam are those found most frequently. Many drugs lie on the diagonal, showing they are ranked similarly in both locations. Diazepam and Heroin are highest ranked in terms of presence with Fentanyl being the lowest ranked. There are some drugs that are ranked higher in Dundee than the Rest of Scotland (those lying below the diagonal), including Etizolam, Phenazepam and Gabapentin. There are some with a lower rank than compared to Rest of Scotland (those lying above the diagonal), including Cocaine, Buprenorphine and Paracetamol.

**Table 16b Analysis:**

**Table 16b: Number & % of DRDs with selected drugs<sup>30</sup> present at post mortem<sup>31</sup>; 2009-16.**



**Figure 29: Overall drugs present**

Overall drugs present in DRDs in both Dundee and the rest of Scotland has become more evenly distributed between these drugs; Diazepam and Heroin are no longer clearly most prevalent as in 2009.

The pattern for most drugs has been the same across Dundee and the rest of Scotland, on the next pages we only show the ones that differ.

<sup>30</sup> Rows with fewer than 20 cases across the time series 2009-16 (specified in the total column) have been removed in order to minimise the effect of suppression of small numbers to protect patient confidentiality. However, they have been inferred with error bars.

<sup>31</sup> Multiple drugs may be found at post-mortem. Therefore, the sum of the individual drug categories is greater than the total.

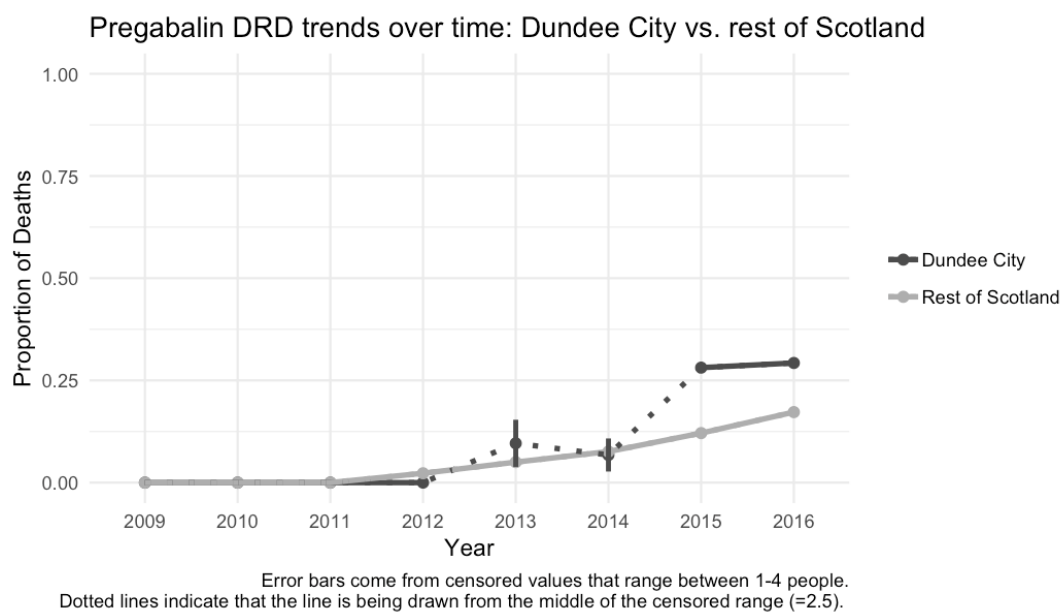


Figure 30: Pregabalin was approximate the same until 2015, where it's prevalence in Dundee rose above that of the rest of Scotland.

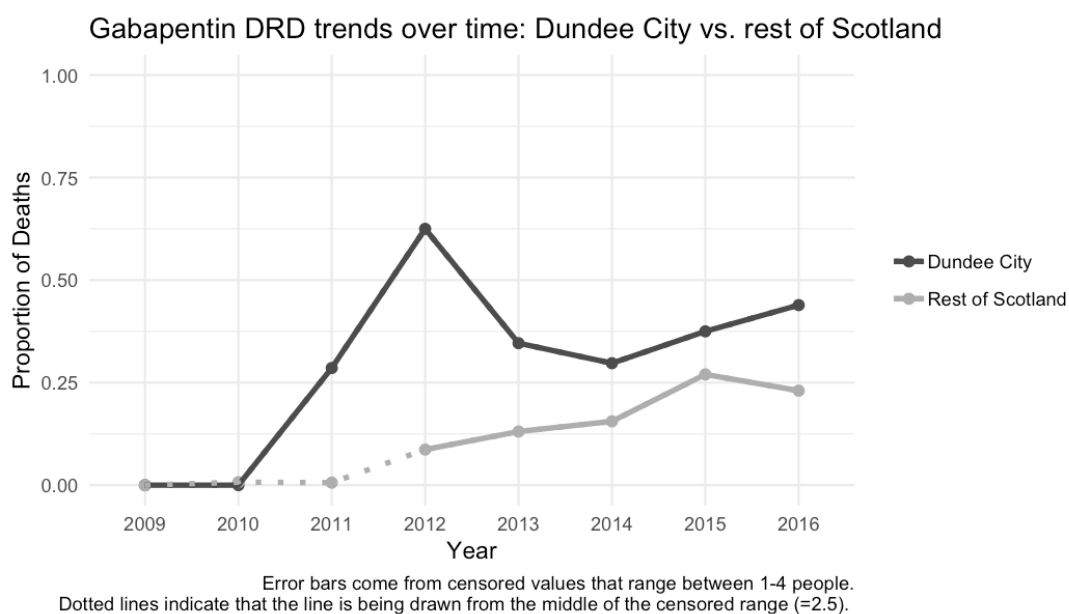


Figure 31: Gabapentin sharply rose in Dundee after 2010 and still remains above the prevalence in the rest of Scotland.

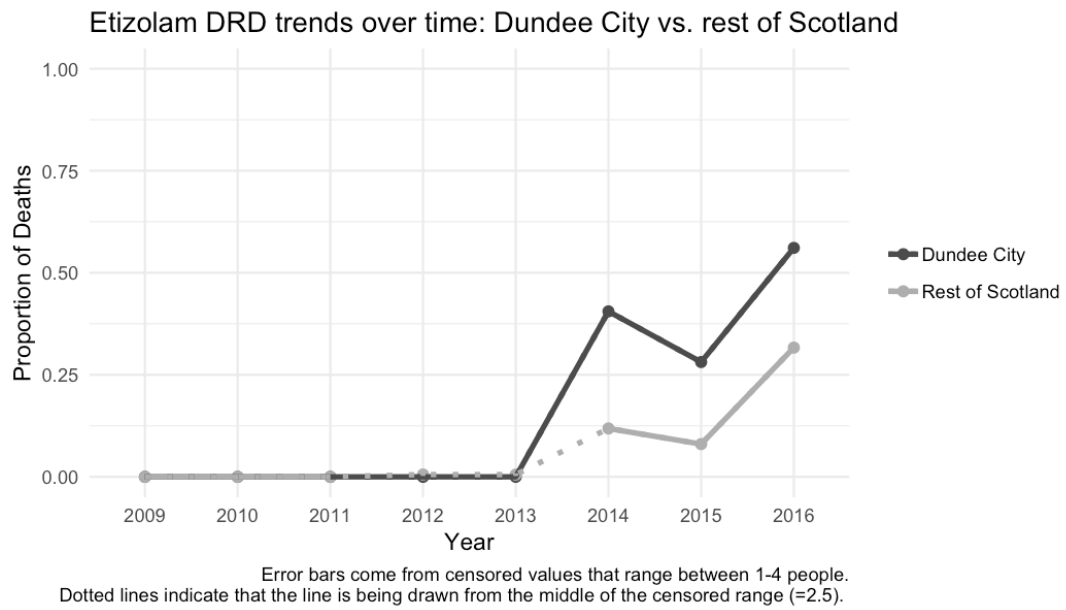


Figure 32: Etizolam sharply rose in Dundee in 2014 with a dip in 2015 and sharp rise in 2016. The rest of Scotland followed this trend to a lesser degree.

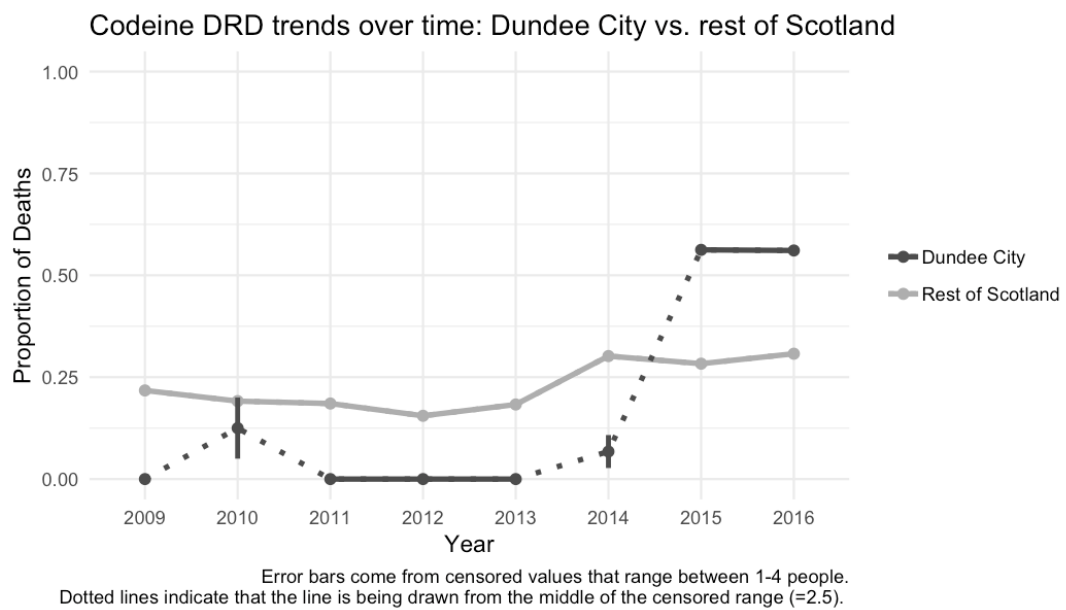


Figure 33: Codeine prevalence in Dundee DRDs was mostly below the rest of Scotland until 2015 when it saw a sharp rise.

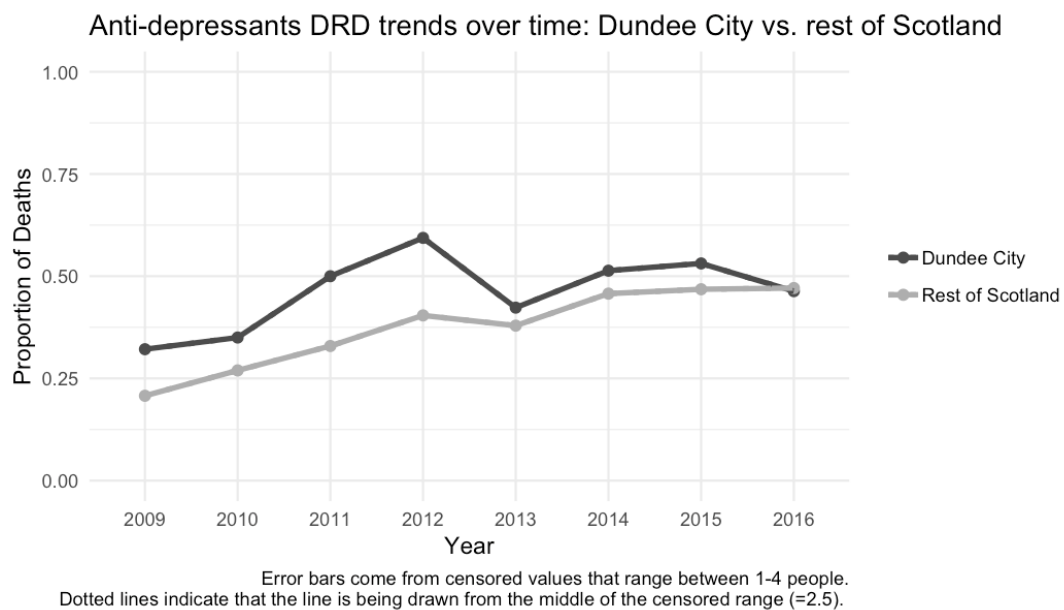


Figure34: Anti-depressant prevalence DRDs in Dundee City has steadily converged to the rate of the rest of Scotland.

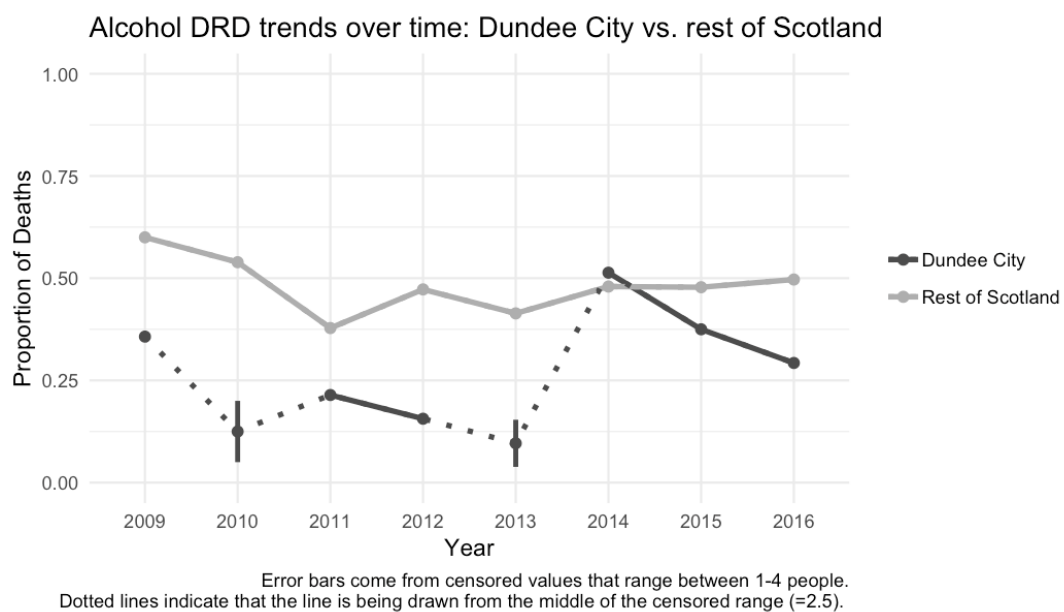


Figure 35: Alcohol presence in DRDs in Dundee City was much lower than the rest of Scotland until a sharp rise in 2014. Since then it has gradually decreased.

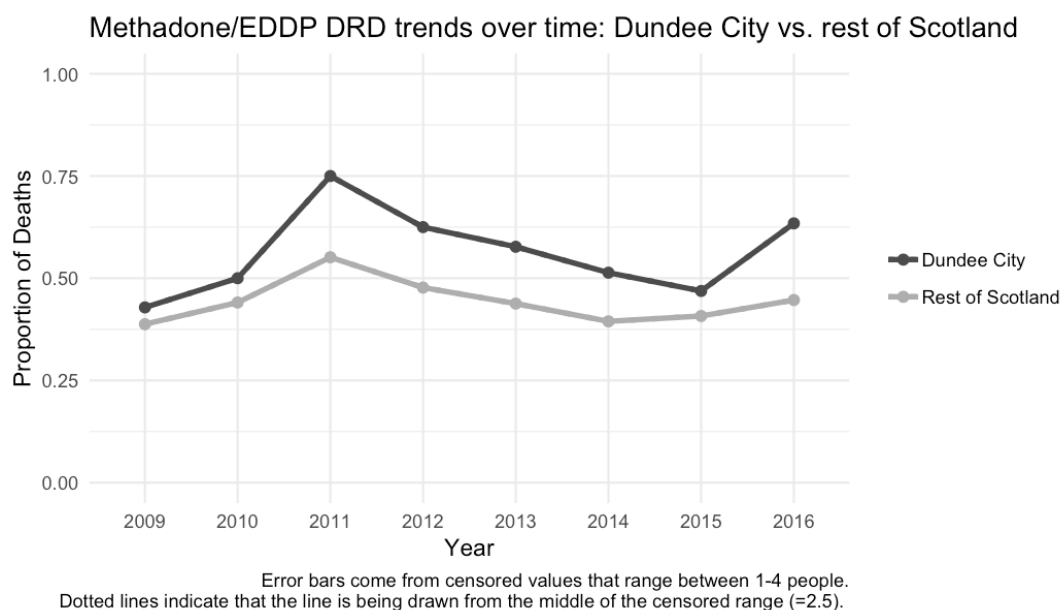


Figure36: Dundee City follows the trend over time present in the rest of Scotland for prevalence of Methadone in DRDs but is consistently higher.

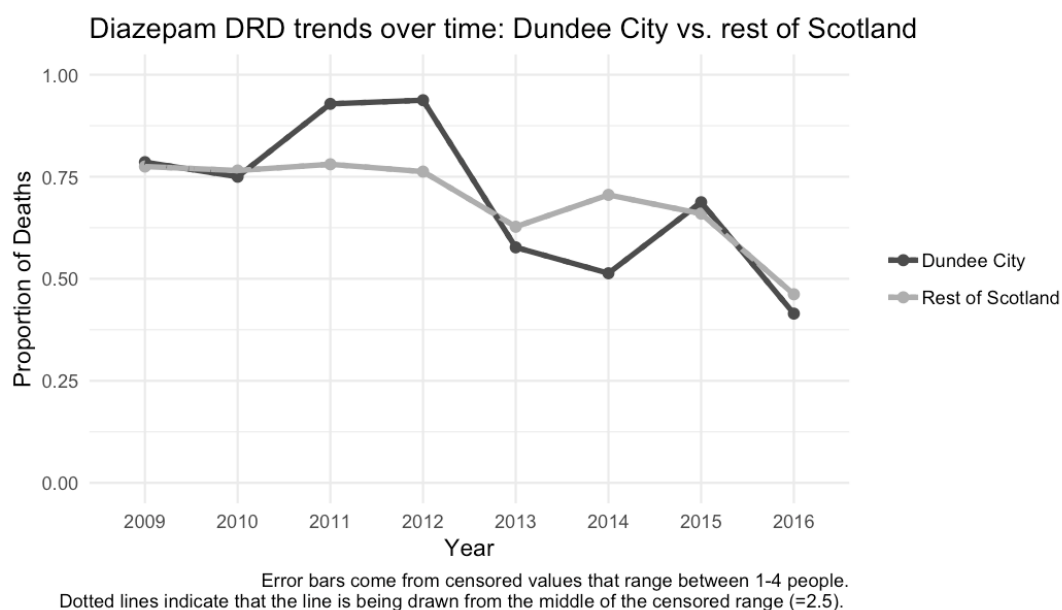


Figure 37: Diazepam presence in DRDs has decreased over time in both Dundee City and the rest of Scotland.

### Table 17a Analysis:

Table 17a: Number & % of DRDs with drugs implicated<sup>32</sup> in death; 2011-16 aggregate.<sup>33</sup>

<sup>32</sup> Drug implication data not available for 2009 and 2010.

Multiple drugs may be considered to have been implicated in death. Therefore, the sum of the individual drug categories is greater than the total.

<sup>33</sup> Note: table number, title and footnote are taken from the data provided.

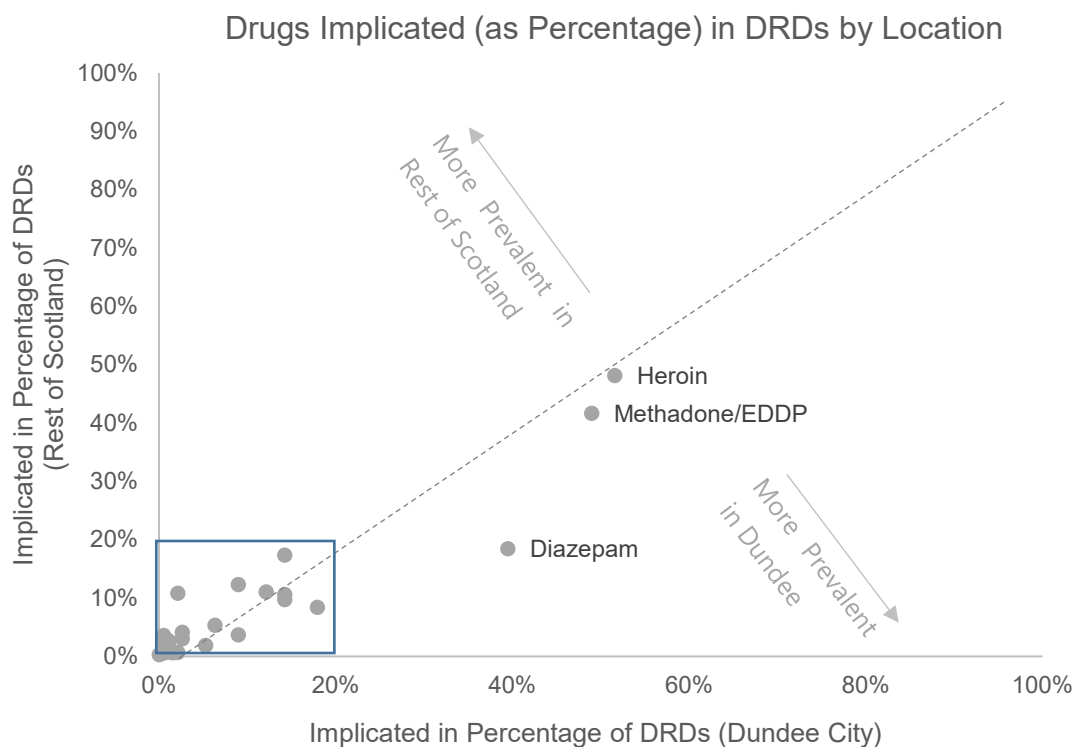


Figure 38: The percentage of DRDs a drug was implicated in – comparison of Dundee City and Rest of Scotland. Drugs lying below the diagonal line are those found in a higher percentage of DRDs in Dundee as compared to Rest of Scotland, such as Diazepam. The drugs lying above the diagonal line are those found in a lower percentage of DRDs in Dundee City when compared to Rest of Scotland. Heroin and Methadone/EDDP are implicated in the highest percentage of DRDs in both locations. For a more detailed view of the drugs implicated in up to 20% of the DRDs, see figure below.

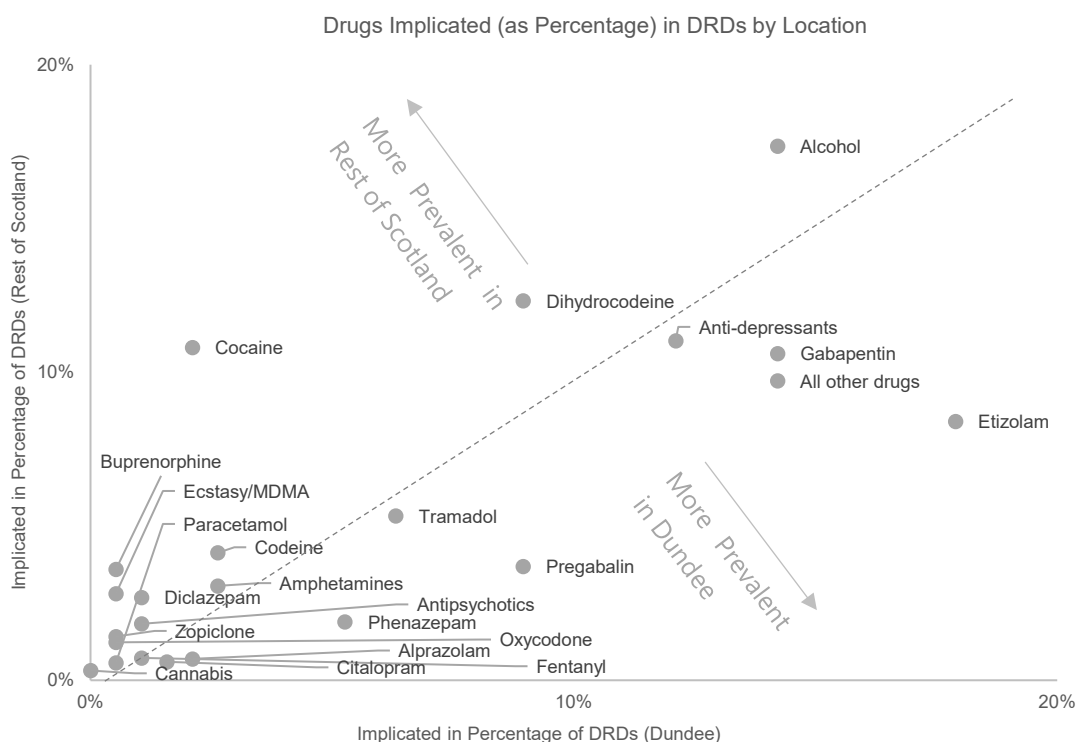


Figure 39: A more detailed view of the above figure, showing only up to 20%.



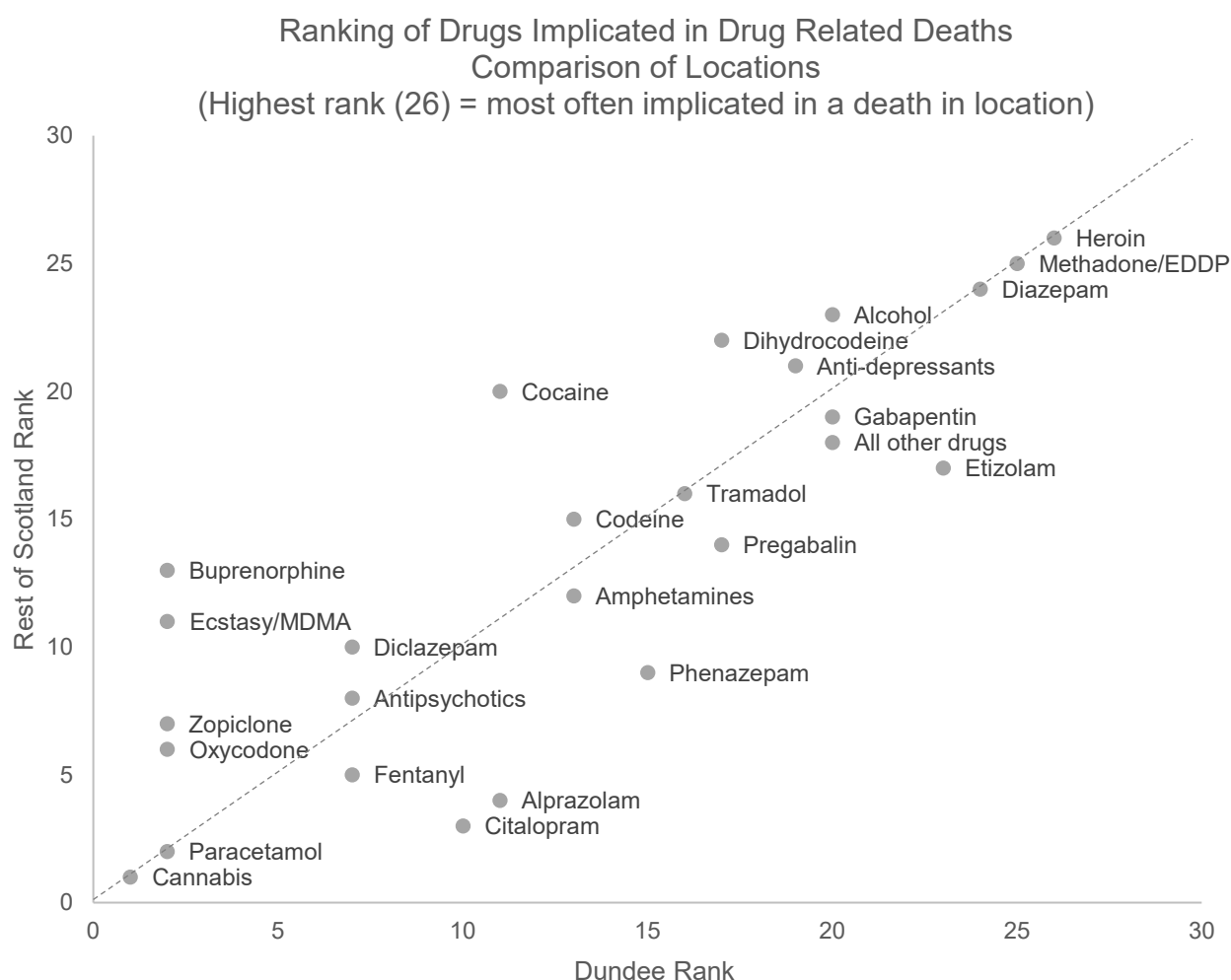


Figure 40: For each location, the drugs have been ranked where a high rank (26) means that they have been implicated in DRDs most often. Some scattering of the drugs, as opposed to the drugs falling on the diagonal, showing that there are differences between the rankings of the drugs in the two locations. Heroin, Methadone/EDDP and Diazepam are ranked the top 3 drugs implicated in deaths in both locations. The lowest ranked drugs for both locations are Cannabis and Paracetamol. Buprenorphine, Ecstasy/MDMA and Cocaine are higher ranked in rest of Scotland than in Dundee. Whereas Citalopram, Alprazolam, Phenazepam and Etizolam are higher ranked in Dundee as compared to Rest of Scotland.

Comparing Tables 16a and 17a:

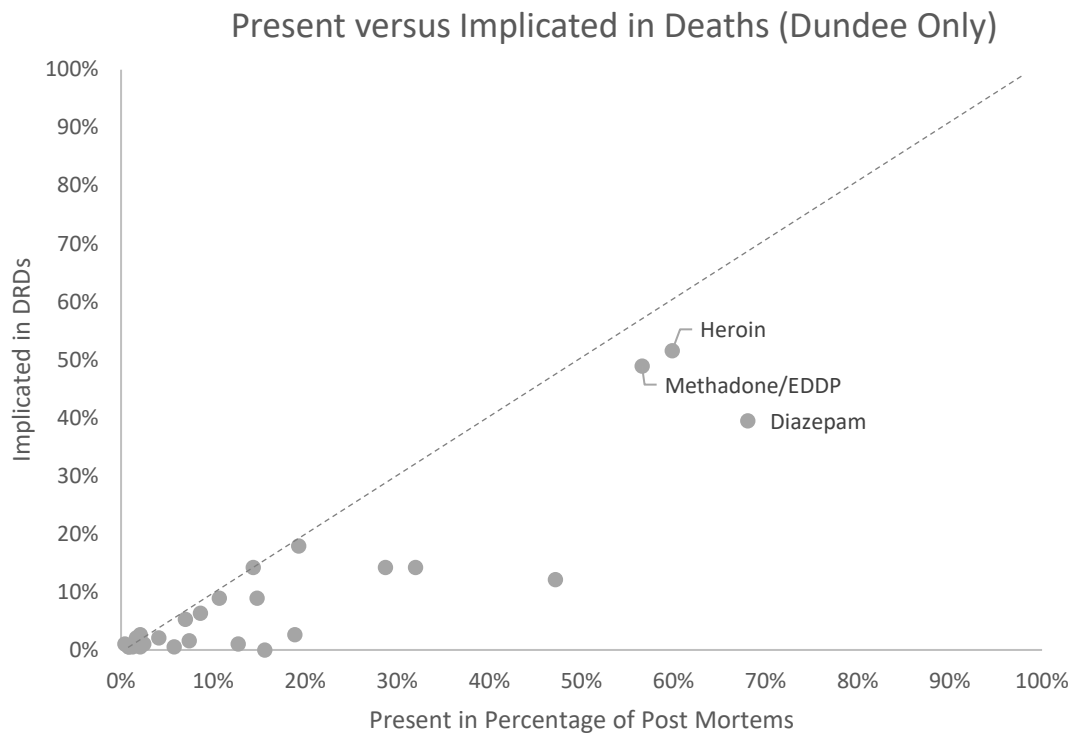


Figure 41: Comparison of present in percentage of post mortems and implicated in DRDs.

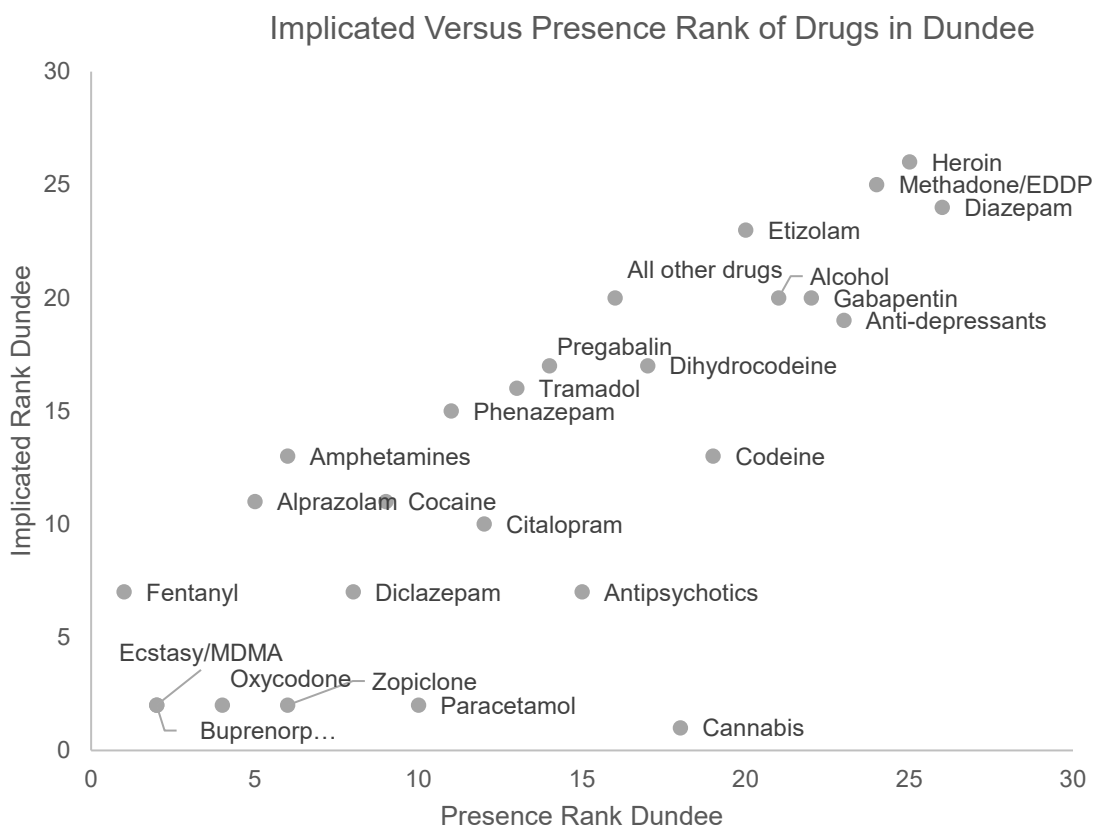


Figure 42: Dundee only rank comparison of drugs implicated and drugs present. In Dundee DRDs, Cannabis has a high rank for in terms of presence at post mortem but low rank for being implicated in a death. Heroin, Methadone and Diazepam all are ranked high for presence and implicated in DRDs.

### Table 17b Analysis:

Table 17b: Number & % of DRDs with selected<sup>34</sup> drugs implicated<sup>35</sup> in death<sup>36</sup>; 2011-16.

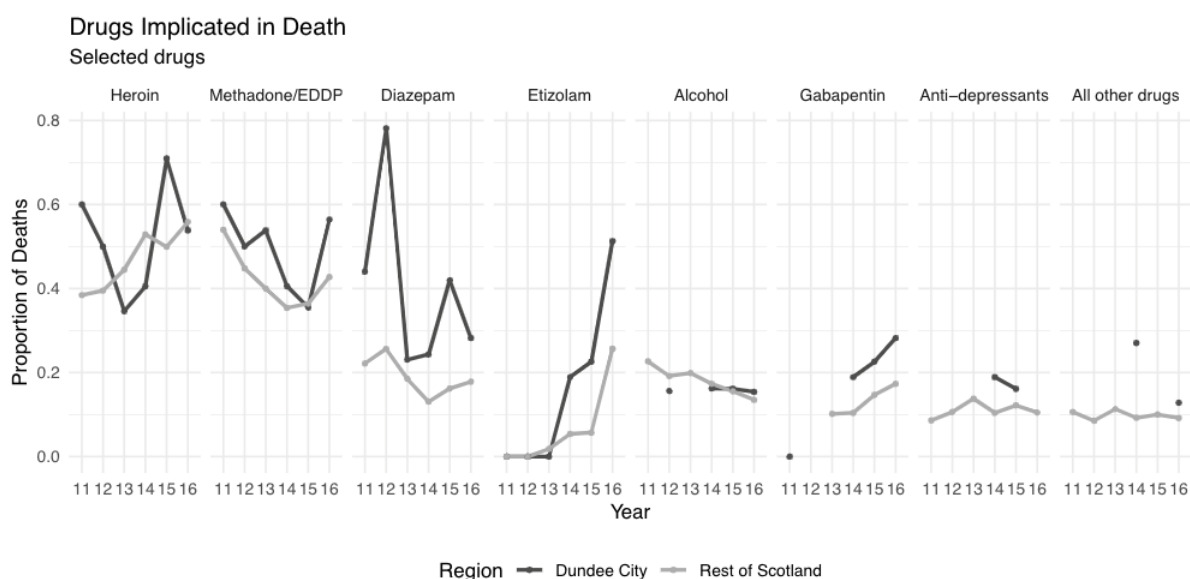


Figure 43: 2011-2016 trend of drugs implicated in death for Dundee and rest of Scotland. Dundee has a predilection for benzodiazepines; diazepam prior to 2014 and etizolam since, plus gabapentin and anti-depressants appear more prevalent in Dundee than the rest of Scotland. Some data is missing to protect patient confidentiality due to low numbers.

### Table 18 Analysis:

No analysis conducted

### Table 19a Analysis:

No analysis conducted

### Table 19b Analysis:

No analysis conducted

### Table 19c Analysis:

No analysis conducted

<sup>34</sup> Rows with fewer than 20 cases across the time series 2009-16 (specified in the total column) have been removed in order to minimise the effect of suppression of small numbers to protect patient confidentiality.

<sup>35</sup> Drug implication data not available for 2009 and 2010.

<sup>36</sup> Multiple drugs may be considered to have been implicated in death. Therefore, the sum of the individual drug categories is greater than the total.

### Table 20a Analysis:

Table 20a: Number & % of DRDs with drugs recently prescribed<sup>37</sup>; 2009-16 aggregate.<sup>38</sup>

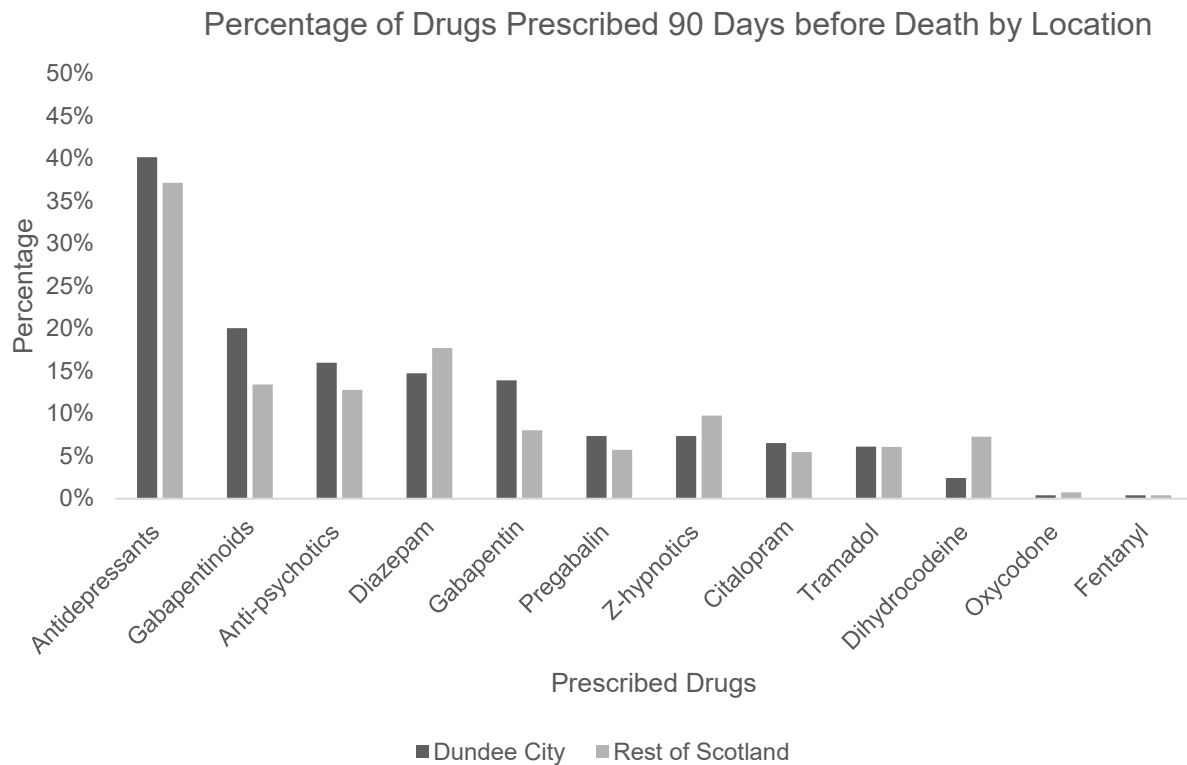


Figure 44: Antidepressants make up the highest percentage of prescribed drugs in both locations.

In Figure 44 antidepressants make up the highest percentage of prescribed drugs in both locations. Dundee City is over 5% higher than the rest of Scotland for prescribed gabapentin or gabapentinoids and is 4.8% lower for prescribed dihydrocodeine DRDs.

### Table 21 Analysis:

Table 21: Mean number of drugs recently prescribed<sup>39</sup> by Sex and DRD Location; 2009-16.<sup>40</sup>

<sup>37</sup> Multiple drugs may have been prescribed prior to death. Therefore, the sum of the individual drug categories is greater than the total.

<sup>38</sup> Note: table number, title and footnote are taken from the data provided.

<sup>39</sup> Based on an aggregation of the number of the following drug types prescribed to an individual in the 90 days before death (diazepam, antidepressants, tramadol, dihydrocodeine, gabapentinoids, z-hypnotics, oxycodone, fentanyl, citalopram, antipsychotics).

<sup>40</sup> Note: table number, title and footnote are taken from the data provided.

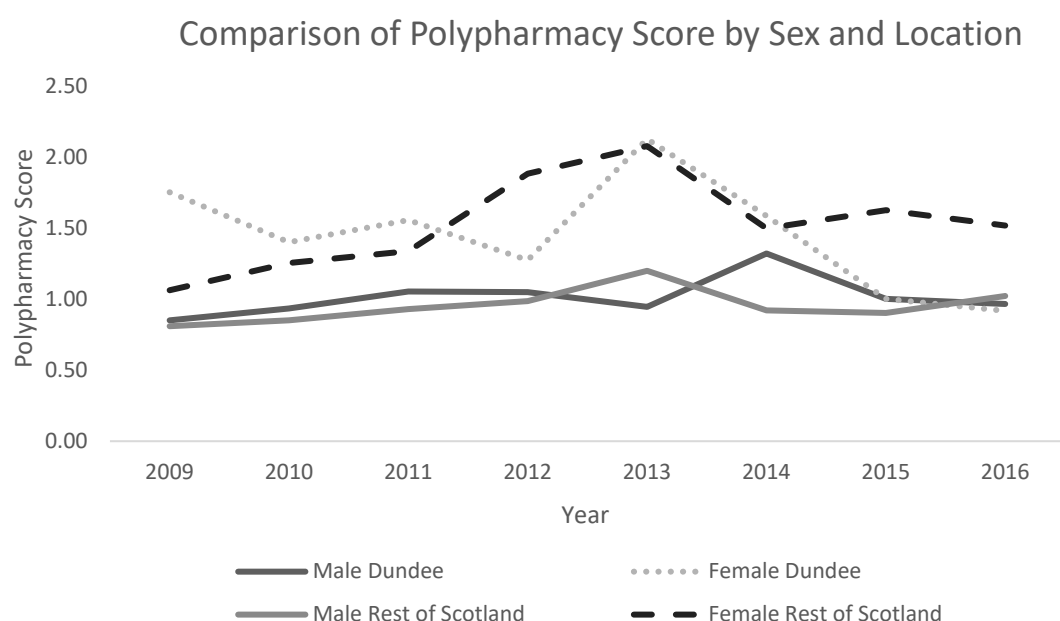


Figure 45: In the period 2009-16, there is a higher yearly mean number of drugs prescribed to females. In 2015 and 2016 the polypharmacy score of females in Dundee drops to a similar level seen in males in Dundee and Rest of Scotland. Male polypharmacy scores in Dundee DRD are similar to those in the Rest of Scotland.

Figure 45 shows that in the period 2009-16, there is a higher yearly mean number of drugs prescribed to females. In 2015 and 2016 the polypharmacy score of females in Dundee drops to a similar level seen in males in Dundee and Rest of Scotland. Male polypharmacy scores in Dundee DRD are similar to those in the Rest of Scotland.



## APPENDIX XIII: PUBLIC EVIDENCE SESSIONS

Over the course of the last year, the Drugs Commission has held six public evidence sessions where a range of experts were invited to either present to the Commission or discuss certain topics as part of a panel-based question and answer session with the Commission.

All of these sessions were open to members of the public to sit and observe, and were also well attended by members of the local press.

Copies of all publicly available presentations and minutes of Commission meetings are available for download at:

<http://www.figure8consultancy.co.uk/latest-news/dundee-drugs-commission/>

Meetings were held on the following dates and the names/titles of speakers and topics covered were as follows:

Date	Speaker(s)	Titles
26 <sup>th</sup> June 2018	<b>Dr Emma Fletcher</b> (Consultant in Public Health Medicine, NHS Tayside Directorate of Public Health) <b>Alexis Chappell</b> (Locality Manager, Dundee Health & Social Care Partnership) & <b>Diane McCulloch</b> (Head of Service, Health and Community Care, Dundee Health & Social Care Partnership)	<u>Presentation:</u> 'The Scale of the Challenge Facing Dundee'  <u>Presentation:</u> 'Dundee Integrated Substance Misuse Partnership: New Model and Approach in Dundee - Whole Systems Transformation'
22 <sup>nd</sup> August 2018	<b>Diane McCulloch</b> (Head of Service, Health and Community Care, Dundee Health & Social Care Partnership) and <b>Christine Lowden</b> (CEO, Dundee Voluntary Action) <b>Professor John Dillon</b> (Consultant Hepatologist and Gastroenterologist, NHS Tayside; Professor of Hepatology and Gastroenterology, University of Dundee) <b>Ann Eriksen</b> (Head of Strategic Planning, Executive Lead - Sexual Health & BBV)	<u>Presentation:</u> Evidence from Dundee Alcohol and Drugs Partnership  <u>Presentation:</u> 'What lessons can be learned for and applied in Dundee from the Hepatitis C (HCV) Eradiction Study?'  <u>Presentation:</u> 'What lessons can be learned from work to reduce teenage pregnancies across Tayside?'

26 <sup>th</sup> September 2018	<p><b>Lee Barnsdale</b> (Principal Information Analyst [Drugs], ISD)</p> <p><b>Elinor Dickie</b> (Public Health Intelligence Adviser, NHS Health Scotland)</p> <p><b>Dr Lesley Graham</b> (Clinical Lead for Alcohol, Drugs and Health in Justice Settings, ISD Consultant Team)</p> <p><b>Kirsten Horsburgh</b> (Strategy Coordinator for Drug Death Prevention, Scottish Drugs Forum)</p>	<p><u>Panel-based discussion</u>: 'Drug Deaths – What is the evidence and the way forward for Dundee?'</p>
12 <sup>th</sup> December 2018	<p><b>Dr Drew Walker</b> (Director of Public Health, NHS Tayside)</p> <p><b>Ann Hamilton</b> (Independent Chair of the Violence Against Women [VAW] Partnership)</p>	<p><u>Discussion</u>: 'Reflections on the challenges of being a chair of Dundee ADP and the future role of Public Health in helping to deliver on the new national Alcohol and Drugs Strategy for Dundee.'</p> <p><u>Discussion</u>: 'Gender-informed issues and approaches in Dundee.'</p>
16 <sup>th</sup> January 2019	<p><b>Jed Brady</b> (REACH Advocacy, Lanarkshire)</p> <p><b>Jardine Simpson</b> (CEO, Scottish Recovery Consortium) – in place of Forth Valley Recovery Community</p>	<p><u>Panel-based discussion</u>: 'The role of advocacy and recovery communities in Dundee.'</p>
20 <sup>th</sup> February 2019	<p><b>Prof Roy Robertson</b> (Professor of Addiction Medicine, Usher Institute of Population Health Sciences and Informatics, College of Medicine and Veterinary Medicine, University of Edinburgh; GP; member of the Royal Medical Household)</p> <p><b>Dr John Budd</b> (Edinburgh Access Practice)</p> <p><b>Dr Joe Tay</b> (Sighthill Green Medical Practice, Edinburgh)</p>	<p><u>Panel-based discussion</u>: 'The role of General Practitioner's and Primary Care in the treatment of persons experiencing drug problems.'</p>



## APPENDIX XIV: FOCUS GROUPS – THOSE WITH LIVED EXPERIENCE AND FAMILIES

### Introduction

The following seven focus groups, with a total of 60 participants, were conducted by Figure 8 Consultancy with a range of groups with people experiencing drug problems and family/carers support groups across Dundee between June – August 2018:

- Lochee Community Hub (10)
- Kith n Kin group (10)
- The Lifeline Group (12)
- Addaction (12)
- Eagles Wings (5)
- Gowrie Care (5)
- Positive Steps (6)

An information sheet about the focus groups was given to participants and a consent form completed.

Notes of each group were taken and a summary analysis of the key emerging themes from the groups was prepared for presentation at the second meeting of the Commission.

The key themes identified are noted in the table below:

Key Theme/Message	Examples
Co-occurring mental health issues	<ul style="list-style-type: none"><li>• Those who need MH help (treatment or assessment) can't get it due to their drug use/treatment.</li><li>• It's the 'biggest problem'.</li><li>• Impact of trauma.</li></ul>
Drug-related deaths	<ul style="list-style-type: none"><li>• Many people taking whole cocktails of substances (morphine, heroin, etizolam, pregabalin, gabapentin – with heroin and etizolam the easiest to get hold of in Dundee)</li></ul>

	<ul style="list-style-type: none"> <li>• 'If we filled a balloon every time there was a drug death in Dundee, we could fill a room with balloons and you wouldn't get in.'</li> <li>• People being treated unfairly and inhumanely (e.g. travelling to Perth every day to get methadone).</li> <li>• What support is being put around the children (and families)?</li> <li>• '[Name] wanted to let you know about the issues her daughter has had in trying to access a space she has been given at [named service outside Dundee]. However, she needs a letter/form that her GP which needs to be filled in, but he is off for the next 2 weeks and no one else at the practise can fill this in. [Anon's] daughter really needs this space. Even the worker who took her through to [the named service for an assessment] has stated if she cannot take up this bed she could die. This is the kind of issue they [the Commission] are needing to deal with.'</li> </ul>
Role of professionals	<ul style="list-style-type: none"> <li>• 'Professionals have all the power'.</li> <li>• 'Pharmacists have too much power – they play God'.</li> <li>• GP's – 'you just get fobbed off'.</li> <li>• 'Hospital staff – they do what they've got to do and then send you on your way.'</li> </ul>
Access to a rehabilitation programme/unit	<ul style="list-style-type: none"> <li>• All groups talked about the lack of a rehab facility in Dundee.</li> <li>• Many see this as the solution to the problem.</li> <li>• However, when you scratch under the surface the clear frustration is one of a lack of treatment options being available – often expressed in the form of 'it's methadone or nothing.'</li> </ul>
Benefits	<ul style="list-style-type: none"> <li>• The introduction of Universal Credit is causing real concern and real hardship.</li> <li>• 'You've got to really put it on. You need to look half-dead to get benefits.'</li> <li>• High levels of benefit sanctions.</li> </ul>
<b>OVERALL IMPRESSION FROM FOCUS GROUPS: People do not want platitudes from the Drugs Commission. People are asking 'what is going to be different?'</b>	

## **APPENDIX XV: THIRD SECTOR SERVICE VISITS**

### **Introduction**

A range of visits to third sector service in Dundee were undertaken by groups of Commission members on 14<sup>th</sup> November 2018. In total, the following six services were visited, with an opportunity for Commission members to meet with staff and service users or family members:

- Addaction
- Dundee Carers Centre – the Lifeline Group
- Eagle's Wings
- Gowrie Care
- Positive Steps
- Women's Rape and Sexual Abuse Centre, Dundee (WRASAC)

Notes were written up by Commission members from the visits and summaries are presented below. The names of the services and the people met at each service have been anonymised and are not presented in the order of services listed above.

### **Service 1**

#### **Commission Members: Sharon Brand, John Owens and Eric Knox**

We met with staff of this service. Unfortunately, two service users had agreed to take part but were unable to attend.

Staff members were very knowledgeable and the visit was worthwhile. The general client group were women involved in prostitution or who had been subject to human trafficking. They all had complex issues often stemming from various traumatic events throughout their childhood and into their adult lives. The majority of women had suffered childhood sexual abuse, neglect, rape, assault, and domestic abuse. These factors contributed to a chaotic life style including substance use, poor mental health, homelessness, exploitation and some had children who had been removed from them under child protection. 95% have substance issues. The service has been running for over eight years generally on short term funding that was continued or new funding streams were secured. This was unsettling for women who were supported by the service.

The service used to provide an outreach service which frequented the areas that are known for kerb-crawling. However, as funding was reduced, the organisation responsible for this service has had to make the decision to withdraw it. The value of this was that the service could keep good contact with the women who were hard to reach and would not access normal services. They were also able to identify new women involved in on-street prostitution and get them involved with services. The loss of this services is seen a real gap.

Main issues for service users:

- Stigma surrounding their involvement in prostitution.
- Ability to access services when they are chaotic.
- Lack of a crisis service particularly out of normally working hours.
- Lack of caring support from treatment services.
- Time to get access to be prescribed.
- Lack of support from Mental Health services.
- High risk of overdose or suicide risk.
- Don't feel supported by 'the system'.

The worker reported that women feel they have better relationships with workers from the CAIRN Centre due to it being a more relaxed / informal environment. Also, some women do not like engaging with ISMS due to previous social work input and how this has effected them and now reflects their current support, i.e previous childhood social work, or when children were removed from their care.

The worker also reported that, "Even under the new drop-in service, a woman had been waiting a lengthy amount of time to get on a programme due to the process. Women have to go through several stages before being placed on treatment, including an opiate withdrawal test and pre-tolerance tests (which means going 24 hours each time without opiates). This is a struggle for anyone who is addicted to opiates and can be a barrier to access treatment. Many women are involved in prostitution as a way to fund their substance addiction and the inability to get on a prescription due to barriers can mean their involvement in prostitution may increase. However, the early signs are that the new drop-in service has started to bring some welcome changes (not as many tolerance tests and faster appointments provided for some)."

## **Service 2**

### **Commission Members: Sharon Brand, John Owens and Eric Knox**

We met with two staff members and five carers/family members, some of whom have experienced a drug-related death within their family. All the group members stated that if it was not for the support of this group, then they would have had little or no support in dealing with the impact of their loved one's drug use.

The main issues discussed by the group were:

- They felt abandoned by the system as they were the parents/carers for the individual with the issues. There was no recognition of their role or how they could help in the care of the individual.
- Getting information on how they could help their loved ones was extremely difficult because the services stated they could not disclose information because of data protection issues.
- There was a complete lack of bereavement support for families.
- They talked about lack of support from GPs who would not listen to them or their loved ones when they were asking for help.

- They recognised that it was sometimes difficult as their loved ones did not always want help.
- The lead into getting medication was too long.
- There was a perception of the punitive nature of treatment services.
- Lack of family support while someone is in treatment and after someone had died. They felt they were left to get on with it, with no support.
- The schools were excluding problem pupils because of their behaviour. They felt that schools were too attainment focussed and did not cater well for individuals who struggled with school work and their behaviour deteriorated because of this. This pushed the young people away from what was seen as the normal education process and started that spiral downwards.

They were asked what would have helped and they stated recognition as carers that they were trying to help their children. They wanted more low level support for families when an individual is in treatment. They wanted statutory services to be more caring after bereavement and some bereavement support to be available.

### **Service 3**

**Commission Group Members: Justina Murray, Jenni Turnbull, Robert Peat and Maureen Walker**

- We met with two mums and one staff member. One of the mum's has an adult son who is still actively using drugs; the other has an adult daughter who is currently abstinent and is getting help from [a named service outside Dundee].
- This service offers one-to-one support to families and encourages families involvement. There isn't a family support group so the families don't meet together – this was the first time these two mums had met each other.
- This service was described as providing "wonderful support. ... This is the first time that I've really had support". Both mums were very grateful for the support given to them and their children.
- One of the mum's is gravely concerned for her son, "I have accepted he is going to die. ... I can't do any more". He overdosed 4 times in [month] 2018, including a [three times] in a single week. He was "minutes from death". He was told just to go to 'the DPC' (ISMS) on discharge from hospital. There was no assertive outreach. He did not attend and his worker from this service contacted ISMS voicing concerns. Her son had given permission for the worker to have this conversation. The worker is still waiting for the return phone call.
- The other mum's daughter started using heroin when she was 16 and met a guy who was significantly older and who used heroin. Since then "She's done everything – drug dealing, prostitution". The mum heard about this service as she is friends with the manager and she had suggested they could help. Her daughter is doing very well at [named service outside Dundee], "You're hopeful as you want to be hopeful. ... I've got my daughter back". Her daughter had previously been at another residential rehab at a cost of £6000.

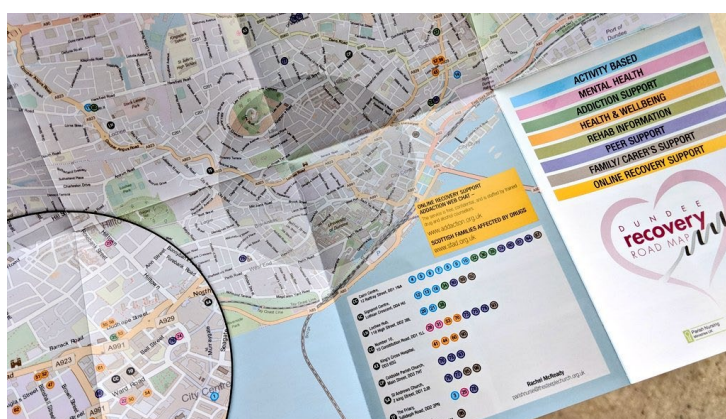
- In both cases, the mums felt sexual assaults which had not been dealt with had contributed to mental health and substance use issues for their children. One of the mum's son had been indecently assaulted in prison by prisoners looking for drugs. There were two High Court trials, and although he asked for support in prison he was told this was not available. He had a breakdown in [date], sometime after this. The other mum's daughter had been sexually assaulted by a group of men twice and had tried to take her own life "6 or 7 times". One of the mum's noted "There has to be more work emotionally, not just dishing out methadone". They recognised the link between drug use as self-medication' e.g. due to previous abuse.
- Interestingly, one of the mum's said her son's experience of Carseview was "wonderful, great support". He is now on a waiting list for a psychiatrist, but she understands there is only one for the whole of Tayside. She described how her son takes valium as he likes the way it "blocks everything out" and feels he only takes heroin when he's on valium. He buys valium online.
- One of the mum's has always attended 'the DPC' with her son. She describes the current experience of the service as "horrendous" and said "I can talk to them but they don't listen". She feels the sheer volume of cases is an issue. The other mum said her daughter was told by a worker at the service when she was late and missed her appointment to "just take heroin" instead. She felt her daughter was treated better when she went with her to appointments. She described the security arrangements at the service as "very intimidating". She described being assaulted with her daughter right outside the service and no-one came out to help – a service user helped them – "There's no compassion".
- Both mums were keen to see residential rehab as an option in Dundee. One mum felt it would be hard for her daughter to come home from [named service outside Dundee] as the same support isn't available locally. They said there was nowhere to go out of hours.
- One mum said she now feels stronger and recognises her own role. She looks after her grand-daughter. The grand-daughter is on a waiting list for "help" but is currently getting counselling at school.
- One of the mum's older son had previously died (not drug-related) and she felt she had no time to grieve for him as she was so taken up with her younger son's issues. She had paid off drug dealers previously. She had been offered naloxone but not the training so didn't want it (and had experience of the paramedics using it with no effect due to the drugs her son had taken).
- She said her son has no friends, is bored and isolated and only knows drug associates. His keyworker at this service had offered to link him in with SMART Recovery, with gardening and a café but he has physical limitations (he almost lost his leg due to injecting). The support worker felt it was hard for people to move from a chaotic life to a boring life, but also that "Encouraging people that they are worth something, that's harder than anything else".
- The support worker explained that the organisation uses the 'Tree of Life' model, which encourages people to work on the positives. Building trust is the biggest challenge, as "people have been let down". The support worker said the organisation is persistent and tries hard to engage but acknowledged that this is hard when service users say they don't want their family involved. The service encourages a review at any time. Sometimes they change their minds once

trust has developed. The support worker's view is "You can't be supported by one person" so the service needs the family: "The mums in Dundee are unique ... They don't give up on their children. ... They are always on the case to make sure they are safe".

#### Service 4

**Commission Group Members: Justina Murray, Jenni Turnbull, Robert Peat and Maureen Walker**

Notes were not taken as it wasn't a sit-down visit but more of a wander round and chat to the staff and people dropping in. It was very warm, welcoming and friendly, with a very relaxed atmosphere. There was hot food available but also clothes, access to IT, and chat and advice. It was busy with people accessing all of these kinds of support. The team clearly had good relationships with those using the drop-in and knew people well.



One young man said he heard about the service from a flyer which was advertising all the drop-ins around the city every day. This is linked to the Dundee Recovery Map project (pictured) with lots of maps and leaflets available for people (and handed out by the team when they are doing outreach).

This service also described the difficulties of working in partnership with the ISMS, although they say partnership working is improving across other organisations in the city.

#### Service 5

**Commission Group Members: Dave Liddell, Eilish Gilvarry, Pat Tyrie and Simon Little**

A support worker commented on the lack of communication between services and a lack of information sharing. They felt that service users are not treated fairly. For example, a user arrived at ISMS for an appointment to be told it wasn't on that day but the worker was able to challenge this with evidence of an appointment letter. The support worker felt that if they hadn't been there to advocate for the service user then he would simply have been sent away. The support worker related that this is a common occurrence.

A family member we spoke to related that her brother shared similar experiences [number] years ago and this is still happening now. They feel that service users are expected to jump through hoops but are too scared to be honest for fear of losing their script. They feel that the testing for routine dirty samples and removing a script can be dependent on the worker rather than a protocol.

This service has care plans in place and review every 6-8 weeks. ISMS do not share their care plans with other services. There is no apparent formal information sharing agreement.



Keyworkers described a difficulty in getting to speak directly with ISMS workers.

The quality of relationships with ISMS can be patchy - some good, some bad - there is a lack of consistency of good working relationships.

The family member we spoke to feels that ISMS staff need training in forming good relationships with clients and in dealing with difficult and challenging behaviours.

[Name] related a story whereby a service user had been tired of a lack of respect given to him and was removed from his script and subsequently died.

There was also a comment that nine out of ten service users who are taking methadone are also using street drugs - asking key workers for help and being told to do it themselves.

The staff members we spoke to related a user's experience of being out of service for four days and described there being barriers to re-engagement.

The staff members also commented that there is a lack of professional trust between ISMS and other services - working on this would be a positive step. They feel that ISMS is strategically led with no reference to practical issues.

Staff members also commented that there is a lack of empathy by workers for service users at ISMS. Concern was expressed that this also impacts on the workers themselves, resulting in low morale, fatigue, trauma and a lack of job satisfaction. There appears to be little care for the workers in ISMS.

We asked the staff present about what is working well? They didn't strictly answer the question but comments made were more in relation to what they would like to see working (e.g. team building between services). Staff accepted that there are difficulties, but there is a need to move forward.

When asked if there is there opportunity for things to move forward, staff noted a number of things:

- Sharing models and information would be a good start for promoting joint working.
- Suggestion that diazepam be prescribed daily rather than using street drugs.
- Suggestion that they should look at the Seek/Keep/Treat work done in Norway.

A family member described how her daughter had been put off her methadone script twice and had tried to access a [named service outside of Dundee] but was unable to get a referral form signed as the GP was on leave for 3 weeks.

Another family member described how her daughter was having difficulty making afternoon appointments, but was not offered morning appointments instead. The family member also described that whilst attending consultations at ISMS, there are constant interruptions.

One mum noted there is a new provision of a talking service available at some GPs.

One service user described a good relationship with a worker who was respectful and compassionate and this proved helpful to him in being open and honest and resulted in good drug management.

One person in recovery described being clean of drugs but felt that she had been left in limbo with no support in going forward. Lives in a street where drugs are readily available. She felt Subutex was a good option. She hasn't started any relapse prevention. She is in isolation with no family support.



Another person in recovery said that drug workers were supportive and she recognises personal responsibility and said she felt it was up to the individual to make the choice to stop.

## **Service 6**

### **Commission Group Members: Dave Liddle, Eilish Gilvarry, Pat Tyrie and Simon Little**

One service user described there being no access to mental health services if they are a person experiencing problems with drugs, or via ISMS. They described how, in order to gain access to mental health services, they engaged with them without letting them know they were a person experiencing drug problems, then told them once they had engaged. This service user felt that drug use and mental health issues are closely related and this should be recognised. They also related that they had asked not to be prescribed methadone but their preference was Subutex - this request was ignored and the worker had been planning methadone treatment. The service user questioned why they could not have this as an option and felt that methadone was being promoted by the service.

Chemists - the screen in a chemist does not provide sufficient privacy to maintain dignity - it is obvious to others that the client is being given methadone. A feeling that there is less respect in larger pharmacies.

The six weeks wait for a script to start is difficult (due to completion of drug diaries).

It was noted that once you get an appointment at ISMS it is a hurried process to get you in and out the door. There is no discussion of treatment goals.

On release from prison, one person experiencing drug problems waited 14 days for Methadone treatment to start.

Meeting other people experiencing drug problems at ISMS makes it difficult to sustain recovery.

Group support helps sustain recovery. The [named service] was described as 'the best centre'.

There are a range of activities provided at the [named service] for clients - these change according to user requests.

There are two hubs providing multi-service support for people experiencing drug problems. There is a focus on well-being and recovery.

One person related their experience of engaging with the [named service] cookery classes and how they had gone on to cook their first meal ever for their child, helping to build self-esteem and their relationship with their child.

The [named service] provides cognitive behaviour (SMART) sessions for clients.

Groups allow initial engagement with clients. Outcomes for staff are in relation to client well-being and it was commented that statutory services are concerned only with numbers through doors and clean samples.

One staff member commented that they had taken part in a similar re-design 4/5 years ago and can see no change. People experiencing drug problems are using street valium to fill the gap in mental health support.

When asked what would you change, a staff member replied 'look at what people want'. A service user replied by saying there needs to be more places for clients to talk. They were embarrassed by relapse, and described the [named service] workers as helpful and that they provide a place to talk. They also asked why there is no court involvement in referring young people to 'groups' and commented that young people are using diazepam to manage anxiety (which can spiral into chaos).

One service user (currently on methadone) felt that high doses of methadone are unnecessary and clients are using this to manage their anxiety.

A staff member questioned 'why are we prescribing Class A drugs to people and not providing them with support?' They noted a comment by a senior member of ISMS who said, 'we are not here to deal with mental health.'

## **APPENDIX XVI: EVIDENCE SUBMISSIONS FROM DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP**

Across the lifespan of the Drugs Commission, a wide range of Requests were made to Dundee Health and Social Care Partnership for information regarding the Integrated Substance Misuse Service [ISMS].

The Commission requested detailed information from Dundee Health and Social Care Partnership on the services it provides. It provided detailed documents to the Commission as part of its evidence submissions, with the key documents being:

1. Provision of a 'factsheet' from ISMS
2. Written response to questions posed by the Commission
3. Written submission to the Drug Commission's Final Call for Evidence
4. Analysis of the Deeper Dive of DRD Data commissioned from ISD (Dundee v's Rest of Scotland)

Copies of each of these are provided below. A further four packs of detailed information were provided to the Commission in relation to: (1) Clinical Guidelines; (2) Service Redesign Plans; (3) Performance and Governance; and (4) Carers.

All the above information has been considered by the Commission in its findings.

### **1. Substance Misuse Services Factsheet for the Commission**

What is the background to Substance Misuse Services in Dundee?

Prior to 2016 - 2017, health, social care and third sector substance misuse services were operationally managed separately mainly through NHS Tayside Mental Health Services, Alcohol and Drug Partnership and Dundee City Council Social Work Department.

As part of the integration of health and social care, a Dundee Integration Scheme was developed to set out the integration arrangements within Dundee. This includes the vision, delegated services and accountability for Clinical and Care Governance and Professional Governance.

Through integration, substance misuse services were delegated to each Integration Joint Board across Tayside with arrangements as follows:

Dundee IJB	<p>Dundee Community Substance Misuse Nursing, Social Work and NHS Admin Services, including third sector contracts. This includes the nursing staff within DTTO and New Beginnings Services.</p> <p>Tayside Primary Care Liaison Service (Hosted by Dundee IJB) Tayside Substance Misuse Hospital Liaison (Hosted by Dundee IJB)</p> <p>Tayside Substance Misuse Psychology Service (Hosted by Dundee IJB).</p>
Perth and Kinross IJB	<p>Perth &amp; Kinross Community Substance Misuse Nursing, Social Work and NHS and LA Admin Services, including third sector contracts.</p> <p>Tayside Psychiatry Workforce (Hosted by P &amp; K IJB)</p> <p>Tayside Inpatient Alcohol and Drugs Unit (Hosted by P &amp; K IJB)</p> <p>Tayside Prison Healthcare Substance Misuse Service (Hosted by P &amp; K IJB) Tayside Admin Provision to Improvement and Quality Group (Hosted by P &amp; K IJB)</p>
Angus IJB	<p>Angus Community Substance Misuse Nursing, Social Work and NHS and LA Admin Services, including third sector contracts.</p> <p>Tayside Service User Engagement Service (Hosted by Angus IJB).</p> <p>Tayside Alcohol Brief Interventions (Hosted by Angus IJB).</p>

To enable development of locality based integrated health and social care services and the ambitions of HSCP strategic plan to be realised, a new leadership structure was developed by the Dundee IJB.

In summary, at an operational level the new operational leadership structure created a Head of Health and Community Care Services, four Locality Managers, a Lead Nurse and Lead AHP. The new leadership structure was implemented during 2016 with Locality Managers coming into post in January 2017 and using the period January to March 2017 to both allocate responsibility for services and transition into the new roles.

#### *What were the Challenges and Risks Identified Upon Transfer?*

After transfer a number of historical challenges, which created operational risks in relation to capacity and service delivery, were identified which included:

- Culture and Communications – Although there was a collective voice that agencies involved in substance misuse wished change for the benefit of individuals, the culture and communications around substance misuse service delivery could be described as centred around mistrust creating a challenging environment in which to establish a recovery orientated system of care.

- Recovery Orientated Care Operating System – Although there had been numerous attempts to integrate services and build a recovery orientated system of care; health, social care and third sector services were not integrated and there was no cohesive and coordinated approach or model to promoting recovery in Dundee. Additionally, there was no shared approach to personalisation, early intervention and prevention, promoting the range of treatment and support options and reducing admission and readmission to hospital.
- Risk Management - There was no shared understanding or collective approach to managing individual risks outwith statutory processes and no shared understanding of roles and responsibilities in relation to managing risk. This had in turn generated service risks and pressures, particularly on healthcare staff, to manage risk alongside managing high caseloads.
- Capacity to Deliver Recovery Orientated Services and Manage Risks – It had been recorded since 2015 by NHS Tayside Substance Misuse Services that there was increasing patient demand in excess of resources and insufficient numbers of staff with prescribing competencies. This service risk also generated other risks such as high caseloads (90 for Drugs Service Nursing staff), unallocated patients, waiting times standards not being met, ability for staff to meet individuals and with that promote recovery and prevent harm, respond to the protection of Adults and Children and manage risk on a coordinated basis.
- Understanding of Resources – Health and social care finances and resource management were not integrated and due to this there was no overview of totality of resource available in relation to substance misuse service delivery in Dundee.
- Governance and Performance – Health, social care and third sector governance and performance review and management arrangements were not integrated which meant that there was a number of groups in place but no cohesive understanding or approach to continuous improvement. In addition to this, due to service capacity issues identified within NHS Tayside Substance Misuse Services, the NHS Tayside Adverse Event Management Standards were difficult to achieve.
- Infrastructure – Health, social care and third sector IT, admin systems, procedures and operating systems were not integrated and there was insufficient support to gain the service performance and clinical data required to support continuous improvement and redesign services.

These historical operational challenges and risks were articulated through reports to the DHSCP Clinical, Care and Professional Governance in March 2017 and September 2017, to the Alcohol and Drug Partnership, NHS Tayside Mental Health Governance Groups. These reports were provided on 5th November 2018 to the Drugs Commission.

*What Has Been Undertaken Since Substance Misuse Services transferred to Dundee IJB to Respond to Challenges and Risks Identified?*

Although these significant challenges and risks were identified upon transfer, a clear strength was a stated commitment from across health, social care, third sector and partners towards implementing sustainable change so that recovery can be realised in Dundee.

To build upon this commitment and evidence change, the main actions through 2017 – 2018 were to:

- Build relationships with and involve a range of partners which includes mental health, children & families, prisons, primary care, community justice, housing and communities, third sector and acute services and establish the organisational and cultural conditions that would support and enable sustained change.
- Develop and implement a substance misuse strategic plan. The plan was subsequently approved at Dundee ADP and Dundee IJB.
- Develop and implement a redesign programme based on self-evaluation and through discussion and collaboration with a range of individuals and groups. The redesign was subsequently approved by Dundee ADP and Dundee IJB.
- Investing in substance misuse services to build capacity for change and mitigate risks identified in relation to capacity to meet demand.
- Integrate health and social care services into a locality model, in line with the strategic direction of the HSCP, and alongside this a) integrate clinical care and professional governance and finances and resource management b) develop health and social care workforce and operational leadership.
- Implemented a direct access services so that people can directly access substance misuse services and treatment.
- Further developed our approach to overdose prevention and risk management.

Our focus through 2019 – 2021 is to:

- Continue to promote a culture which enables and values learning, collaboration, innovation and transparency.
- Implement the whole systems redesign programme building upon arrangements developed during 2017 – 2018.
- Continuing to manage and escalate risks during the process of redesign.
- Implement an integrated workforce plan which sets out workforce development and workforce skill mix and numbers required to deliver recovery orientated services. As part of this implement a plan to build non-medical prescribing workforce over the next 4 years.
- Implement a Public Sector Partnership to coproduce further development of services and promote a culture of transparency, collaboration and learning.
- Publish a bi-annual service report and use this to demonstrate our ongoing development and improvement.

### *What is the aim of the Redesign Programme and What Has Been Completed?*

A redesign programme was developed and implemented to enable citizens of Dundee to have access to the information and support that they need to live a fulfilled life and recover. In addition, that we intervene early to prevent a negative impact of substance use on citizens of Dundee, children, families, carers and communities.

The redesign was approved at Dundee IJB on 18th December 2019 and is supported through use of six principles to inform the development of a new model of working. These are that a new operating model for Substance Misuse Services should be:

- Based in localities across Dundee and available over 7 days and at evenings to improve accessibility, reduce inequalities and support people in employment.
- Holistic, person centred and focused on enabling people to recover, achieve their personal outcomes and be protected from harm. This includes proactively engaging with individuals to support their recovery.
- Underpinned by excellent governance arrangements so that an assurance is provided regarding the quality, safety and effectiveness of the advice, support, treatment and information provided.
- Implemented collaboratively so that people experience well-coordinated support which is integrated from their perspective.
- Organised from a single referral point in localities using integrated documentation so that we make effective use of resources available to support recovery and protect people from harm.
- Responsive to Carers and family members, so that Carers and family members receive the support they need to continue in the caring role.

A summary of progress is provided below:

Strategic and Operational Direction	Strategic Plan and Redesign Programme were endorsed by Dundee ADP and Dundee IJB. These set out the direction, principles and programme of activity in order to achieve sustained change within Dundee.
Operational Leadership	<p>Through review of operational arrangements, operational leadership capacity has been strengthened to enable implementation of the redesign. This has involved establishing key posts and arrangements as follows:</p> <ul style="list-style-type: none"><li>• East and West Integrated Managers to manage locality community substance misuse services, lead integration of health, social care and third sector substance misuse services and develop integrated pathways which promote recovery and support to family members.</li><li>• Integrated Manager Discharge Management to manage hospital liaison and discharge services, lead integration of hospital discharge and liaison services and develop integrated pathways which will enable people who use substances to return home from hospital when they are well and reduce admission and readmission from hospital.</li></ul>

	<ul style="list-style-type: none"> <li>Integrated Manager Governance to further develop our Clinical, Care and Professional Governance arrangements and implementation of non-medical prescribing and technology enabled care.</li> </ul>
Clinical, Care and Professional Governance	<p>Through review of arrangements, since 2017 Health and Social Care Substance Misuse Services have focused on developing a learning culture focused around continuous improvement. This has included:</p> <ul style="list-style-type: none"> <li>Establishing integrated health and social care clinical, care and professional governance arrangements and reporting to DHSCP Governance Group and Clinical Forum using the Tayside Clinical, Care and Professional Governance Framework.</li> <li>A review of Local Adverse Event Reviews and using the learning from the review to establish areas for improvement.</li> <li>This informed the redesign programme, reporting to DHSCP Governance Group and provision of information to the Tayside Drug Death Review Group.</li> <li>Reviewing how service user and carer feedback informs continuous improvement and service design. The Service is now working with Dundee Carers Centre Lifeline Group to involve Carers in development of the service and during 2019 intends to review how service user feedback is gained and service users are involved in co-design of the service.</li> <li>Developing professional forums in which to further support development of professional practice within the service.</li> <li>The Integrated Manager Governance will further support these developments and our approach to governance across all services in my remit during 2019 – 2020.</li> </ul>
Building Capacity for a Recovery Orientated System Of Care Through Redesign of Services	<p>Through strengthening our leadership capacity and building relationships this has enabled development of Multi-Disciplinary East and West Integrated Community Substance Misuse Services, which is a key part of the redesign. Key developments include:</p> <ul style="list-style-type: none"> <li>East and West Substance Misuse Services - Reconfiguration of previously separate social work, drugs nursing, alcohol nursing, drugs medical team and alcohol medical team into East and West Dundee Integrated locality teams (2 x Teams in East Dundee and 2 x Teams West Dundee) who are now delivering locality based clinics and a direct access service. The teams are now in place. As part of this referrals are now received from a single access point.</li> <li>Mental Health Support as part of East and West Substance Misuse Services – Increasing psychology resource available to people who use</li> </ul>



	<p>substances and developing our health, social care and third sector workforce. This will mean that from September 2019 a Clinical Psychologist will be part of East Dundee Substance Misuse Service and a Clinical Psychologist will be part of West Dundee Substance Misuse Service. The Clinical Psychologists will also take a lead role in supporting our health, social care and third sector workforce to further develop and implement psychological interventions and trauma informed practice in line with Scottish Government Guidance and best practice.</p> <ul style="list-style-type: none"> <li>• Housing Support and Assertive Outreach as part of East and West Substance Misuse Services – Developing previously separate commissioned Third Sector Housing Support Services as part of the East and West Substance Misuse Teams. The aim is to promote recovery, enable independent living and reduce risk of harm through enabling individuals to engage with recovery orientated supports, manage their own tenancies and prevent homelessness occurring. It is expected this development will be completed by end 2019.</li> <li>• Integrated IT, Documentation and Infrastructure - All substance misuse health and social care staff are now using the same IT, documentation and admin systems to record activity. We are currently exploring options with IT and partners to support shared approaches with third sector.</li> <li>• Early Intervention and Recovery Support as part of East and West Substance Misuse Services - A Public Social Partnership Model (PSP) was introduced in 2018 as a way of coproducing the development of early intervention and recovery support and further developing East and West Substance Misuse Services with service users, carers and partners. As we have now been awarded funding from the Challenge Fund this will enable a Steering Group to be formed to oversee implementation of the PSP.</li> </ul> <p>In addition to this, through a range of partnership arrangements we have also focused on:</p> <ul style="list-style-type: none"> <li>• Integrated Hospital Discharge Teams – Developing an integrated approach within hospital settings to discharge management to improve support available to people who misuse services in a hospital setting. Through this change integrated pathways and resources are being developed which have already improved support to individuals upon discharge from hospital.</li> <li>• Working with Risk – A multi-agency and multi-disciplinary steering group is now established and is developing a multiagency approach</li> </ul>
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	and guidance towards working with risk, managing risk and embedding the lead professional model as a means of coproducing improved outcomes for individuals.
Financial and Resource Management	<p>Through review of budgets, financial governance has been strengthened to enable implementation of the redesign. This has involved establishing:</p> <ul style="list-style-type: none"> <li>• An integrated understanding and approach to the DHSCP health and social care budget and resource management by bringing together both local authority and NHS resources. This has enabled a greater understanding of the totality of resources available and financial pressures.</li> <li>• A transparent process for the allocation of new funding from Scottish Government through the ADP Strategic Planning Group - Finance, Performance and Commissioning Group. The resultant investment plan was approved at Dundee ADP and subsequently Dundee IJB on 30.10.18.</li> <li>• A transparent process for the allocation of ADP underspend funding through the ADP Strategic Planning Group - Finance, Performance and Commissioning Group. The resultant investment plan was approved at Dundee ADP and subsequently Dundee IJB on 18.12.18.</li> </ul>

## 2. Written response in relation to questions posed by the Commission

Ahead of a first meeting with management from ISMS on 22<sup>nd</sup> August 2018, the Commission submitted a request to the service for information in relation to a number of questions. Following a number of communications, a revised set of fourteen questions was submitted to ISMS on 11<sup>th</sup> February 2019. A response to the Commission was provided on 15<sup>th</sup> February 2019. It was subsequently updated (with cross-references to national guidance – provided in **red text**) and re-submitted on 15<sup>th</sup> March 2019. The final version is provided below.

### **Question 1:**

**What are the current total numbers in ISMS for drug problems and how many are on ORT and what type of ORT (methadone/suboxone/buprenorphine)?**

### **Answer:**

Methadone 919; Buprenorphine 211.

Total number of cases open on our electronic records system [EMIS – Egton Medical Information Systems] will be emailed when available.<sup>41</sup> As we are a drug and alcohol service there will be people open to ISMS who are not on OST, and cases are not electronically assigned by substance used.

### **Question 2:**

**What are the current caseloads by types of clinical staff (band 5,6 etc)?**

#### **Answer:**

Current systems pressures are recorded as a DATIX risk<sup>42</sup>: increasing patient demand in excess of resources and escalated through DHSCP governance and operational structures and to the IJB.

### **Question 3:**

**What is the current capacity of doctors in the service – e.g. numbers working and number of sessions offered and delivered?**

#### **Answer:**

Due to vacancy and absence we currently have the equivalent of 2.1WTE medical staff in the service, including fixed term contract, substantive and locum staff.

I include the BMA document regarding doctors working in systems under pressure.



Working in Systems  
Under Pressure

We are currently unable to meet the needs of the service to fully cover access to OST, review of Opiate Substitution Treatment (OST), risk escalation and unscheduled care, impacting on safety and quality of OST delivery. In line with the BMA guidance regarding raising concerns in systems under pressure, insufficient numbers of staff with prescribing competencies is recorded as a DATIX risk and has been escalated to NHST Clinical Risk Management Group, Dundee HSCP R2 Group, and Dundee IJB. Funding has recently been secured to develop the non-medical prescribing workforce but recruitment has been unsuccessful, and medical staff are increasingly working on a consultation basis to meet clinical demand more efficiently.

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<sup>41</sup> The Commission were subsequently informed (19/02/19) that the total number of people open to ISMS on EMIS was 1249, which also includes alcohol patients.

<sup>42</sup> DATIX is a web-based incident reporting and risk management software tool utilised by NHS Tayside as part of its management of adverse events reporting policy.

**Question 4:**

**Can you please forward a copy of any “treatment contract” used?**

**Answer:**



Treatment.pdf

**Question 5:**

**Can you please describe the process from first assessment e.g. how many urines to be positive, does a person need to be in withdrawal objectively before prescribing is commenced, what is the tolerance testing that has been noted, etc.?**

**Answer:**

People are asked to provide the following:

- 2 x opiate positive urine samples
- Substance use history consistent with dependence (drug diaries if possible)
- Clinical Opiate Withdrawal Scale (COWS) > 8; see below.

*Orange guidelines 2017 state 'a prescription for OST should normally only be considered if;*

*-Opiates are being taken on a regular basis (ISMS - substance use history and preferably drug diaries)*

*-There is convincing evidence of current dependence (ISMS - tolerance testing and observed withdrawal COWS>8)*

*-The assessment including history, examination and toxicology – clearly substantiates the diagnosis and the need for treatment - when objective signs can be particularly useful or sometimes essential e.g. evidence of injecting sites (ISMS –injection site check) or evidence of opioid withdrawals (ISMS – COWS>8).*

*-The clinician is satisfied that the patient may be able to comply with the prescribing regimen'*

*'Collecting a urine or oral fluid specimen for toxicological analysis is essential to confirm or refute recent drug use. However, a positive test for opioids does not establish the diagnosis of dependence. In situations of doubt it may be useful to repeat a screening test, or to conduct a confirmatory test, although this does not confirm dependence. (ISMS – collect two drug screens)'*

*With regards to tolerance testing we note the Orange Guidelines 2017 recommend 'close observation of the first dose during induction', and 'there is an increased risk of overdose death during induction into methadone treatment and a consistent finding is that multiple drugs, particularly benzodiazepines and alcohol are usually involved'.*

Polysubstance use with drugs enhancing the effects of GABA such as benzodiazepines and gabapentoids are common in the population we are inducting on to opiate substitution treatment, therefore to enable safe induction and rapid optimisation to effectively eliminate heroin use, we ask people to present in opioid withdrawal at Constitution House on the day of their first dose which is usually 40mg methadone and then monitor their response over a four hour period, on day two we can increase to 50mg at the community pharmacy. These doses may change depending on the clinical assessment. We have had no deaths related to induction in this high-risk population. We are aware that this process of tolerance testing was already established practice in other services and is not unique to Dundee. We include the NHS Fife Tolerance testing policy.



NHS Fife Tolerance  
Testing

*Orange guidelines 2017 state 'with heavily dependent users who are tolerant , and where the clinician is experienced with access to close supervision and skilled key working support, a first dose can be up to 40mg (methadone)but it is usually unwise to exceed this dose...*

*The process of dose induction requires clinical judgement from the prescriber. Clearly those prescribers with more experience may feel able to take more and proportionate risks following thorough assessment. In general, more caution should be taken with high risk patients but this caution is normally best managed, where possible, by assuring compliance and tolerance through supervised consumption rather than by providing low doses...*

*Where doses need to be increased during the first seven days, the increment should be no more than 5-10mg (methadone) on one day.'*

With regards to buprenorphine induction, tolerance testing involves people being asked to present in opioid withdrawal at Constitution House to mitigate the risk of precipitated withdrawal. Buprenorphine naloxone 4mg is administered and if no precipitated withdrawal is evident a further 4mg is given one hour later, we can increase to 16mg day two at community pharmacy. As the risk of overdose is not increased with buprenorphine induction we had a test of change administering the first dose at the community pharmacy but had a higher incidence of precipitated withdrawal and treatment discontinuation, as such we returned to administering the initial dose at Constitution House after observing withdrawal.

*With buprenorphine 'an experienced and competent clinician may increase the starting dose to 8mg on day one, the 16mg day two and thereafter increase the dose more slowly if necessary'.*

As people are staying on site for one to four hours at the start of treatment, we would welcome partner agencies providing input to this process to support recovery care planning. Narcotics Anonymous have been engaging with patients in our waiting area for a number of years.

### **Question 6:**

**What happens if an individual is off RX by 4 days? Do they go back to start of assessment process or is RX reinstated and/or built back up to dose? What happens if an individual is off RX for a while e.g. weeks to months? What is the length of wait?**

### **Answer:**

Please see the embedded pathway for missed doses. Basically, if assessment determines that someone remains tolerant to opioids, treatment is continued: *Orange guidelines 2017 added in comments in embedded document.*



Missed ost.docx

### **Question 7:**

**Is RX for those discharged from Prison continued on day of release or the next day?**

### **Answer:**

For planned prison liberations, HMP Perth contacts us prior to liberation and a prescription is generated and delivered to the pharmacy prior to liberation. People are dispensed by the prison on the morning of liberation, with dispensing continuing at the community pharmacy the day following liberation. People are asked to drop-in to Constitution House on the day of liberation to develop an initial care plan, risk management plan, and child safeguarding plan and to offer naloxone if declined in prison.

For unplanned court liberations there may be no opportunity to establish a community prescription prior to liberation as we may not be notified. People are asked to drop-in to Constitution House as soon as possible after liberation so we can establish a prescription at a community pharmacy the day following liberation to ensure uninterrupted continuation of OST prescribing.

This well-established process is a particular strength of ISMS with a rapid response to significant risks, which has included nursing, social work or psychiatric assessment within an hour of presentation. This process has supported the development of multi agency risk management plans with follow up professionals' meetings in high risk cases.

ISMS have large numbers of patients transferring into and out of prison, and hospital which relates to the complex risk of the population maintained on opiate substitution treatment In Dundee. This is a significant workload for all ISMS disciplines in addition to clinics. We would welcome partner agencies joining the daily drop in unscheduled care clinics at Constitution House to support multiagency recovery care planning, naloxone training, BBV screening for our highest risk cases and our understanding is that ISMS has already discussed this with the third sector.

**Question 8:**

**Do you ever retox?**

**Answer:**

Orange Guidelines 2017 state that 'in a prison setting, where a patient who was previously on OST in the community and was detoxified following imprisonment, a process of re-toxification may sometimes be justified prior to release'. Our understanding is that this guidance does not apply to Dundee as Tayside Substance Misuse Services provide the substance use service to HMP Perth and prisoners are maintained on OST following incarceration, and the Integrated Substance Misuse Service in Dundee then continue prescribing following liberation. TSMS would not support enforced detoxification from OST of patients in prison, indeed we understand that the TSMS Clinical Lead who provides Consultant input to HMP Perth has opposed this poor practice and led change at national groups to support person centred care.

**Question 9:**

**How many in the last year have been discharged from the service (quick reduction of RX and then discharged) and for what reason?**

**Answer:**

If referencing this in the report, please advise our number is too small therefore details not provided.

*Orange guidelines state 'It may be necessary, following a careful assessment of the risks to the patient and staff to conclude that a prescription must be suspended or in rare cases withdrawn. This may occur for example, following repeated attempts at induction on to OST that have continued to fail to achieve a stabilisation phase. There may for example be continuing concerns about risks of overdose from unstable tolerance in cases of repeatedly unsuccessful attempts at stabilisation. Other serious concerns about the safety and suitability of continued prescribing may also raise this question. Such decisions must involve the prescribing clinician and other members of the multidisciplinary team. Patients must be forewarned of the potential actions that the prescriber and team may take where there is repeated failure to achieve suitable, usually minimum treatment goals, and they should be offered the opportunity to set new goals or identify contingencies that might influence their progress from this point.'*

**Question 10:**

**Do you ever have a situation where you won't take on someone until they have enacted some life style change or given a person a time scale e.g. won't take back for 6 months or however long?**

**Answer:**

We have a direct access service in place from September 2018, and no patient is banned from accessing this service.

The number of disciplinary discharges is too small therefore please do not include detail in the report. Disciplinary discharge is a government definition, our values are not to punish but if violence risk cannot be managed within community agencies, we would review options to continue prescribing with other agencies.

**Question 11:**

**What are the number of planned and unplanned discharges (and how are these defined by the service) – over the 12 months and trends over time?**

**Answer:**

- Planned discharge: 22
- Unplanned discharge: 452

Our view is that this data is so inaccurate it should not be included in the report. There are systemic issues related to SMR data quality in Dundee and that should be what is considered in the report, ISMS and other Tayside agencies have contributed to the quality issues. SMR data quality is a resolved risk on DATIX, the consequences for ISMS are current.

Unplanned discharge rates are likely to be high for the following reasons:

- Long standing issues with SMR data quality in Dundee
- Prison transfers may be coded as unplanned discharges, individuals with multiple brief incarcerations.
- Non-compliance with OST and disengagement related to high levels of polysubstance use.

Planned discharge rates are likely to be low for the following reasons:

- Decisions to detox from OST are patient led and we do not force detox to increase planned discharge rates
- There is no service to discharge people who are stable on OST or prescribed naltrexone to support abstinence from opiates.



DAWT definitions



**Question 12:**

**Over the last 12 months how many individuals DNA'd their first appointment with the drugs service?**

**Answer:**

ISMS has drop-in direct access assessment in place since September 2018, therefore this is no longer relevant.

**Question 13:**

**What is the actual wait from first assessment to Rx for the last three months?**

**Answer:**

We revised our pathway to provide a direct access assessment, followed by an appointment with a prescriber, then a tolerance testing appointment. When initiated we were able to commence treatment within 8 days of direct access which provided good engagement and retention. However, the prescribing capacity of the service could not sustain this and time to start treatment has fluctuated, currently sitting at about three weeks.

**Question 14:**

**Partnership Working**

We have a long-standing commitment to partnership working and understand how this contributes to people's wider recovery, to effective resource utilisation and delivery of services in local communities. To demonstrate this, I include copies of the analyses of the multiagency alcohol pathway from 2015 in which we played a leadership role and replicated the Brighton pathway. All agencies involved supported the implementation following the test of change, except the direct access agency, therefore the referral pathway was not implemented. However, ISMS are now providing our own direct access drop-in service for alcohol, which also has the benefit of less repetition of assessment than accessing via another agency.



ACPA.doc



Referral  
Pathway.docx

In line with this we have supported the service redesign from the outset, to deliver interventions in locality teams in people's communities in collaboration with voluntary sector agencies. To support this, we have undergone integration of drug and alcohol services, integration of the health and social work force and have transferred patients to locality teams. This scale of change can only be challenging for staff and we hope service redesign will support effective partnership working, resolving the current challenges of working with a large number of agencies and interfaces, and supporting recovery.

### **3. Written submission to the Drug Commission's Final Call for Evidence**

In response to the Commission's Final Call for Evidence, Dundee Health and Social Care Partnership provided a detailed response (April 2019), which is presented in its entirety below. This submission was also included in the Commission's analysis of all responses to the Final Call for Evidence (see **Appendix XIV**).

#### **1. Please provide any comments or evidence you have in relation to theme 1 – 'A need to prioritise all possible efforts to reduce Drug Related Deaths in the city.'**

##### **1.1 National Trends**

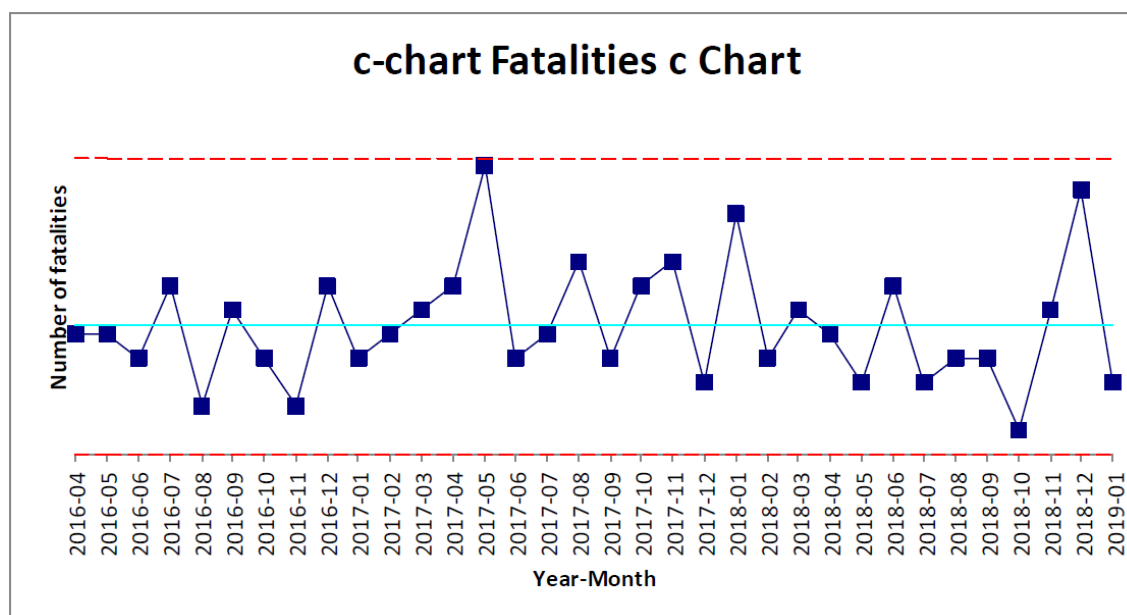
In 2017 Dundee City had the highest rate of DRD per 1,000 population of all council areas in Scotland. However, when prevalence was considered 10 council areas had higher DRD rates per 1,000 Problem Drug users than Dundee City. This relationship between prevalence and drug deaths is replicated globally and ISMS hopes the drugs commission recognises this, and weights the recommendations to address the biological, psychological and social aetiological factors contributing to substance related harms in Dundee. Data collection to support accurate prevalence figures and aetiological factors is vital.

With regards to drug poisoning deaths; last month, members of the Harm Reduction Group of the Partnership for Action on Drugs in Scotland saw some interim figures for 'drug poisoning deaths' registered in 2018. They have a wider definition than normal drug related death figures, because they cover more than just deaths involving controlled drugs (they also include deaths from poisoning by some legal substances, such as over the counter medicines). There was a breakdown by NHS Board area, but not for individual councils like Dundee. It appeared that between 2017 and 2018, Tayside had an increase of about 5%, compared with a rise of well over 20% for Scotland as a whole. However these figures may not be reliable, because the data collection process is still underway, and the numbers for some parts of the country could have been significantly incomplete: interim figures like those are at best, only a rough indication of what may have happened in 2018. [*National Records for Scotland*].

##### **1.2 ISMS All-Cause Mortality Trends**

The Integrated Substance Misuse Service takes every death seriously whatever the cause. In terms of all-cause mortality ISMS observed a 10% reduction in deaths between 2017 and 2018. When comparing the time periods 1st January to 15th May in 2018 and 2019, ISMS had a 35% reduction in death notifications. ISMS has a well-established governance process for deaths which includes analyses of trends and contributing factors as demonstrated below:

Figure XX: ISMS All-Cause Mortality Trends (April 2016 – December 2018)



Peaks tend to occur at Christmas and Easter holidays. These periods are associated with closure of community pharmacies and reduced access to daily supervised consumption of opiate substitution treatment (OST) and provision of collected doses, although we have not demonstrated a causal effect. The UK Guidelines state the aims for supervised consumption are; to ensure the patient receives the prescribed dose, reducing diversion of prescribed doses, reducing the risk of drug related overdose and deaths, minimising the risk of accidental consumption by children, providing an opportunity for the pharmacist to build a therapeutic relationship and make a regular assessment of the patient. 'It should not be used or viewed as a punishment.' This is in line with ISMS clinical values to use supervised consumption to mitigate risk and the trends chart demonstrates the potential efficacy of this. We would hope the Drugs Commission would support UK guidelines and not describe our use of this intervention as a punishment.

Another scenario where there is reduced access to supervised dispensing is when patients are banned by all seven day dispensing pharmacies in Dundee. Dundee is well served by three seven days dispensing pharmacies and banning becomes problematic if risk assessment indicates that the provision of a collected dose on a Sunday may increase risk. This places ISMS in a position where there are imperfect solutions to mitigate this risk, such as dispensing out of area, not providing a Sunday dose, accepting the risk and providing a collected Sunday dose, or changing OST. ISMS would respectfully request the drugs commission carefully reviews our mortality trends chart above and consider potential unintended consequences, prior to making any recommendations to remove any of these imperfect risk mitigation options.

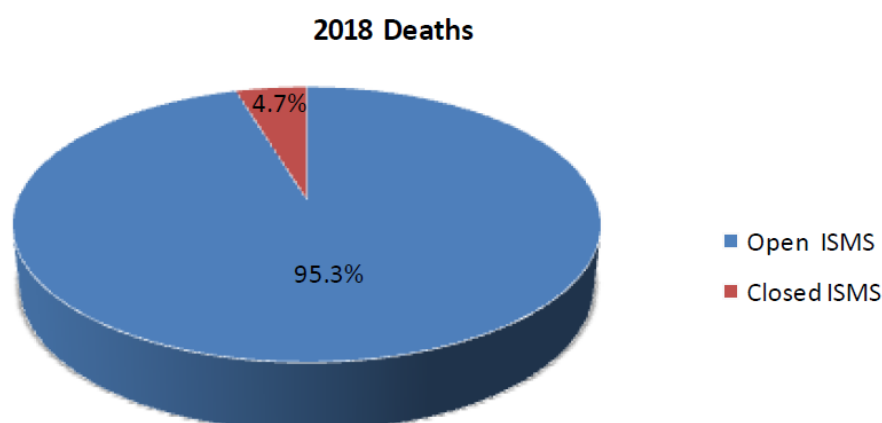
ISMS does not own the risk related to limitations of access to supervised dispensing but completed DATIX actions 5033 evidences this issue was escalated and assurance provided that this was considered an unmet need, that work would be undertaken to assess the scale of this need and would be published in the Pharmaceutical Care Services Plan at the NHS Board.

### 1.3 ISMS 2018 deaths

ISMS undertook further analyses of deaths in 2018 related to drug poisoning including drug deaths, drug related deaths, suicides by poisoning, and deaths from unascertained cause. The majority of deaths were drug deaths and drug related deaths. We included deaths of individuals who were either open cases to ISMS or died within a year of ISMS closing the case. We excluded a small number of deaths where ISMS was not the lead organisation investigating the death.

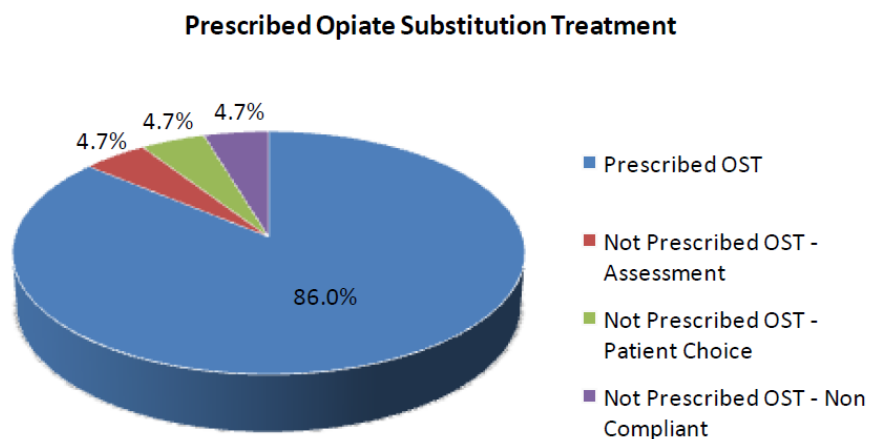
The figure below demonstrates that the majority of cases were open to ISMS at the time of death, with 95.3% being retained in the service.

Figure XX: 2018 Deaths



The figure below demonstrates that the majority of deaths were prescribed opiate substitution treatment (OST) with 86% being retained on OST. Of the 14% not prescribed 4.7% were being assessed to commence OST with no cases being declined starting OST by ISMS. 4.7% had stopped OST to support their recovery goals, and 4.7% had become non-compliant with OST and attendance at appointments and had been discharged from ISMS. No deaths had OST stopped by ISMS.

Figure XX: Prescribed Opiate Substitution Treatment



ISMS opiate substitution treatment population consists of 1,130 people maintained on opiate substitution treatment with 919 (81.3%) prescribed methadone and 211 (18.7%) prescribed buprenorphine. The figure below demonstrates that the fatality population has a higher population prescribed methadone 94.6% and lower percentage prescribed buprenorphine 5.4% compared to the treatment population. The fatality population had an average maintenance dose of 16mg buprenorphine and 67mg methadone.

Figure XX: Opiate Substitution Treatment Choice (Treatment Population)

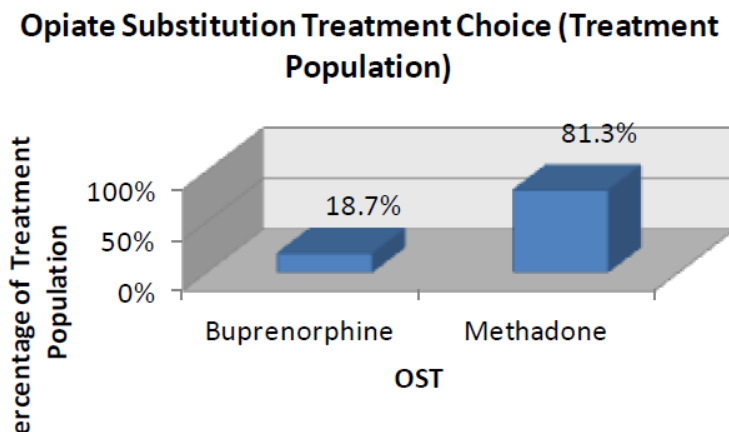
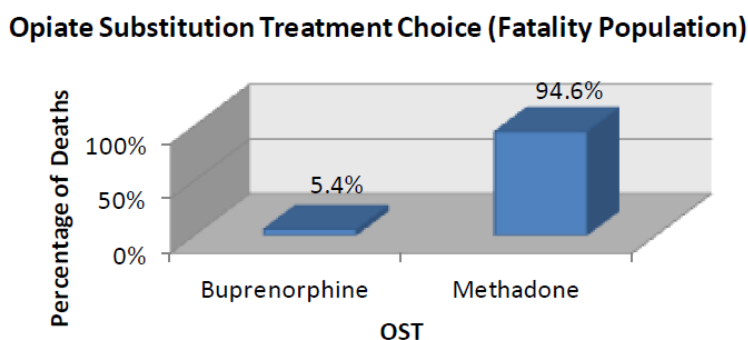
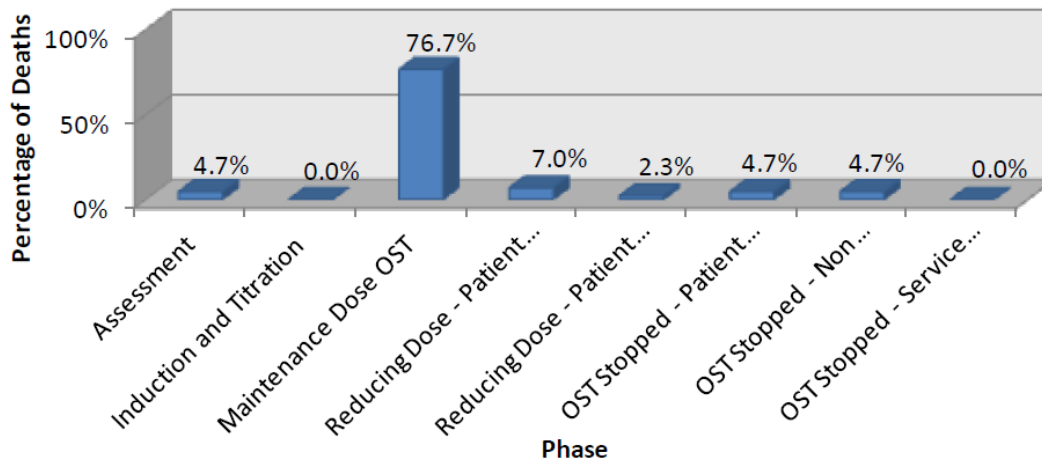


Figure XX: Opiate Substitution Treatment Choice (Fatality Population)



Analyses of the treatment phase in which death occurs is undertaken annually to inform service development. The figure below indicates that the majority of deaths 76.7% occurred in people on maintenance dose OST. 4.7% occurred in people being assessed to commence OST, 7.0% were on a reduction regimen to support a goal of OST detoxification, 2.3% were on a reducing dose to support transfer to buprenorphine, 4.7% were no longer prescribed OST to support a goal of opioid abstinence, 4.7% had become non-compliant with OST. There were no deaths during OST induction, dose titration, or due to ISMS stopping OST.

Figure XX: Drug Related Deaths by Treatment Phase



In terms of substances contributing to deaths, the figures below indicate the minority of deaths 47% had opiates present and a smaller percentage 21% had intravenous substance use present.

Figure XX: Contribution of Opiates in deaths

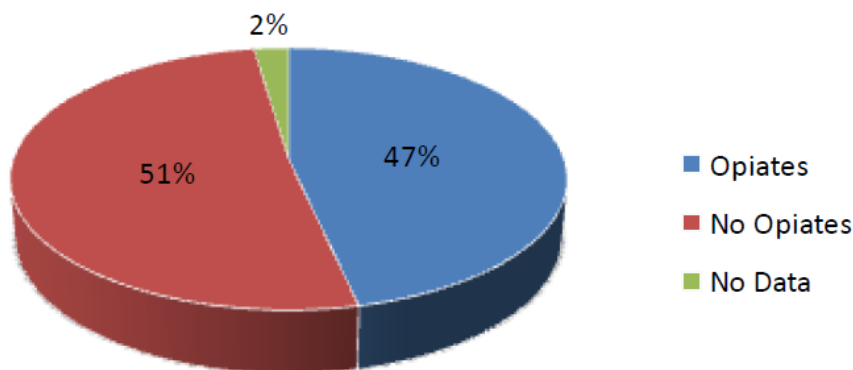
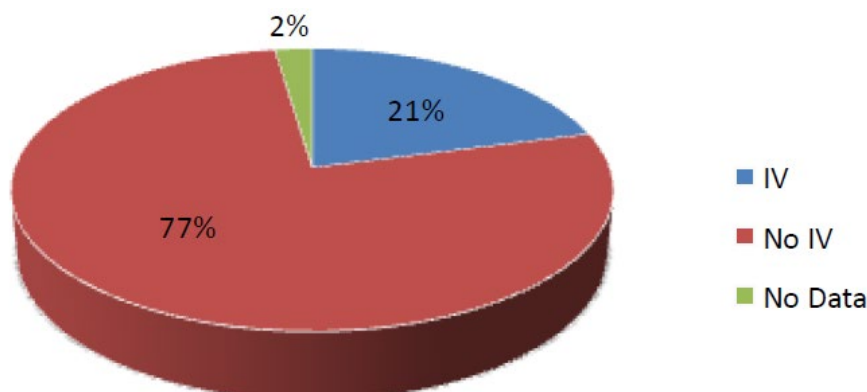


Figure XX: Contribution of Intravenous Substance Use in deaths



To summarise, there is no evidence that clinical decision making regarding opiate substitution treatment provides a systemic contribution to deaths in ISMS, with the majority of cases being retained in ISMS on opiate substitution treatment, with intravenous opiate use being eliminated in the most cases. The proportion of cases being prescribed buprenorphine by ISMS is increasing.

However ISMS has escalated (DATIX risk 612) that as a result of low numbers of staff with prescribing competencies in Dundee Integrated Substance Misuse Service, there may be delays accessing and reviewing prescribing interventions, which could impact on the quality of delivery of prescribing interventions and cause clinical risk.

**2. Please provide any comments or evidence you have in relation to theme 2 – 'A general lack of mental health support for those with drug use issues.'**

**2.1 Community Programme**

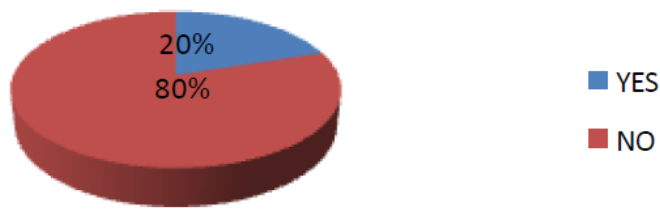
ISMS Consultant Psychiatrist and Senior Nursing staff led on establishing a two-week community programme in 2015 initially to provide support to those completing a withdrawal from alcohol, and then extended to support opiate detoxification. People who have completed an inpatient withdrawal can also attend the programme following discharge. The programme consists of:

1. Chlordiazepoxide prescribed alcohol withdrawal.
2. Reduction regimens of methadone or buprenorphine.
3. Prescribing to support abstinence; naltrexone, acamprosate, disulfiram.
4. The ISMS Clinical Psychologist took a lead role in reviewing the psychological component of the programme which involved observation and facilitation of two programmes and informal discussion with service users and staff. Following this an improved programme for opiates and alcohol was implemented, and staff delivering the programme are clinically supervised by the ISMS Clinical Psychologist.
5. Third sector input from Gowrie Care and Tayside Council for Alcohol regarding their provision to support recovery, and SMART recovery. This is a good example of ISMS leading on establishing structures to foster collaborative working with the third sector.
6. Peer support from fellow group members.
7. Daily structure.

The programme receives good patient feedback as detailed below. The majority of people attending the programme had not completed the programme previously, indicating most attendees had not previously completed the programme and then relapsed.

Figure XX: Programme completions within the last 3 months

**Have you completed this programme previously, within the last 3 months?**



Most attendees felt more confident they could maintain sobriety at the end of the programme.

Figure XX: Confidence in maintaining sobriety (pre-programme commencement)

**Prior to commencing this programme, how confident were you in maintaining your sobriety?**

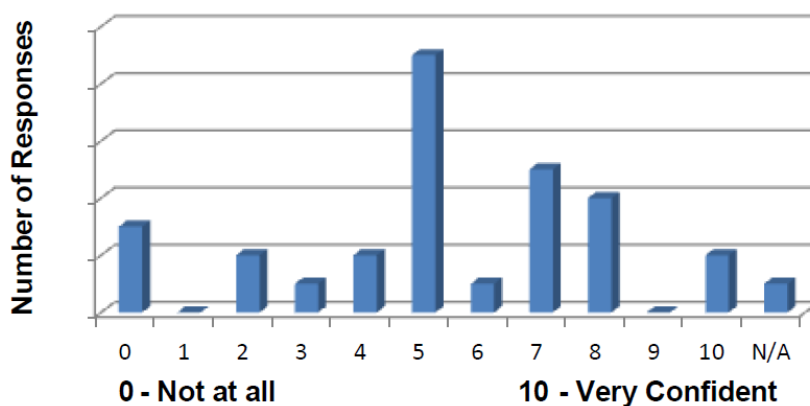
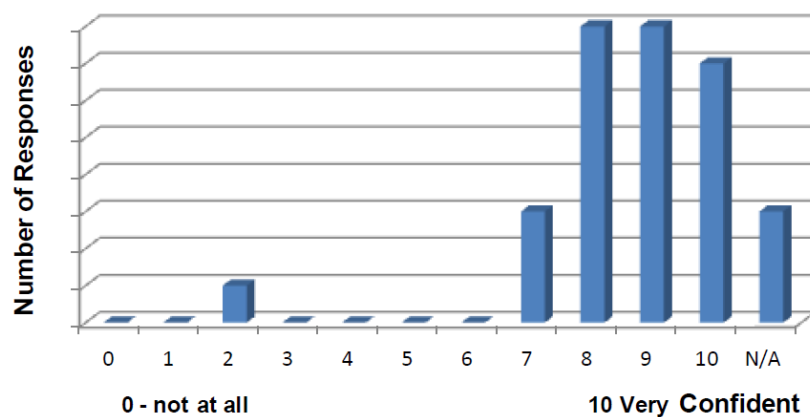


Figure XX: Ability to maintain sobriety (post-programme completion)

**Now you have completed the programme, how would you rate your ability to maintain your sobriety**

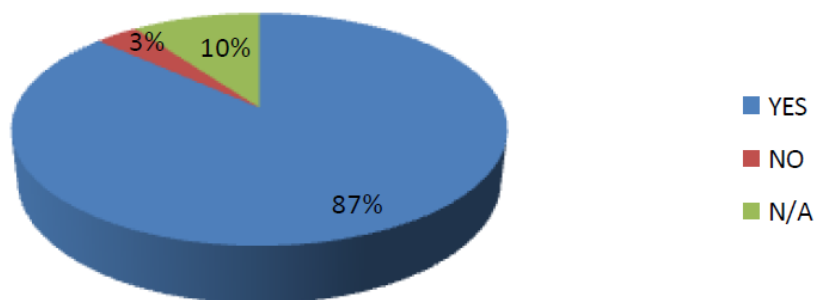




Most patients 87% planned to engage with other supports following the programme.

Figure XX: Plans to engage with other supports

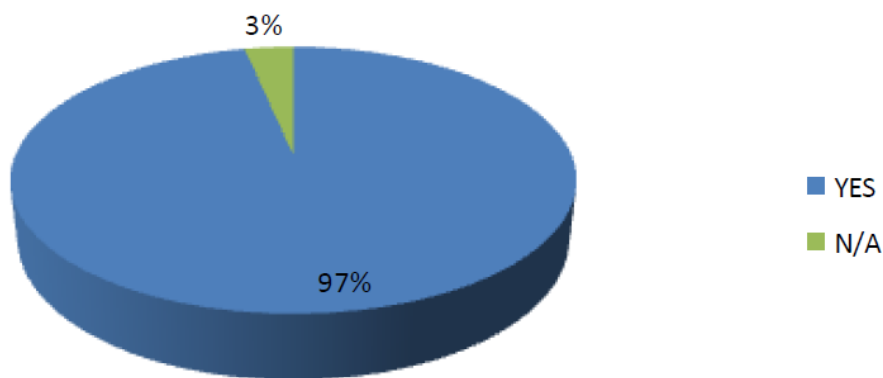
**Are you planning to engage with any of the following:  
SMART recovery, Peer Mentoring, Relapse Prevention,  
Psychology, TCA or Community Health Teams**



Most patients 97% would recommend the programme to others.

Figure XX: Likelihood of recommending the programme to others

**Would you recommend this programme to others**



There is a wealth of lovely comments from patients attending the programme which we have collated. Out of respect to those attending the programme we have not included the comments in this report but would be happy to meet with any DDC members wishing to read them.

In summary, ISMS patients value detox supported by a comprehensive group programme with prescribing, psychosocial and peer support, delivered in partnership with the third sector.

## 2.2 Survive and Thrive Project

Survive and Thrive is a psycho-educational course which is designed for service users who are experiencing the psychological and emotional difficulties which can result from life experiences often described as complex trauma. Dundee ISMS Clinical psychology led on establishing a Survive and Thrive pathway for those patients open to ISMS in 2017. The ISMS Clinical Psychologist facilitates Survive and Thrive groups running as part of the wider S&T project across the city. This allows ISMS patients to access these groups and cases are screened via a consultation appointment with the patient and key worker as per the usual referral pathway. Informal feedback is that ISMS patients find accessing a generic group alongside non-substance use patients very validating. In summary, ISMS patients with complex trauma who would benefit from a Survive and Thrive course can access this intervention.

## 2.3 ISMS Psychology Outpatient Clinics

Patients open to ISMS can access a joint key worker and clinical psychologist appointment via discussion at the multidisciplinary team meeting or by a request from their GP. A plan may be developed for their key worker to deliver psychosocial interventions, or for clinical psychology to assess and deliver higher intensity psychological interventions. Patient feedback is undertaken periodically for the professional development of clinical psychology staff and is summarised below.

Figure XX: Did your Clinician listen to you and take your concerns seriously?

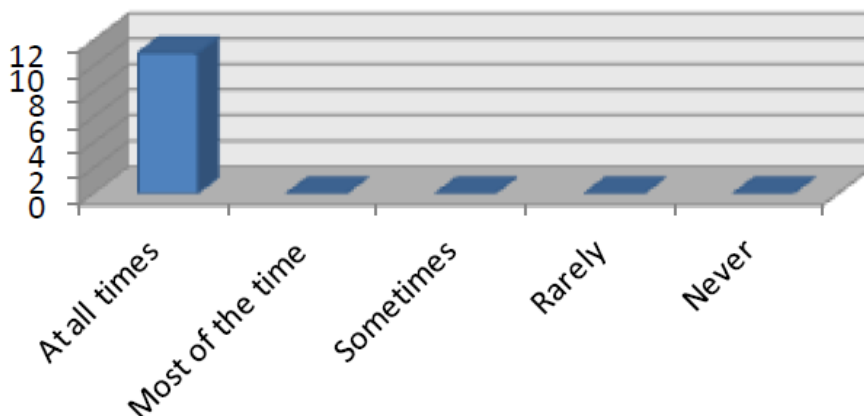


Figure XX: Do you feel that the service has helped you to better understand and address your difficulties?

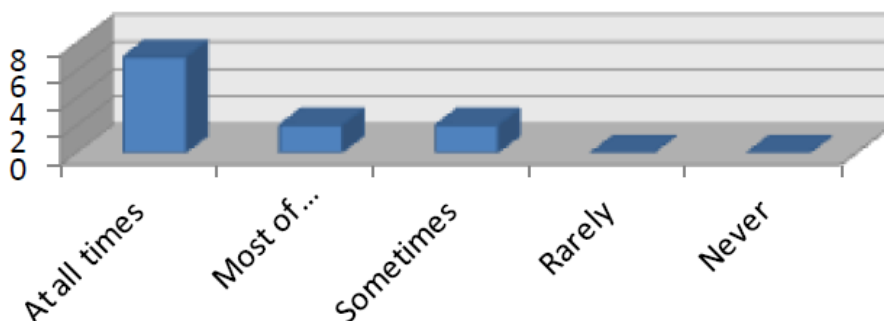


Figure XX: Did you feel involved in making choices about your treatment and care?

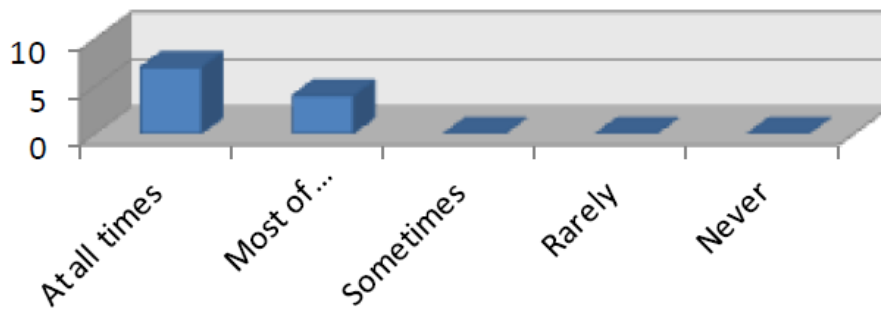


Figure XX: On reflection, did you get the help that mattered to you?

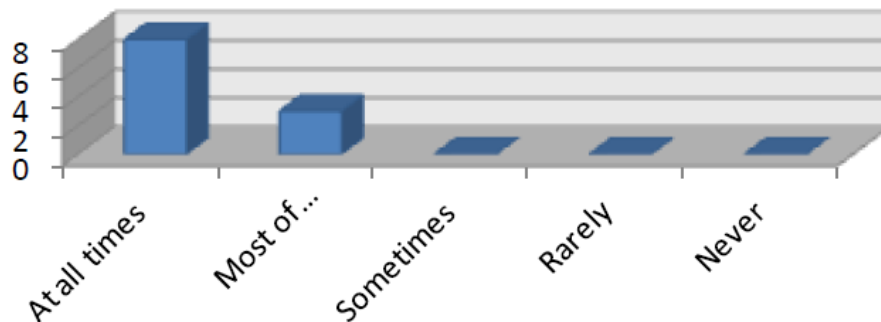
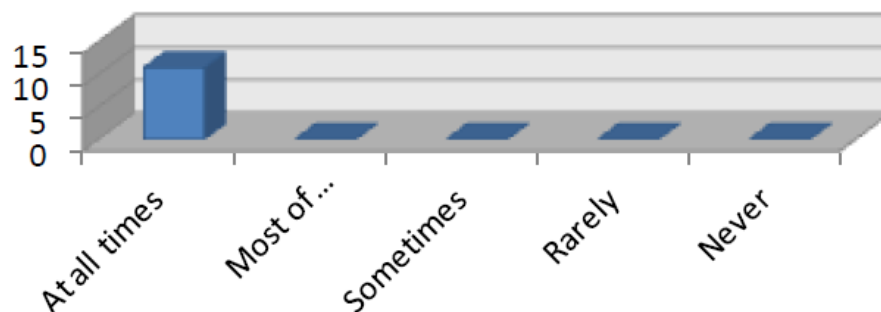


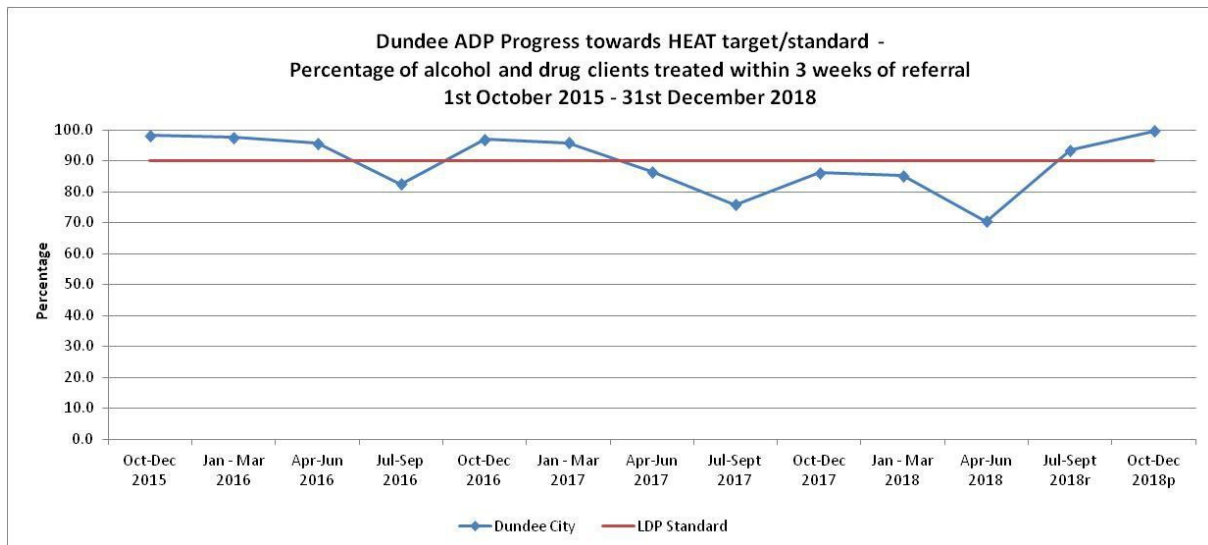
Figure XX: Did you have confidence in your therapist and their skills and techniques?



## 2.4 ISMS Psychiatric Outpatient Clinics

Patients open to ISMS can access a Psychiatric assessment of their mental health via discussion at the multidisciplinary team meeting or by a request from their GP. This involves assessment, formulation, diagnosis and the development of a management plan including prescribing, risk management and wider care planning and referral. However, this is a limited resource for those with the most complex needs and a resource which is also used to manage opiate substitution prescribing, OST risk escalation and substance use risk escalation. Direct access was introduced in September 2018 which has supported the service to achieve compliance with HEAT A11 targets but has resulted in the ISMS Psychiatric resource being further diverted to those requiring access to opiate substitution treatment.

Figure XX: Progress towards HEAT target/standard



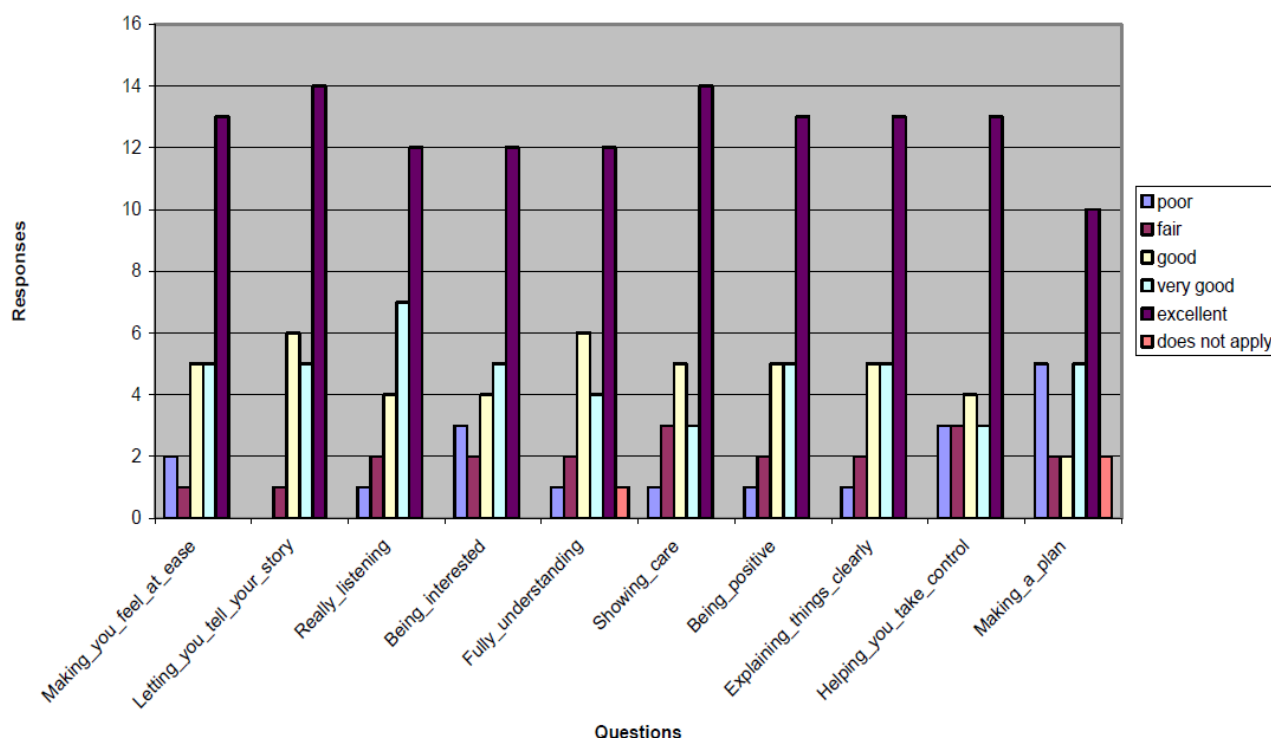
A brief analysis of 17 consecutive cases attending an outpatient clinic is provided below to give a flavour of the service provided:

- <ten were also open to a Community Mental Health Team.
- <five had a mental state examination and diagnosis and were admitted to Caresview Hospital directly from the clinic.
- <ten had a mental state examination, diagnosis, and review of psychotropic medication; 3 had a joint assessment with ISMS Psychology planned, 1 had a joint assessment with CJSW.
- <ten had an assessment to commence OST; 6 commenced OST within 7 days.
- <five were on maximum dose OST, engaged in polysubstance use and were at increased overdose risk; the risk management plan was revised.
- <five were patients with complex risk requiring OST dose titration.

This data confirms that ISMS Psychiatry appointments are used for the management of complex risk related to substance use and mental health, and to provide access to OST, and that there is collaboration across disciplines. There is no evidence that patients are systematically denied access to Community Mental Health Teams although we acknowledge there may be individual exceptions to this.

Patients periodically provide feedback to medical staff for their professional development a summary of which is provided below. Consecutive patients attending clinics are included to limit selection bias. Patients have been kind enough to provide comments which are largely positive, out of respect to the patients these have not been included in this report but we would be happy to meet with any DDC members wishing to read them.

Figure XX: Patient feedback report



## 2.5 Inpatient treatment

ISMS accesses planned admissions to Kinclaven Unit, which is a specialist Substance Use ward. However, ISMS patients with mental health risk requiring admission are admitted predominantly to Caresview Hospital. Inpatient admissions figures from 01.07.2017 to 07.02.2019 indicate that 15.9% of admissions to wards serving a Dundee catchment area have a primary diagnosis of F10-F19 Substance Use Disorder. These figures suggest there is no systemic issue with a lack of inpatient support for those with substance use disorders, but we acknowledge there may be individual exceptions to this.

## 2.6 Training

ISMS have a comprehensive mandatory training plan which encompasses mental health and other competencies. In addition, the following mental health training has been delivered by the ISMS Clinical Psychologist:

- Suicide 5P risk formulation; all staff offered training tailored for substance misuse staff to assess / formulate and manage the risk of suicide
- Trauma awareness delivered to social work staff based on the NES KSF Trauma Training Framework
- Relapse Prevention Training
- An introduction to CBT at the Team Development Day.

## 2.7 Consultation and Supervision

- ISMS Psychology attend multidisciplinary team meetings to advise on the psychological

components of care. Cases can be escalated for joint assessment with ISMS Psychology.

- ISMS Psychology provides consultations with service users and keyworkers to assess and formulate recommendations for keyworkers regarding the delivery of tier 1 and tier 2 interventions or referral for one to one higher intensity psychological interventions with ISMS Psychology.
- ISMS Psychology regularly liaises with other psychological specialities to discuss management of referrals for co-occurring mental health problems to ensure service users access the right intervention at the right time.
- ISMS Psychology supervises staff delivering the community programme.
- ISMS Psychology commenced supervision / coaching for substance use and co-occurring mental disorders in 2019.
- ISMS Consultant Psychiatrist attend multidisciplinary team meetings to advise on mental health and substance use risks, and to provide opiate substitute prescribing interventions. Cases can be escalated for review in ISMS Psychiatric outpatient clinics.
- ISMS Consultant Psychiatrists supervise medical and non-medical prescribing staff.
- ISMS Consultant Psychiatrists liaise with other psychiatric specialities regarding referral for co-occurring mental disorders.

## 2.8 Research

ISMS Clinical Psychologist supervises a systematic review looking at the evidence base for Relapse Prevention and psychological interventions for co-morbid mental health problems in a substance misuse population. Clinical Psychologist has also liaised with the Drug Research Network Scotland (DRSN) as part of the LPASS data collection for trauma interventions currently delivered within Addiction services in Scotland.

### **3. Please provide any comments or evidence you have in relation to theme 1 – ‘A need to improve leadership and governance.’**

Our approach to clinical leadership and governance is evidenced throughout this and previous reports, we would welcome discussion of any specific concerns the DDC has. Further information regarding leadership, governance and redesign from an HSCP perspective will be provided by Dundee Health and Social Care Partnership.

### **4. Please provide any comments or evidence you have in relation to theme 1 – ‘A need to improve the quality and breadth of treatment and support for those with drug issues – and their families.’**

TSMS Prescribing Guidelines outline our values to deliver person centred, evidenced based prescribing to achieve the best outcomes for people using the service, we have previously provided a copy of the

guideline. We deliver prescribing interventions in multidisciplinary pathways incorporating psychosocial interventions to support recovery goals.

The quality of our interventions is impacted on by capacity issues which have been escalated (DATIX risk 233).

### **3. Analysis of the Deeper Dive of DRD Data commissioned from ISD (Dundee v's Rest of Scotland)**



#### **Comparison of DRD's in Dundee City vs Rest of Scotland, NDRDD 2009-2016**

**Authors: Tayside Substance Misuse Services and NHS Tayside Public Health**

**Date of report: 21<sup>st</sup> June 2019**

The percentage of Scottish drug deaths located in Dundee was 5.0% in 2015 and 2016, compared to a range of 5.4% to 6.5% between 2009 to 2014.

The percentage of deaths where the person affected was female has remained approximately constant in Dundee in recent years but is increasing in the rest of Scotland.

A higher percentage of drug death casualties were in the 25-44 age range in Dundee (73%) compared to the rest of Scotland (65.3%), and a higher percentage were living in areas included in the most deprived SIMD quintile (66.4% v 51.6%). A lower percentage of casualties had been 'living alone' immediately prior to death (50.8% v 54.8%) or 'living alone only' (39.3% v 50.7%). ISMS hope any plan to address drug deaths in Dundee incorporates organisational strategies to support communities with high levels of deprivation.

More drug death casualties in Dundee were prescribed Opiate Substitution Treatment (OST) at the time of death than the rest of Scotland (42.2% v 28.7%), this suggests access to treatment and retention in treatment is less of a factor in drug deaths in Dundee compared to elsewhere.

Compared with the rest of Scotland more casualties of a drug death had been prescribed methadone in Dundee (98.1% v 90.9%), fewer prescribed buprenorphine/naloxone (0% v 5.9%), and a similar proportion prescribed buprenorphine (1.9% v 1.7%). In 2018 the ISMS opiate substitution treatment population consisted of 1,130 people maintained on opiate substitution treatment. In this group, people who were subsequent casualties of a drug death were more likely to have been prescribed methadone (94.6% of people who died compared to 81.3% of people who did not die) and were less likely to have been prescribed buprenorphine (5.4% of people who died compared to 18.7% of people who did not die). Given the association of increased risk of death in people taking methadone

compared to buprenorphine ISMS has increased the prescribing of buprenorphine/ naloxone (suboxone) to people considered at particular increased risk of drug death in recent years.

No individuals had been prescribed dihydrocodeine in line with the British National Formulary - dihydrocodeine is not indicated or licensed for opiate substitution treatment.

Compared to the rest of Scotland, a lower proportion of drug deaths occurred in Dundee whilst the patient was engaged with treatment in the first three months (5.8% v 9.5%); this would suggest optimal assessment, prescribing process and skills during OST induction and titration which is a period associated with increased mortality risk.

However, a higher proportion of drug deaths occurred in Dundee when the patient had been engaged with the service longer than three months and up to ten years (79.6% v 62.8%). This relates to DATIX risks raised regarding capacity challenges of allocating cases and providing routine prescriber reviews for people maintained on OST. A workforce plan and funding is in place to continue to develop the non-medical prescribing workforce for case allocation to deliver key working and prescribing interventions.

Compared to the rest of Scotland, a lower proportion of drug deaths occurred in Dundee where the person had been engaged with treatment for more than ten years (12.6% v 19.1% in the rest of Scotland), challenging the narrative around deaths related to being 'parked' on methadone.

A greater proportion of drug deaths occurred in Dundee where the person affected was engaged with treatment and OST was within therapeutic dose range (methadone 60-120mg, buprenorphine 12-16mg). This indicates other factors contributing to death and ISMS has been escalating concerns around the contribution of polysubstance use with gabapentoids and illicit benzodiazepines to increased risk of death whilst on OST for some time now. This also relates to the DATIX risks raised regarding the capacity challenges of allocating cases and providing routine prescriber reviews for those maintained on OST. Lack of NHS Tayside drug screening for gabapentoids, etizolam and buprenorphine to guide case management, and the lack of oral fluid testing have also been escalated.

Dundee had a higher percentage of drug death casualties where the person was prescribed low dose methadone. In 2018 ISMS completed an audit cycle of cases prescribed methadone 30mg or lower to review prescribing goals in partnership with patients to assure optimal methadone treatment. As such the percentage of deaths on low dose methadone may have reduced over the last eighteen months.

Dundee has a higher percentage of drug death casualties who have been in contact with drug treatment service at the time of death (48.8% v 36.3%) and a lower percentage waiting for the drug treatment service (4.9% v 5.2%) compared to the rest of Scotland. This would suggest there are fewer challenges accessing services in Dundee compared to the rest of Scotland.

Dundee has a higher percentage diagnosed with a blood borne virus compared to the rest of Scotland (25% v 17.4%). ISMS conducted a quality improvement project to offer blood borne virus testing to 550 people established on OST prior to the implementation of the OST access blood borne virus pathway. This identified those with historic intravenous substance use risks for testing and referral, and as such more of the population at risk in ISMS may have been tested when compared to the rest



of Scotland. This is recorded as a resolved DATIX risk. It is estimated that in Tayside 85-90% of our prevalent HCV case load has been diagnosed against a 56% estimate for the rest of Scotland.

There is a higher percentage of drug death casualties who have had a DVT diagnosis (3.3% v 2.5%), which indicates higher levels of intravenous substance use, at some point in six months prior to death. Of note, this is for all casualties. Data considering people engaged with ISMS at time of death or within a year of death, confirmed the majority 77% had no intravenous substance use at the time of death on post-mortem results.

Dundee has a higher percentage of drug death casualties who had been diagnosed with epilepsy (7.8% v 6.1%) compared to the rest of Scotland. This may impact on rates of other concurrent substance use, in particular other substances that enhance the effects of GABA, e.g. alcohol, benzodiazepines, gabapentoids which are associated with increased risk of death.

Dundee has a higher percentage of drug death casualties known to have problem alcohol use (68.9% v 59.7%), again relating to concerns about higher levels of polysubstance use.

Dundee has a higher percentage of drug death casualties who have been diagnosed with back pain / injury (9.0% v 5.1%), which could also account for increased gabapentoid prescribing.

With regards to substances present in the toxicology at death, diazepam figures for 2009 to 2016 were similar to the rest of Scotland (68% v 66.8%). However it is of note that ISMS reduced diazepam prescribing from 2013-2016 informed by McCowan et al BMJ 2009 findings that co-prescribing of diazepam with methadone was the strongest predictor of drug dependent death for people prescribed methadone in Tayside, and this was corroborated by learning from Local Adverse Event Reviews of drug death casualties in Dundee. The contribution of diazepam to drug death casualties was higher in Dundee compared to the rest of Scotland from 2009 to 2012 (85% v 77%), but following the reduction in diazepam prescribing was lower in Dundee from 2013 to 2016 (54.9% v 61.4%).

With regards to opiate substitution treatment present in the post mortem toxicology of drug death casualties, Dundee had a lower percentage with buprenorphine present (0.8% v 4.5%), and a higher percentage with methadone (56.6% v 44%) present. The following substances had higher percentages than the rest of Scotland, etizolam (19.3% v 9.4%), gabapentin (32.0% v 13.5%), and pregabalin (10.7% v 7.1%), which may relate to increased availability of these substances in Dundee. More had gabapentoids prescribed in the 90 days prior to death (20.1% v 13.4%), which is of note as Lyndon et al Addiction 2017 conclude that increasing gabapentoid prescribing correlates with increasing deaths, and that 79% of gabapentoid deaths occur in the presence of opioids. Dundee carried a higher polypharmacy score (1.14 v 1.11). ISMS have escalated the contribution of polypharmacy with gabapentoids in drug deaths and this is incorporated in the Dundee Drug Death plan. In line with the values of realistic medicine ISMS prescribing staff review GP and ISMS prescribing at each prescriber review, highlight any overdose risk to GP's and request a review of continued gabapentoid prescribing.

Dundee has a lower percentage of deaths where the person has committed suicide using illicit or illicitly obtained drugs compared to the rest of Scotland (2.0% v 5.6%). As Dundee has a higher

percentage of people with a diagnosed psychiatric condition (66.8% v 54.9%) this would suggest good risk management of this population. This also endorses the role of mental health professionals in ISMS and more broadly in Addiction Psychiatry, including Psychiatrists and Registered Mental Health Nurses.

## APPENDIX XVII: STAFF FOCUS GROUPS (ISMS)

### Introduction

A process for conducting focus groups with staff was agreed in line with NHS Tayside policies.

Three sessions were scheduled, with attendance numbers as follows:

Friday 15<sup>th</sup> March 2019 (am) – 5 staff attended (all health staff)

Friday 15<sup>th</sup> March 2019 (pm) – 9 staff attended (mix of health and social work staff)

Friday 22<sup>nd</sup> March 2019 (pm) – 2 staff attended (one health and one psychology)

The focus groups were led by John Goldie (Commission Member) and supported by Andy Perkins (Figure 8).

### Notes and observations

The initial comment has to be to those who participated, thanking them on behalf of the Commission. These staff participated and shared their thoughts in an open and professional manner. Although it has to be said it did come as a surprise the number of staff that did participate (or maybe more apt that should be 'did not participate') in relation to the size of the full ISMS team. It was hard to establish if all professional groups were represented but certainly nursing, social care, psychology and middle management attended.

A common theme that was very apparent from the outset of all the sessions was the suspicion staff had in relation to the work of the Commission and an apparent lack of understanding of the business and the full purpose/scope of the Commission. It had to be stressed on several occasions that the Commission's primary job was not to review ISMS as this seemed to be a belief held by some staff. It was also reported disappointingly that staff had been positively discouraged from attending and participating by senior management and were cautioned to be "careful in what they say/disclose to the Commission". This may be the reason for smaller than expected participation.

Themes that came out from the sessions highlighted similar issues to many drug services nationally: i.e. a very busy service struggling with challenges of delivering service user requirements within a backdrop of reduced resources and an organisation struggling to find its feet whilst in the middle of a major integration change agenda. Below are listed the common themes staff highlighted in their day to day delivery of service challenges.

**Resources** - Staffing changes/vacancies it was commented (i.e. the inability to fill certain posts) have impacted negatively in the service's ability to offer the provision it would like to. This is especially relevant to medical vacancies including a long term vacant Consultant position, nursing posts, psychology post. It was also highlighted that the physical resources (buildings) used to engage clients are described as poor and not conducive to positive engagement and promoting recovery options. It was commented that the service is due to move to a locality based model which would see

provision more community based and staff appear to welcome this as a positive development, although it was commented that partners were not openly welcoming ISMS to use their facilities. This again is a common theme nationally when substance misuse services attempt to integrate into wider primary care areas.

**Integration** - The service is presently in the process of adopting a fully integrated model of service delivery transitioning from separate social care and health structures. It is clear that this is still at an early stage and some staff are struggling with what this means for their role going forward. This was specifically highlighted in relation to the role and function of the Qualified Social Workers in the team. It was not clear that there was a common understanding of the direction of travel and clarity regards the ultimate service strategy.

**Workload** - It was highlighted that the reported caseloads of staff were a challenge and at present the service concentrated on progressing prescribing availability with wider care management taking a "back seat". There appeared to be no clear treatment journey process to allow clients to positively exit the service, with the service concentrating on attempting to engage and retain as many clients as possible without a clear understanding of treatment interventions that will be adopted to deliver a positive outcome.

**Partnership Working** - It did not come across in the session that staff had a full understanding or clarity of the role of Dundee's 3rd sector providers in working together to deliver joint client outcomes. Staff were not aware of the role or function of the Alcohol and Drug Partnership (ADP). Again, this is likely to be no different to other areas as staff have a greater concern on operational priorities that ADP strategic direction.

**Service Perception** - It came across strongly that staff felt undervalued and "under seige" with the recent media attention and drug death figures. The media coverage of the work of the Commission inadvertently has probably contributed to this sense. It did come across that management, rather than reducing these perceptions or anxieties, have in fact strengthened this view amongst staff. As a consequence, the work of the Commission has been viewed with heightened suspicion, rather than as a positive agent for change. This is unfortunate, as once staff engaged in these sessions, some positive views came across. Staff clearly wondered why the Commission did not come and talk to them first at the beginning of the Commission process and assumed that there was some planning behind this decision. Once it was explained that it had taken considerable time for the Commission to navigate a course through the management structure and it would have been the Commissions desire to speak to staff at the earliest possible date, but this had not been possible, the staff in attendance felt reassured that the Commission's work could and should be positive.

In summary, the sessions were very open and honest but disappointing in the numbers in attendance. As the majority of staff did not attend, it is not clear that the views expressed at the sessions are representative of the total workforce or reflect only those who have a specific view and a desire to express it.

## APPENDIX XVIII: KEY STAKEHOLDER MEETINGS AND INTERVIEWS

### Introduction

A whole range of key stakeholder meetings and interviews took place over the course of the year, on a whole range of themes. Although it has not been possible to write all of these up for the purposes of this report, the discussions that have taken place have consistently helped to shape the findings of the Commission's work. The organisations represented in these meetings and interviews were:

ORGANISATION
Addaction
Boots Pharmacy
Dundee Carers Centre
Dundee City Council
Dundee HSCP
Dundee Protecting People Team
Dundee Voluntary Action
Dundee Women's Aid
Dundee Women's Rape and Sexual Abuse Centre (WRASAC)
Eagles Wings Trust
Hillcrest Futures
HMP Perth
Independent Inquiry into Mental Health Services in NHS Tayside
Members of UK and Scottish Parliaments
NHS Tayside
Parish Nursing Team
Positive Steps
Public Health, NHS Tayside
Scottish Government



## APPENDIX XIX: SERVICE USER, FAMILY AND MEMBERS OF THE PUBLIC – MEETINGS AND CORRESPONDENCE

### Introduction

Invitations were extended through the Commission's Calls for Evidence and by word of mouth through services and via meetings for individuals with lived experience and family members to speak directly to the Commission (via discussions with Andy Perkins and or Robert Peat). This has been added as an extra layer of informal evidence gathering to the initial planned methods of the Commission.

Over 30 individuals and family members have come forward over the last year to speak of their experiences of the treatment and support that is available in Dundee and to discuss the changes they would like to see to improve the situation in Dundee. These meetings were all conducted in confidence and no names will be reported in this document.

The meetings included a wide range of discussions ranging from very positive experiences to one's that have been very difficult to listen too. The balance of views are reflected in the key themes that the Commission have heard about through their formal evidence gathering methods.

Additionally, on 2<sup>nd</sup> November 2018, a series of meetings with family members and people who are experiencing (or have experienced) problems with drug use were set up – five meetings in total, involving nine people:

- One current person experiencing drug problems (supported by his support worker);
- Two former people experiencing drug problems (one of whom talked extensively about her experience of both mental health and substance use services);
- One family member;
- Three members of a family/carer support group (supported by the manager of Dundee Carers Centre).

The meetings were held in private and facilitated by Justina Murray (Commission Member). Andy Perkins (Figure 8) and Sharon Brand (Commission Member) were also in attendance.

### Key Themes

1. Use of substances for **pain management**, "not a typical addict". In the support worker's view, the service "made him an addict". This link between pain and substance use not fully recognised (pain management clinic no longer running?). "You have to find out where the hurt is coming from".
2. **Lack of choice** by ISMS and **lack of explanation** for changes in prescribing e.g. Valium to pregabalin.
3. **Critical role of advocacy/ mentors** for service users and families to navigate system, get their voice heard, manage frustration e.g. as soon as one of the service users got a support worker

who went with him to appointments, "services jumped to attention". However, ISMS proactively sought to exclude advocacy worker. The worker was told that all of her client's appointments would be on a one-to-one basis only. This is in contravention of the NHS's own advocacy policy.

4. **Lack of joined up working** between GPs and ISMS, including people in crisis being bounced between them (have to go to GP first, no have to go to ISMS first etc). Also, a lack of joined up working across services e.g. following prison release – "The dots are just not joined up".
5. Ability of treatment services to **act as gatekeeper** to all other services once on their books, e.g. no independent access to psychiatrist via GP, have to go through ISMS. People are seen as "stuck there for years" with "military style appointments" and "Staff have no aspirations for recovery ... 'You're not ready'."
6. No evidence of **person-centred care** and lots of evidence of assumption and judgement (e.g. "as soon as see you are on methadone, GPs assume you want to sell drugs").
7. Very **infrequent contact** with ISMS e.g. one service user we spoke too had been on script for 2 years with no appointments. No capacity for **crisis/ emergency appointments**. The support worker has the paper trail of evidence of their client being told this and that he could have an appointment in 3 weeks only. Suggestion that Direct Access service has a 4 month wait, not 10 days! Story of man leaving HMP Perth, waited 4 months in prison for treatment (prescriber on leave) then treatment not set up on release as had been promised. Man went to Direct Access every day for 4 weeks "begging for help".
8. There is no evidence that services are **trauma-informed** or responsive to chaotic lifestyles, or of awareness of **psychologically informed environments** (PIE). Suggestion that services are making people do urine tests in front of them. No evidence that services recognise the link between addiction and loss of self, as they don't give people any control over their treatment.
9. In contrast ISMS seen as **authoritarian and controlling**: "Once they [service users] are addicted to methadone, they [ISMS] have got control". No recognition of the importance of building **trusted relationships** – long periods between appointments, staff changes (view that good staff leave), personality clashes. Similarly at Carseview, "It was like jail – good behaviour will get you out of here. ... I wasn't better but I knew what I had to do to get out of there".
10. Very **hierarchical structure** disempowers good front line staff as they are over-ruled by the senior clinicians.
11. **Clerical errors** e.g. wrong phone numbers on letters to contact re appointments etc. Advocacy worker had been told letters could be issued in large print in breach of Equality Act.
12. Did you have any **positive experiences**? "No". Tho new ISMS key worker seen as better.
13. Lack of **LOVE, compassion**: "There's no' enough caring, there's a lack of empathy ... People can't even crack a smile", "Services need to show love".
14. Very positive feedback on the impact of **Recovery Dundee** which has demonstrated it is perfectly possible to build trusted relationships and support people to grow sense of self-worth. However, there is a sense that services do not acknowledge or respect this – not a partnership approach.



ISMS should recognise they are a small part of recovery but sense that all resources have been targeted there. Recovery Dundee not a service so not seen as controlling, instead helps people understand they can take control over their lives and can make changes themselves. Also accepts you can learn from mistakes, you are not punished for them like a service. Sense that services feel threatened by Recovery Dundee and don't acknowledge how it can complement – they can never do what Recovery Dundee does. The approach is that the support worker's been there, knows what it's like, and doesn't give up on people.

15. LOTS of evidence of **positive impact of families**, e.g. practical, financial, emotional help and grandparents taking on caring responsibilities of grandchildren so not taken into care. But also how addiction causes conflict within families, "I was the one who stuck by my son", rest of family turned away and too embarrassed to engage. Lifeline Group been doing appreciative inquiry process with Animate, very positive. The group is becoming more outspoken, "people are finding their voice".
16. Little evidence that **families included by services** ("The involvement of people is zero") and families feel they are blamed (common view that "People say it's the way they were brought up, but it's not true!"). Staff see families as "getting on their nerves", "as a nuisance" – when they phone up they don't get answers and no-one phones them back. Families see their family member every day and can tell the service what is going on, compared to workers seeing them once a month if they're lucky. "What services see as risk and what families see as risk is different".
17. There is a sense that **ISMS is changing** though not quickly enough, still not inviting families in. One of the managers is seen to be bringing changes, seen as really listening to families. "there are some good people in the system".
18. Even if families **manage to attend appointments** they are not allowed to speak. In one case a woman and her son were kept waiting for 45 mins, and when he went up to ask what was happening was treated disrespectfully.
19. Families feel "You have enough guilt" without judgement from others – including the wider community.
20. Recovery Dundee **does involve families** with a description of how they "help keep the balance of the family together" and help build up connections.
21. Families have had **quicker response when escalated** e.g. threatened to contact health minister.
22. **Few families engage in family support** – Lifeline Group keen for more members. For them the benefit of family support is that:
  - a. Realise you are not the only person
  - b. Find out information
  - c. Concerns validated
  - d. Treated like a human
  - e. Everyone listens, people don't interrupt

- f. Never feel attacked
  - g. Helps you find solutions.
23. Also evidence of **key individuals** having a very positive impact, e.g. former employer giving you a job, a particular Throughcare Support Officer from HMP Perth.
24. We MUST look at impact of **poverty, destitution** e.g. [anon] released from prison with nothing – was weeks before got carpets, fridge, cooker. Ongoing difficulty getting housing benefit directly paid to council. Availability of bus passes for people in treatment not advertised.
25. Links with **domestic abuse** must also be explored e.g. controlling men keeping women on drugs.
26. Contradiction between Police stating **we can't arrest our way out of this** and drug raids – all the same people!
27. Need to ensure young carers and children are included in the Commission's work.
28. **What needs to change?**
- a. "Everything"
  - b. "Sort the disconnect between those experiencing addiction and those trying to help."
  - c. Diazepam/ valium prescription to stop people buying street drugs.
  - d. Flexible service.
  - e. Don't brand everyone the same.
  - f. Recognise recovery and connect across – "This will save lives."
  - g. "Listen to people who have come out the other side."
  - h. "There needs to be family and community ... love."
  - i. Local rehab including residential but definitely intensive, 7 days a week.
  - j. More mental health support including psychiatrists and psychologists.
  - k. We need to engage the public and media via a big public debate and series of public meetings. This includes challenging stigma and discrimination (people openly speak of 'junkies' but would not openly make racist or sexist comments).
  - l. Commission is an opportunity: "Here's a chance to do something. ... I think it can change if we put pressure in the right places" / "We keep hoping that a miracle's going to happen and someone's going to wave a wand."
  - m. Concerns that Commission becomes "another glossy report" – Commission needs to be held to account itself.

## APPENDIX XX: DRUG RELATED DEATHS SURVEY – THEMATIC ANALYSIS

### Introduction

The purpose of the survey was two-fold: to gather a rich strand of qualitative evidence of what the problem is in terms of exploring the high rates of drug-related deaths in Dundee, and to gain insight on what can be done about reducing these deaths; and to engage a wider audience in the work of the Dundee Drugs Commission. The survey was distributed online and via hardcopy through various networks and was open during July - September 2018. The survey consisted of demographic questions and one key open-ended question:

***‘What has to be done in Dundee (and across Scotland/elsewhere) to radically reduce the increasing numbers of drug-related deaths?’***

In total, **1075** people started the survey. However, several respondents chose not to answer the key open-ended question or noted that they had nothing to say regarding the key question. Furthermore, some respondents did not answer the key survey question but did request to be kept in touch with a regular e-newsletter through the duration of the Commission. This left a final total of **956** of which **927** responses to the key survey question which have been included in this initial analysis.

Most responses were received from people in Scotland (n=**948**; 99%), and of those from Scotland, respondents predominantly identified Dundee (n=**754**; 80.6%,) as the local authority in which they worked or lived. Respondents were asked to state which category best described them from a pre-defined list. An ‘other’ category was included with the ability to add a description. A third of respondents described themselves as members of the public (n=**312**; 33%). This was followed by responses of those who work in a health and social care service (not alcohol or drugs) (n=**199**; 21%). A total of **100** (10.5%) of respondents described themselves as a family member (or carer) of a current or former person experiencing drug problems. A total of **98** (10%) of respondents described themselves as a current or former person experiencing drug problems.

### Key Themes

Three members of the Figure 8 Consultancy team have separately analysed the responses for the purpose of identifying consistent (key) themes. All responses were then entered into text analysis software which allowed for coding of responses to be completed by two members of the team. A key theme was identified if **5%** or more of respondents mentioned the theme. The information collected from respondents provides rich and novel data on what has to be done in Dundee (and across Scotland/elsewhere) to radically reduce the increasing numbers of drug-related deaths. The key themes identified in the analysis of survey responses are as follows and are presented from the highest number of responses first and descending thereafter.

## Education

**154** (16.6%) respondents mentioned education in their comments in relation to what must be done in Dundee (and across Scotland/elsewhere) to radically reduce the increasing numbers of drug-related deaths. The impression given by respondents was that there should be a focus on drugs and alcohol education at an early stage in a young person's life:

*"More focus on drugs at earlier stage in education system."*

*"Education to prevent young people going down this path and support and guidance to parents to manage youngsters whose behaviours they are concerned about."*

*"We do need to educate children from a young age about the dangers of drug misuse."*

*"Early education for young people to assist them in making the correct choice."*

*"More involvement with school children and young people to education them through schools but incorporating Police and other trained organisations to regularly have a presence in schools and the local community to try to prevent the beginnings of drug issues in young people's lives."*

Furthermore, it was also indicated that children and young people should be taught social and life skills to increase life options and reduce risk of adverse experiences:

*"Life skills courses as mandatory in school and community - a must!"*

*"Young people are not being taught life skills. Schools in the most deprived areas have less Home Economic and Technical Teachers than they did in the 70s, 80s, 90s, 2000s. Children should not have to pay for materials for these subjects. Support for Learning teaching and support staff have been dramatically cut in schools, thus less mentoring and teaching for pupils with additional support needs and missing a crucial opportunity to help young people keep on the road to a successful and happy life."*

Moreover, it was also suggested that education could involve former people experiencing drug problems and/or family/carers:

*"Introduced early education programmes, peer education programmes in secondary schools. NHS programmes to support work in school Theses initiatives have helped support the on-going work of education and the NHS but they have not radically reduced the drug related deaths."*

*"Peer education - people there to educate younger ones/next generation coming up to warn against dangers of drugs. Powerful impact."*

*"Education in secondary schools, including visits by survivors/relatives of victims."*

Several respondents noted that educating people experiencing drug problems to enable them to safely use drugs was an approach going forward to reduce the drug deaths:

*"Education and support to drug users with information about how to use certain drugs more safely. They are going to use anyway at this stage so would it not make sense to educate and therefore reduce the risk of overdose or other physical injuries (i.e. Sepsis, abscess, amputation)."*

*"Tackling the culture of poly drug use through education/information on the risk of mixing street drugs."*

### Opiate Replacement Therapy (ORT)

Opiate Replacement Therapy was stated by **153** (16.5%) respondents, with Methadone a frequent topic, however there are mixed views on this. Respondents stated that greater support for people receiving ORT was an approach to take to reduce the increasing numbers of drug-related deaths:

*"Methadone should be provided, but only as part of a structured rehabilitation programme which includes education and employment opportunities. Too many addicts seem to be put on the methadone and antidepressant scrapheap by doctors as an easy answer."*

*"Increase in support and rehabilitation services for drug users. Focus on methadone programme and support provided round this programme."*

*"There needs to be better support services in place. At present we have patients who are on Methadone programmes and also using illicit drugs who are only seen monthly and who are actively seeking a higher level of support from drugs services."*

*"Supporting people to reduce in the community before they are on any methadone programme."*

The effectiveness of Methadone, however, is a contentious issue as demonstrated below:

*"Methadone is clearly not working. It's supposed to be a process that has a start, middle and end. In all the cases I've seen methadone has either been a long-term prescription where service users have not been reviewed or even reduced, to service users refusing to go back onto it as they feel it's a form of control. I feel that we should go down the route of injection rooms supervised with multi agencies involvement. Not only tackling the addiction but also the wider issues all at the point of contact. The amount of money being wasted with methadone and the only ones profiting is the pharmacy."*

*"People need supported to identify that they can have a better quality of life as at the moment the answer seems to be methadone nothing else."*

*"The answer is also not methadone, more psychological help needs to be available and its about catching the drug use at an early stage to give that person the best chance of a full recovery and normal life."*

*"More drug counselling and rehabilitation. Most drug dependent individuals are successful in abstaining from drug abuse for a short period but more often than not, they relapse. They are basically just put on the Methadone Programme and left to their own devices. We all know that users on methadone supplement this with illegal drugs found on the street. Their motivation alone is not enough with drug culture in Dundee. Long term guidance and support is required."*

For several respondents there appears to be a punitive aspect for those receiving Methadone as part of their care, with several quotes giving a flavour of respondents' views:

*"Methadone prescribing has been a sanction led programme, improvements have been made in respect of drop in time for appointment but there are still significant gaps in services in particular during the evenings and weekends."*

*"Stop cutting people off methadone too quick unless they are non-compliant."*

*"There is a lot off people I know who had been cut off there methadone and turned to heroin, that makes them prone to overdosing and living a chaotic lifestyle."*

*"A lot of deaths are seem to happen not to long after being cut off there methadone, they go on a downward spiral and start mixing drugs."*

Some felt that Methadone prescribing should be removed from Dundee city centre:

*"Take the methadone dispensing out of city centre."*

*"Having methadone available in the city centre is causing large congregations of drug users to hang about together which is encouraging dealing and also is intimidating for the public. I think this is also turning the public against drug users and creating a bad image for the city."*

*"It seems that meeting to collect your methadone is a social occasion for most of the drug users. It is intimidating when there are groups of them regularly gathered on street corners (beside the chemists) and passing drugs around which are clearly not part of the methadone programme."*

*"Remove the problem from the city centre by not issuing methadone from city centre pharmacies! Centralise elsewhere with 'community help centres.'"*

One respondent with lived experience, stated the following:

*"Me personally was moved from methadone and put on suboxone which has a blocker which blocks the opiate receptors and now I don't even think about heroin now, I think all drug users who are on methadone should be changed to suboxone as it really works."*

### Rehab/ Detox

**132** (14.2%) respondents mentioned rehab / detox. A recurring theme in terms of reducing the increasing numbers of drug-related deaths was having an accessible rehab where individuals can safely detox with professional support:

*"More rehab needs to be available, that is accessible to the masses, not the select few, and that is local - that deals with not just the physical withdrawal and dependence but everything that goes hand in hand, like the mental health, and links into local supports to help with housing, community, work/training etc as otherwise people are more likely to slip back into habitual roles as they frequent the same places, with the same people and all the previous issues are still there, encouraging relapse."*

*"First of all, I think a proper drug/alcohol rehab centre with proper addiction trained doctors and nurses. The psychiatric hospital cannot cope with the amount of people who need help."*

*"Effective rehabilitation of current drug users, actual rehab programmes instead of infinite methadone prescriptions."*

The issue of individuals having to travel out-with the local area was mentioned by one respondent:

*"People should be able to access a detox programme, in Dundee, without needing to go considerable distances to Christian rehabs, which don't seem to work well."*

Abstinence-based rehabs were seen to be of value for some:

*"On going support groups with access to programmes that promote and support detox and abstinence rather than reliance on methadone etc."*

*"More residential rehab and aftercare More abstinence-based services within Dundee and the whole of Scotland."*

### Mental Health

Mental health was stated by **97** (10.4%) respondents. A key preventative factor appears to be greater access to mental health support, with some feeling that mental health support appears to be difficult to access for those with a substance use issue:

*"Access to mental health services which don't require the drug user to have given up or stabilised drug use before the mental health is treated."*

*"Put better services in place, so far in Dundee there is a 3 month waiting list just to talk to someone about your addiction ... Where is the support for people? Where is the counselling for people? Who is there to help with the mental health issues that come hand in hand with substance misuse? No one because the answer is take your medicine and be on your way."*

*"Quicker and easier access to mental health services... a focus needs to be on prevention rather than "firefighting" the issue as most services seem to now have to do due to cuts."*

*"More access to talking therapy and counselling, as people often use alcohol and drugs as a coping mechanism having experienced abuse, trauma and bereavement."*

An increase in mental health support provision overall was also cited by several respondents:

*"Provide more mental health diagnosis and support - perhaps using volunteers or community members to assist."*

*"We need to increase the amount of Mental health professionals to cope with the crisis. My son was in Carseview after attempting suicide and was then discharged with a follow up appointment four weeks later. They need much more support on a daily basis. My son died hopefully if the right processes are put in place, we can save someone."*

*"More support in terms of mental health promotion such as counselling opportunities specifically for drug users to allow them to be supported and understand why and how they have ended up drug dependant and to work to achieve improved mental health with them 12 week counselling waiting times is too long to wait to access mental health facilities and a person can become extremely dependant on drugs in this time frame."*



*"Develop new or utilise existing mental health resources to address the root causes of drug use in individuals. Explore new or less commonly employed mental health/ drug addiction intervention methods. - Understand how drug addiction and other issues develop in a community where there is low investment in the local economy and that drug addiction will likely always be a part of a community with limited vision of development."*

Tackling mental health issues earlier in the life cycle appears key to several respondents as demonstrated in the comments below:

*"Improving the mental health of children to enable them to develop the resilience to cope with life's challenges was also mentioned."*

*"Better access to support services and mental health support for young people, teaching people from school age ways to cope with difficult emotions or situations."*

*"Healthy resilience from an early age is the key. At the heart of all addiction is suffering and drug/alcohol use alleviates emotional suffering. This is a societal issue that can only be addressed holistically by giving people the emotional security that enables them to look after themselves appropriately. Children need to be 'trained' in mental resilience as they develop; self-esteem, awareness and understanding of their place in the natural world and emotional security are all vital building blocks of a mentally strong individual."*

Whereas, there was the view that earlier interventions with current people experiencing drug problems could be a way forward:

*"Should be more holistic services that can deal with drug users from early stages especially when there are other underlying issues like mental health. It is very hard to find help for people with complex issues."*

*"More responsive mental health services for adults who are drug user."*

*"Better mental health support. Most drug users (and ex-users) are in desperate need of counselling and support to remain off them. Instead they're just given sort term solutions like methadone, which never lasts long on its own. A more holistic long-term approach is needed."*

Mental health provision for families, individuals who are alone and those socially excluded was also highlighted suggested by one respondent:

*"Mental health/trauma-informed care Social care for families and people who live alone/socially isolated."*

### Access to Treatment

Access to treatment was a theme stated by **94** (10%) respondents. Reducing the waiting lists and improving access to treatment were suggested as a measure to reduce the increasing numbers of drug-related deaths:

*"I think there needs to be a more streamlined access to treatment services, it appears that when someone misses an appointment with their treatment service or if there is concerns that someone is using illicit drugs in addition to their prescribed medication e.g. methadone their prescription*



*will be stopped and the length of time they must wait to get back on treatment. I think more needs to be done to include those accessing services on how services should operate. More treatment options should be available and more flexibility to change treatment options sooner."*

*"Make all forms of support and treatment more accessible. Consider the benefits of a wider range of treatment options. More outreach support and provision of safe and secure housing for those who have no personal supports."*

*"And quicker access to treatment. There is nothing worse than when you tell someone your problem and they give you a drug diary and told come back in 3 months, this should be shortened."*

*"Access to treatment to be quicker."*

*"Ensure that treatment can be accessed easily and timeously - long waiting lists for treatment/help need to be a thing of the past."*

Opening times of services was also noted regarding accessing treatment, with increased opening times, e.g. weekend/s out of hours, an issue for some:

*"Improvements have been made in respect of drop in time for appointment but there are still significant gaps in services in particular during the evenings and weekends."*

*"Widen availability of services to weekend and evening."*

*"I would like to see services available evenings and weekends not just 9-5 Monday to Friday."*

*"More support especially over the weekends."*

### Drug dealers / Dealing

Drug dealers / dealing was mentioned by **83** (8.7%) respondents. An approach suggested to reduce the drug deaths is that police be more proactive in terms of investigating drug dealers:

*"Try to stop the drugs getting into the cities/country - disrupt dealers and suppliers break the chain of supply and demand."*

*"Police to be more active in arresting dealers."*

*"I would think more police resources placed at dealing with drug dealers."*

Similarly, punishment should be greater for drug dealers, with several respondents suggesting providing harsher sentencing to those convicted of drug dealing a positive way forward:

*"Start from the beginning and increase targeting of all dealers and impose sentences 10 years minimum for those caught. Current sentencing for dealing makes getting caught just an occupational hazard, and far too many others are quite willing to step into the breach. Punishment must be a deterrent, and at the moment it is not."*

*"Tougher penalties/sanctions for those found using, dealing or any way involved in the use or supply of drugs."*

*"Increase the prison sentences for the dealers to such an extent that they are a real punishment and do not allow them to reduce their sentence for a guilty plea or early parole. This should then reduce the supply of drugs and then attempts can be made to assist the addicts. Also, the assets of anyone convicted of supply should be seized no matter how little and put to use in rehab."*

## Treatment

**82** (8.8%) respondents mentioned treatment in their comments in relation to what must be done in Dundee (and across Scotland/elsewhere) to radically reduce the increasing numbers of drug-related deaths. Respondents emphasised that there should be a better range of treatment options to help people:

*"Increase in services providing assessment, advice and treatment to help access and waiting times assistance in crisis from drugs services not necessarily default to mental health services more access to psychological treatment for drug users/ trauma victims."*

*"More trauma focus approach and flexible treatment options, reduce barriers to treatment and be person centred not process driven as statutory services now are."*

*"Budgets probably don't allow this anymore but I feel treatment must be holistic and involve very regular contact with a supporting person who may need to do more than focus on the physical addiction and help the person/ family with practical support such as daily routines, learning/ relearning social norms, parenting classes, support to access community groups etc."*

Providing more funding to treatment services was seen to be of value as demonstrated below:

*"Increased funding for treatment providers."*

*"More resources / funding for drug support agencies and those around them, to give a more complete 'recovery' route."*

*"More funding to provide better (and quicker) access to services."*

*"Increased funding to fund front line services in terms of: Investment in staff training, 1-2-day courses or online training does not equip staff with the knowledge/ability to support this client group. Investment in services."*

For two respondents there were negatives cited in terms of people who receive treatment in Dundee having to travel out-with the city for medication:

*"People in Dundee have been getting sent to Perth for daily dispensing. This has seen many return to taking and injecting drugs again. The reason being, that people could not afford the daily travel to Perth, they were not familiar with the travel to and from Perth, they did not know how to make their way around Perth and have been late or missed appointments so have been discharged. This has been a completely punitive approach and has saw people with no other choice but to return to taking/injecting drugs as they have started to go into withdrawal. This kind of treatment is inhumane."*

*"End unrealistic expectations of service users for example expecting them to travel from Dundee to Perth on a daily basis to collect prescription."*

One respondent did note improvements with the introduction of community Hubs:

*"Trying to get into treatment appears to be challenging due to the lack of flexibility in terms of how services are delivered. This has improved slightly with the introduction of community hubs. For those who get through the assessment stage there has been a real lack of treatment options - methadone being the thing that has been generally offered. I have seen recent welcome shifts towards an expansion of options."*

#### Decriminalisation / Legalisation of Drugs

Decriminalisation/legalisation of drugs was also mentioned by **82** (8.6%) respondents. Portugal's decriminalising of the use of drugs in 2001 was mentioned by several as an example of a strategy to reduce the deaths:

*"Decriminalisation of drugs - Look to Portugal's approach of the decriminalisation of drugs (around 18 years ago), which moved away from treating drug use as a criminal act and moved towards treating substance use as an illness and linking people with support and therapy. Portugal had some of the worst figures in Europe and now hardly anyone."*

*"I think if you look at Portugal, they have halved their drug usage by decriminalizing (all) drugs. If they have halved their use then it must be it has halved the drug related deaths. So that is one simple solution. All we need is the political will."*

*"In Dundee as the rest of Scotland it seems that more radical approaches are required to all drugs related issues as this is becoming an ever more serious problem. Lessons should be learned from elsewhere where a radical approach has proven to have more beneficial effects. Portugal for example has implemented radical new approaches which seem to be having a positive impact."*

An approach also suggested to reduce the drug deaths rate in Dundee could be for the authorities to legalise some drugs:

*"Legalise drugs, use the money from the profits to provide safe environments for drug users to use or recover in (injecting rooms with medical supervision), provide better living conditions and get the community on board instead of shunning the addict, therapy - a holistic approach. Give people hope."*

*"Stop prohibition. Regulate and control the quality and dosage. Make certain drugs such as Cannabis, Ecstasy and Cocaine available to buy, taking billions of pounds of profit away from criminals. Invest the tax generated in drug rehab facilities. Prohibition does not work. People like taking drugs, they are taken all over the world and have been for thousands of years. Let people make an informed choice and allow drugs to be taken in the safest way possible."*

## Families/ Carers

Families / carers was mentioned by **80** (8.6%) respondents. A preventative measure suggested by several is increasing support for families / carers affected by a loved one's substance use:

*"More help available not just to addicts but to family/friends to make them understand and cope with the problem."*

*"More help for families and user."*

*"Additional family support for families of addicts."*

*"Support for family and Carers is vital."*

*"More help for users and certainly more help for family's who are looking after the users children."*

Support for those family and friends affected by a loved-one's death was proposed:

*"The provision of early support following a drug death to affected friends and family."*

Increasing access to Naloxone for families / carers was also mentioned as an approach to reduce the drug deaths:

*"More naloxone training and kits passed to families/friends."*

## Safe Injecting Site

Safe injection sites, or spaces where people can inject drugs, was mentioned by **71** (7.6%) respondents. A theme was providing a safe injecting site could be an approach to reduce the drug deaths rate as seen in the comments below:

*"Think the shooting gallery idea was a good one. At least the addicts know what they are injecting/consuming rather than etizolam, bad batches of heroin etc... and less chance of overdosing."*

*"The introduction of Drug Consumption Rooms along with an investment in care for alcohol and drug users."*

The possibility of individuals receiving wider support at a safe injection site was also mentioned by several respondents:

*"Provide safe places for administration of medicines ... with this, significant social support must be provided to break habits and teach people how to move forward with their lives, rather than detoxing, becoming addicted to methadone and going back to the same social circles rife with the substance the person is trying to avoid!"*

*"Shooting galleries - where there's a safe place for people to take their drugs where they can receive support and advice, clean needles etc."*

## Stigma

**54** (5.7%) respondents suggested that one way in reducing the drug deaths rate in Dundee (and across Scotland/ elsewhere) would be to reduce stigma attached to drug and/or alcohol use.

Respondents felt that it was important to provide more information, awareness and education to members of the public to reduce stigma:

*"We need to better educate people in our communities and attempt to go some way towards breaking down the stigma associated with drug use. People who use drugs, in particular, injecting drugs users are seen by many as the lowest of the low. People are dehumanised and this type of attitude has been allowed to flourish and grow for too many years."*

*"In my opinion, the social stigma attached to those dependent on drugs is a key influencing factor in drug related deaths. Socially, people appear to view those dependent on drugs as "disgusting" and it is not viewed as something that showed be offered support. This leads to those with a drug addiction issue less likely to seek support when their situation is spiralling out of control due to how they feel they will be perceived, and the lack of support sought/offered leads to them resorting to further dangerous means to source drugs or compounds the issue in the first place."*

Some respondents indicated that media portrayal of the issue has a role to play in stigmatisation of this group and that the media can be utilised to reduce stigma and have a more supportive role in this area, as seen in the comment below:

*"Work with local and national media to reduce the stigma associated with those linked to substance misuse."*

*"Work with the media around how drug use is portrayed."*

*"The local media has a huge role to play in this and should recognise its responsibilities to report in a supportive way. We focus on the negative aspects of the services, however a lot of positive work is being done quietly in Dundee and this should be recognised and celebrated. Doing so would change people's views of the service and encourage those in crisis to come forward and seek help."*

Several respondents felt that attitudes of staff in drug and/or alcohol services were negative towards people experiencing drug problems:

*"Stigma is the real barrier to this, support for a clinic ... would be difficult to procure however a campaign to address this issue of stigma may wield some positive progress at the very least."*

*"If we cannot address the stigmatising attitudes of local communities and many services, the issue will be exacerbated."*

*"The need to engage with the most 'hard to reach' is essential, the stigma and discrimination this group face by services and the public is alarming."*

### Partnership Working

A total of **53** (5.6%) respondents felt that reducing the drug deaths rate in Dundee requires greater partnership working between services:

*"Improve relationships and pathways with mental health services - joint working cases rather than passing people from one service to the other."*

*"Earlier and earlier intervention with families by key services - social services, health and education are key and need even greater partnership working to make best use of specialised resources available."*

Furthermore, it was noted that better communication between the various services and agencies encountering people experiencing drug problems could potentially help to reduce the drug-related deaths:

*"Increased communication with services such as criminal justice in relation to clients who may be struggling, e.g. failed drug tests or appointments that can then be followed up."*

*"Better communication with other agencies to monitor issues that may arise."*

*"More engagement between the service and its partners and professionals on a face to face level, collaboration could result in a tighter plan that could in turn be the difference in service users using the supports, advice and guidance given."*

*"Lack of communication or even access to pass on concerns about drug users, some of whom may not be in a drug using service. For example I have a client who nearly died due to a relapse. He had previously been on a Methadone prescription and Suboxone, but still he has a reluctance to re-engage with services as he did not want to go back on either prescription. He is still deemed to be at a high risk of overdosing. A drug service that responds to referrals about concerns, and perhaps approaches him to try and re-engage him may help in his case."*

Improved and greater partnership working between services and agencies to ensure that those at risk of overdose are identified and supported at the time of crisis was also suggested:

*"Closer partnership working (including with NHS, GPs and the SAS) to ensure that individuals at risk are identified and offered support/treatment at the time of crisis/overdose. The support should include assessing and treating of the underlying causes of their addiction. Information needs to be provided to problematic users on specific dangers and trends (i.e. using cocktails of known dangerous combinations)."*

### Employment

Employment was cited in **52** (5.6%) of the responses with a recurring theme being increasing opportunities to gain employment could be an opportunity to reduce drug deaths rate, specifically to give people skills, a sense of purpose and meaningful activities. Employment was viewed by respondents as a possible preventative activity to decrease the onset of drug use:

*"More youth opportunities for employment and social activities aimed at the prevention of getting into drugs in the first place."*

*"Create job opportunities to stop drug taking in the first place."*

*"We have to put adequate support services in place encouraging people to make positive lifestyle changes and give them assistance to gain and maintain housing, access benefits as required and support with further education and training to maximise employment opportunities."*

Providing more employment opportunities for people in recovery was also highlighted:

*"Improved employment support for people with problem drug use."*

*"Perhaps providing some kind of community work experience so the people feel valued and have a role in life."*

### Therapeutic Services

Therapeutic services were noted by **50** (5.3%) of respondents. Increasing access to therapeutic services such as counselling and psychological support was suggested to help reduce the increasing numbers of drug-related deaths:

*"Increased access to therapeutic services, individual or group."*

*"Additional accessible therapeutic support for drug users."*

*"We need counselling to get to the cause of the drug abuse and people to work with them to rebuild their life."*

*"Reduce waiting times and provide more therapeutic support e.g. counselling, either directly or through partner agencies. Invariably individuals who present with problematic substance use have experienced trauma or emotional upset in their lives which they have been unable to process or resolve."*

*"Additional accessible therapeutic support for drug users."*

Methadone was an antagonistic issue when respondents described therapeutic services as seen in the comments below:

*"An effective service for users would provide effective psychological support and not just provide methadone. Unfortunately, this support would require more time and staff. In a time of constraints neither are available."*

*"Address mental health issues. Get people who use drugs into recovery programs, not just move them to another drug like methadone and leave them there with no counselling and no recovery plan."*

### Naloxone

Naloxone is a drug that can reverse the effects of opioids and prevent death if used within a short period following an opioid overdose. **49** (5.2%) respondents suggested increasing training and access to Naloxone amongst those at risk is a positive way forward in reducing the drug deaths rate in Dundee (and across Scotland/ elsewhere):

*"Easier process for handing out naloxone kits."*

*"Given naloxone to all addiction service users."*

*"Continue and extend naloxone programme."*

Having Naloxone kits available for families and friends of those at risk of overdose appeared valuable:



*"Naloxone readily available and training given to as many people surrounding addicts - workers, volunteers, family members."*

*"In terms of drug deaths Naloxone needs to be readily available to users, their families and friends."*

Having Naloxone kits available for the police and first aiders was also recognised as a possible way to help reduce the drug deaths:

*"Mass naloxone programme including Police Scotland and first aiders and secondary provision."*

*"Naloxone look at how this is package, make it something that everyone would want to carry, have this embedded in all organisations First aid training and kits work with local and national media to reduce the stigma associated with those linked to substance misuse."*

*"Use of naloxone to be incorporated into First Aid training for all sector."*

Respondents also felt that it was important to provide more training, information and education on Naloxone provision:

*"Adequate naloxone provision with trained awareness and dangers of overdose risk factors."*

*"Pushing Naloxone supply and overdose prevention training."*

Peer-led Naloxone distribution has been successful in Glasgow, and this was mentioned by respondents, with one also suggesting that Naloxone be made available as standard in homeless accommodation across the city:

*"Peer led Naloxone distribution (outreach). Naloxone made available as standard in homeless accommodation, all hostels etc."*

*"Extending the reach of Naloxone, including peer supply."*

## **Other Messages Identified Through the Initial Analysis**

As noted above, key themes were identified when mentioned by 5% or more of respondents. Additionally, there were several other relevant themes – but mentioned by fewer respondents (i.e. below the 5% response rate). These messages are as follows:

### Social Inequalities / Deprivation

Social inequalities / deprivation was noted by **46** (4.9%) respondents, with respondents recognising how being at the wrong end of socioeconomic inequality are associated with multiple, overlapping lifestyle-related and other risk factors. Addressing social inequalities / deprivation on a wide scale was suggested as one way to help reduce the increasing numbers of drug-related deaths.

### Misuse of Prescription Drugs

Misuse of prescription drugs was a theme mentioned by **42** (4.5%) respondents. The misuse of benzodiazepines, gabapentinoids and opiates was recognised as a problem with several respondents



suggesting that a preventative measure could be that stricter prescribing measures are introduced. Reducing the availability of 'street Valium' was also highlighted.

### Police

The Police were mentioned by **41** (4.4%) respondents. An approach suggested to reduce the drug deaths is that the presence of police is increased in the streets of Dundee. Another theme was that the police are given more support / resources to prevent drugs coming into the city.

### Addressing the Underlying Causes of Substance Use

**40** (4.3%) of respondents mentioned addressing the underlying causes of substance use in relation to what must be done in Dundee (and across Scotland/elsewhere) to radically reduce the increasing numbers of drug-related deaths. For example, addressing trauma and reducing the Adverse Childhood Experiences that may contribute to alcohol and drug misuse was noted.

### Housing

Housing was noted by **37** (4%) respondents. A theme was that more adequate, safe and secure housing is needed to support people and ultimately help tackle the drug deaths rate in Dundee (and across Scotland/ elsewhere). The Housing First model was also suggested, where people who are actively using substances are housed. Supported housing was also proposed as a possible measure going forward.

### Early Intervention

**27** (2.9%) respondents suggested that one way in reducing the drug deaths rate in Dundee (and across Scotland/ elsewhere) would be to provide early interventions to children at risk to tackle contributing factors such as parental neglect, poverty, poor living conditions and the effects of Adverse Childhood Experiences.

### Lived Experience

**27** (2.9%) respondents stated lived experience in their comments. One way of reducing the drug deaths rate in Dundee (and across Scotland/ elsewhere) would be to embed lived experience into practice and services. Furthermore, it was noted that having more peer-led / recovery groups could also help reduce the deaths.

### Availability of Drugs

Availability of drugs was a theme noted by **26** (2.8%) of respondents. Stopping the supply of drugs, both at a national and street level, was a suggested approach to take to reduce the increasing numbers of drug-related deaths.

### Integrated Substance Misuse Service (I.S.M.S)

Dundee's Integrated Substance Misuse Service (I.S.M.S) was a theme mentioned by **24** (2.6%) respondents. Financial cuts appear to be impacting on the care received, with the length of time to be seen by a keyworker highlighted. Providing more staff was suggested as an approach going forward, whereas the relationship between I.S.M.S and recovery organisations was highlighted as an area to be improved.

### Prescribed Heroin

Prescribed Heroin was stated by **22** (2.4%) respondents. A theme to emerge was that providing prescribed Heroin to those with substance use problems should be considered as an approach to reduce the drug deaths rate.

## APPENDIX XXI: COMMISSION SUB-GROUPS

Following analysis of its Initial Call for Evidence and other early evidence gathering activities, the Commission considered the main themes that it needed to prioritise in timeframe allocated (one year). There were four consistent themes that were identified, over and above any others. A decision was made to set-up four sub-groups of the Commission, who would be tasked with collating all relevant evidence and take the lead in reporting thematic findings.

The four key themes, and the membership of the sub-groups is detailed below:

Key Theme	Membership of Sub-Group
<b>Drug-related deaths</b>	Prof Niamh Nic Daeid (Chair) Sharon Brand Jean Logan Suzie Mertes Dr Tessa Parkes
<b>Leadership</b>	Robert Peat (Chair) Eric Knox Cllr Ken Lynn John Owens Hazel Robertson
<b>Mental Health</b>	Simon Little (Chair) – until stepping down from the Commission in January 2019 Cllr Kevin Keenan Pat Tyrie
<b>Treatment</b>	Prof Eilish Gilvarry (Chair) Prof Alex Baldachinno John Goldie Dave Liddell Justina Murray

All groups were provided with support from Robert Peat (Chair of the Commission) and Andy Perkins (Figure 8).



## APPENDIX XXII: FINAL CALL FOR EVIDENCE – THEMATIC ANALYSIS

### Introduction

A wide range of responses were received to the initial call for evidence in May 2018. The analysis of the responses helped the Commission to identify the key themes that it needed to concentrate on during the time allocated for evidence gathering. Four key themes were identified from the initial round of evidence all of which were re-emphasised and validated through further evidence gathering activities. The four themes were identified as:

- 1. A need to prioritise all possible efforts to reduce Drug Related Deaths in the city
- 2. A general lack of mental health support for those with drug use issues
- 3. A need to improve leadership and governance
- 4. A need to improve the quality and breadth of treatment and support for those with drug use issues– and their families

A final call for evidence was distributed online and via hardcopy through various networks across during March-April 2019. The survey consisted of the following five questions to help gather evidence in relation to the four themes above:

1. Please provide any comments or evidence you have in relation to theme 1- 'A need to prioritise all possible efforts to reduce Drug Related Deaths in the city'
2. Please provide any comments or evidence you have in relation to theme 2- 'A general lack of mental health support for those with drug use issues'
3. Please provide any comments or evidence you have in relation to theme 3- 'A need to improve leadership and governance'
4. Please provide any comments or evidence you have in relation to theme 4- 'A need to improve the quality and breadth of treatment and support for those with drug use issues – and their families'
5. Are there any other critical matters that the Commission should be aware of?

In total, there were **112** responses to the survey, however many respondents did not answer the questions, having inputted demographic data only. Therefore, in the analysis below, the number of responses to the key question is stated in the first paragraph.

Most responses were received from people in Scotland (n=**107**; 96%), and of those from Scotland, respondents predominantly identified Dundee (n=**71**; 67.2%,) as the local authority in which they worked or lived. Respondents were asked to state which category best described them from a pre-defined list. An 'other' category was included with the ability to add a description. **29** (26 %) described themselves as members of the public. This was followed by **19** (17%) respondents who described themselves as a current or former person experiencing drug problems. **18** (16%) responses were received from workers in drug and/or alcohol service and **14** (13%) respondents described themselves as a family member (or carer) of a current or former person experiencing drug problems.

Three members of the Figure 8 Consultancy team have separately analysed the responses for the purpose of identifying consistent (key) themes. All responses were then entered into text analysis software which allowed for coding of responses to be completed by two members of the team. Themes have been identified as a consistent (key) message where a minimum of one in four (25%) of respondents referred to the theme. A summary of all consistent messages noted, with example quotes, is provided below, under each question heading.

**Please provide any comments or evidence you have in relation to theme 1- 'A need to prioritise all possible efforts to reduce Drug Related Deaths in the city'**

In total there were **38** responses to this question. For **23** (60%) respondents, service provision was the key overarching theme in terms of a need to prioritise all possible efforts to reduce drug-related deaths in the city. The comments below demonstrate the breadth of respondents' feelings towards service provision:

*'It would appear that the services within the area are unable to offer a high level of support to people in crisis and therefore may die as a result of their substance misuse. There needs to be a priority of being able to increase support significantly to support people when required so that drug deaths are avoidable.'*

*'The Integrated Substance Misuse Service takes every death seriously whatever the cause. In terms of all cause mortality ISMS observed a 10% reduction in deaths between 2017 and 2018. ISMS has a well established governance process for deaths which includes analyses of trends and contributing factors.'*

*'Drug related deaths ARE preventable. We know what works, and we should get back to evidence-based policy and practice. The unfortunate shift to a recovery model which is really just an abstinence-based recovery has taken its toll on our most vulnerable citizens. Abstinence will be desirable and possible for many, but not all. We need to get away from stigmatising ideas that many people who use drugs apply to themselves. We need to stop demonising methadone, lower the threshold for accessing it and abandon punitive service practices which put lives at risk. Naloxone should be widely available to people who use drugs, their families and friends as well as services where people who use drugs are likely to present.'*

Joined-up working, and its impact on the provision of services was also mentioned:

*'We need to work closely with the services not covered by NHS/council to ensure that we are providing the best possible chance of getting folk into recover. There has to be an easy way to share information to ensure we can get people into services whether that be drug and alcohol services or mental health.'*

*'Too many competing drug services within the city, ISMS doesn't work in the same way as Addaction etc. Support Services and prescribers need to pull together.'*

Another theme to emerge in terms of the need to prioritise all possible efforts to reduce drug-related deaths in the city, relates to treatment options, which was stated by **12** (33%) respondents as seen in the comments below:

*'I collect methadone from the chemist once a week. I've seen others who are prescribed methadone who are clearly using illicit drugs. They will stagger, slur their words and their eyes will be popping. Despite this, they get served methadone. Huge overdose risk. This has happened several times in the chemist I use. I have also seen it at other chemist's across the city. If the appointments for those who are stable are reduced more, this frees up more time for the workers to concentrate on those more in need. I've been stable for 8 years, yet I must still attend monthly appointments, and also an appointment with a doctor every time I reduce. Such a waste of valuable time.'*

*'The highest risk individuals are often the hardest to maintain in treatment. They default from the pharmacy attendance and it is hard to keep them on stable treatment. I would like to see a contingency management programme to target these individuals e.g. when released from custody with specialist keyworker input that is more flexible and responsive. The Dundee HepC treatment programme showed that this does not need to be much in value and had unexpectedly good results. Rewards for attendance every day to pharmacy and appointments. Even just giving coveted nutritional drinks. Mostly it is the personal interest and praise that I think works the best. Bus passes would also be helpful to facilitate staying in treatment. Practical support wherever required. In fact enough quality keyworking that can provide a strong therapeutic alliance is paramount to good outcomes. Consistent keyworking where a strong relationship can develop is extremely helpful and often undervalued by service management. Projects that provide structured useful use of time would also be invaluable. Apprenticeships on joining the treatment programme would illustrate the need to change lifestyle from the outset and help get individuals to think differently about their lives. Real alternative lifestyle would be invaluable. E.g. properly resourced Garden projects with employment outcomes. Premises and resources for woodwork projects. Not enough just to have projects but team required to facilitate attendance and engagement. These individuals need intensive support to make such a change to their lives with incentives to do so. Specialist accommodation projects that offer an alternative lifestyle would be very helpful.'*

*'This needs to occur however it would appear that the access to drug services can be limited due to availability of service provision. I am aware of examples where a service user open to prescribing services was not provided with an appointment for over 6 months following their allocated worker leaving the service, this individual was continuing to be prescribed methadone whilst also using substances chaotically thus increasingly likelihood of individual being at risk of drugs death. Other examples of service users being provided infrequent appointments whilst using chaotically and on prescription.'*

**Please provide any comments or evidence you have in relation to theme 2- 'A general lack of mental health support for those with drug use issues'**

In total there were **39** responses to this question, with service provision, again, the overarching theme cited by **24** (61%) respondents:

*'Mental health would be improved by improved lifestyle and wellbeing which should be a substance misuse service priority. Strategies to offer practical support such as drop in cafes with ready support when required. Improved nutrition also important.'*

*'ISMS patients value detox supported by a comprehensive group programme with prescribing, psychosocial and peer support, delivered in partnership with the third sector.'*

*'Appalling lack of access to recovery oriented mental health support. Ask most mental health and substance use service professionals (and more generic health professionals) about bodies such as the Scottish Recovery Network and the Scottish Recovery Consortium and they are unlikely to have awareness. Luckily the Scottish Drugs Forum does seem to have a far higher level of exposure and profile (probably because of it's Naloxone programme and the Addiction Worker Trainee Programme). Reputation of mental health supports is poor amongst service users often citing a lack of empathy, respect and understanding of the journey of an addict (lack or dismissal of Aces awareness). Access is patchy and longer-term Counselling support (for those with childhood issues in particular) is not the norm. Mental health services seem to be a service designed more for less challenging people with a specific mental illness (eg bipolar, psychosis related) or for those requiring higher level hospital in-patient care (although evidence of consistent health improvement in treating these people is unclear).'*

*'ISMS Consultant Psychiatrist and Senior Nursing staff led on establishing a two week community programme in 2015 initially to provide support to those completing a withdrawal from alcohol, and then extended to support opiate detoxification. People who have completed an inpatient withdrawal can also attend the programme following discharge ... the programme receives good patient feedback ...the majority of people attending the programme had not completed the programme previously, indicating most attendees had not previously completed the programme and then relapsed.'*

Another recurring theme in terms of theme 2 relates to an apparent disconnection between substance use and mental health services, which was mentioned by **11** (28%) respondents. The comments below demonstrate the impact this disconnection has:

*'The experience I have had with adults who use drugs and have mental health issues is that they cannot access mental health support because they use drugs and they cannot stop using drugs because that is their way of self-medicating their mental health issues. It is incredibly frustrating to find a way to move on from this. Many adults talk about needing 'counselling' and do not describe their relationship with their key worker in drug treatment as therapeutic. It would be better to have key individuals who are experienced in drug use and mental health who can offer regular and ongoing support in times of crisis but also in times of stability and that mental health services work hand in hand with drug services.'*



*'Carseview refuses to accept direct admissions from Ambulance service. They also regularly reject patients when under influence of alcohol. Patient is then taken to A&E where they are allowed to leave if they want. Have taken patients to A&E who have self-harmed or threatened to do so and they are allowed to leave. Nightshift and weekend are horrendous. A&E don't want patients if no medical issues. Police often don't want them if it's just alcoholic.'*

*'Trying to refer people as 3rd sector workers is almost impossible. There is no way to share information and it is as if you are not taken seriously. People are being passed between mental health services and drug services, with no one taking the lead in the care. It can feel that 3rd sector charities and services are left to look after the mental wellbeing of drug users, with no help or resources.'*

*'The refusal of mental health services for over 30 years to see beyond single diagnosis, claiming that they could not work with individuals under the influence of illegal drugs has in my opinion contributed directly to the level of drug deaths we see today. This situation is on-going still today with mental health services refusing to come out of there consultant led, centralised model of services delivery. I still engage daily with drug users who are refused mental health service because they are under the influence of illegal substances.'*

*'Many of the people that I work with experience both mental health issues and substance misuse however there does not appear to be services that address both issues in tandem.'*

### **Please provide any comments or evidence you have in relation to theme 3- 'A need to improve leadership and governance'**

In total there were **32** responses to this question. Echoing themes one and two, service provision was mentioned frequently, by **18** (56%) respondents. A lack of joined-up working appears to be impacting on the quality of service provision:

*'Teams are not working together but still in silos i.e mental health teams, drugs and alcohol teams, community health teams and the 3rd sector don't do joint work and often see the same clients. Clarity of roles is required, it has to be person centred instead of service led.'*

*'The ADP is remote and has no impact whatsoever on the day to day functioning of treatment services. It needs to become a lot more open and transparent. Most practitioners have little idea about the purpose of the ADP and would struggle to name who is responsible for it.'*

*'The constant re-structuring or redesign of services is discussed which does not replace the need for good leadership or governance. It can be hard to understand or access the management structure of the Integrated Substance Misuse Service in order to escalate concerns. The connection between services is not always clear either, for example when someone is coming to the end of their treatment program and moving on and requiring to be busy and have a purpose they are often unable to access support or meaningful activity because other agencies are unclear where to signpost them. Sometimes this leads them back into drug use through spending time with active drugs users. The stigma that drugs users talk of means they find it*

*difficult to access mainstream groups for quite a period until they see themselves as 'clean'. There can also be child care issues for those with younger children trying to source help.'*

An apparent lack of leadership was also suggested to be impacting the level of service provision:

*'Drug-related Deaths groups and their leadership (Statutory bodies including ADPs) have shown a lack of influence on overall outcomes. Naloxone provision failed to be delivered on at sufficient level (although distribution had become more prevalent). A lack of ambition (and evidence/outcome of) to see people move through treatment and be encouraged to seek supports into recovery through long-standing (and newer) networks of groups offering the lived experience of recovery (peer support, mutual aid, 12 step fellowship groups) has offered less validity and value of such support. All governance structures of all services should require evidence of availability/connections to a full range of recovery approaches with genuine involvement of lived experience.'*

*'Lack of support from management. A lack of interest or understanding of what we as [...] workers both do and achieve. Senior management need to be working from top down and listening to ground level staff to make informed decisions and hear what the workers have to say as we are probably more aware of what is happening with our clients than the decision makers.'*

**Please provide any comments or evidence you have in relation to theme 4- 'A need to improve the quality and breadth of treatment and support for those with drug use issues – and their families'**

In total there were **34** responses to this question. Again, service provision was a key theme stated by **26** (76%) as seen below:

*'It is heartening that one of the Key Themes for the Commission to report on is a need to improve the quality and breadth of treatment and support for those with drug use issues and their families. Unfortunately our service has introduced, or is in the process of introducing, changes some of which will decrease the quality of the service and will result in the breadth of treatment and support shrinking alarmingly. There are many good and committed people working in our service although due to the pressures many experienced nurses have left in the past couple of years and not been replaced. A high turnover of staff isn't good for the service and particularly the clients that we work for whom having a meaningful long term relationship with a worker can mean the difference between success and failure to achieve recovery. The service needs to undergo some radical realignment [...] and our management are committed to achieving this. Their idea of change however is to take the service back to a clinic based model that only increases the numbers coming into treatment but does nothing to retain them or co produce a plan with the client which keeps them on treatment for the shortest possible length of time and support them post treatment if they so desire.'*

*'ISMS Prescribing Guidelines outline our values to deliver person centred, evidenced based prescribing to achieve the best outcomes for people using the service, we have previously*

*provided a copy of the guideline. We deliver prescribing interventions in multidisciplinary pathways incorporating psychosocial interventions to support recovery goals. The quality of our interventions is impacted on by capacity issues which have been escalated.'*

*'Constitution House is unfit for purpose and only serves to reinforce to clients, their families and the citizens of this city that people experiencing drug dependency are bottom of the pile when it comes to having facilities that respect their dignity and self worth. The wing in Wallacetown Health Centre used for the new Direct Access Service is even more depressing. A 1960's prefab with the public toilet being used by workers to obtain urine samples and then have parade them through the waiting area. Our organisation is riven with all forms of stigma and discrimination and we turn a blind eye to it because it has become the norm... we should have bright open, attractive , welcoming facilities that loudly broadcasts to clients that they are valued by a treatment service that wants to commit to them for the duration of their recovery journey if required. We should have free snacks for people and provide free sanitary products for women. If I had a drug dependency problem and had to access any of these buildings it would only serve to reinforce feelings of shame and inadequacy. We need an outward looking, person centred, holistic service and avoid entrenching ourselves in a clinic(s) where Mohammed always comes to the mountain.'*

Barriers to treatment was another theme to emerge in terms of improving the quality and breadth of treatment and support for those with drug use issues – and their families. **12** (35%) respondents stated this theme in their comments which are presented below:

*'That we still seem to base our treatment approaches on a morality based premise (service users should feel lucky that they are being seen and should listen to the professionals dealing with them as they know better - and if you don't then your treatment may be withheld and you are suspended from treatment) is a devastating blow to service users and their loved ones. It invalidates person- centred care and almost de- humanises the people involved. That staff/professionals (whilst service seem to grasp it more naturally) to have a poor understanding of recovery oriented systems of care is a continuing failure and tragedy for the guiding principles of care.'*

*'The current service that people are able to access for drug support and treatment does not offer a range of treatment option, sees people on a monthly basis in general and this is not enough to be able to fully support people to change in the longer term. There is no access to rehabilitation services within the local area which means that people need to travel which is not conducive to family life. I never hear of people being supported to go to residential rehab and this is a huge gap in services.'*

*'It took over a year for me to get a prescription for methadone my heroin use doubled and many others weren't as lucky.'*

*'What options are people afforded to address addiction & support recovery? What do people wish to do with their time? How do we build up peer support & activities? People in my area can't access their GP for addiction/substitute prescribing as require presenting to addiction services! Where are their rights? Services must be independently evaluated against those*

*Quality Principles- services require being holistic & being accessible, providing outreach. Measure quality of life for individual & family, not service targets & waiting times. How many people within addiction services actually have a care plan, & if so, how up to date & reviewed?? People require advocacy too as scared to make a fuss in genuine fear of losing their script/ removed from services. Services require working collaboratively reflective of needs but egos & silos don't help. Services need to stop hiding behind data sharing.'*

### **Are there any other critical matters that the Commission should be aware of?**

In total there were **31** responses to this question. Again, service provision was the main theme cited with **17** (55%) respondents stating this. A range of comments are offered below:

*'Yes, the independence of ADPs to hold all service delivery agencies to account is flawed, statutory agencies regularly hold the power to dictate the discourse, resource and funding in a manner which is not conducive to better service user outcomes and does not consider the view of lived experiences as valid.'*

*'Multiagency engagement from drugs services is very dependent on individual workers and there are times where workers will engage with us to pass over critical information regarding parents who use their services, however there are many times where this doesn't happen and can leave children at risk of potential harm.'*

*'There are many people in Dundee who just want to be listened to and for what they say to matter. This is the most important thing that the Drug Commission can achieve - recognition and accountability of services and strategic planning groups to members of the public - mainly those directly affected and experiencing challenges with addictions and their families/carers. This process also must not be a one off gathering of evidence that is fed back and acted upon. It is important to develop regular links with those who have shared their views and to continually check if what we are doing is actually working. We must be ready to adapt constantly based on new learning and not see this as a process to make big changes which then stay the same for years and years before realising that it isn't working either.'*

*'There needs to be better shared communication between agencies and not allowing GDPR etc to get in the way of this. There needs to be locality based teams who get to know their clients working together with Children and Families Service to create a package of support to families as opposed to both doing this separately.'*

*'While most services are effectively 'fire fighting', there is a seriously lack of joined up working between statutory and other services. Most of the local charity run drop in's are seeing most of the cities drug users throughout the week, would it not then be beneficial to make use of this and join up with them?'*

*'Many people have been affected by childhood trauma therefore require specialist support on a one to one or in group work. Not enough being offered to people, we are at crisis point now and more suicides because of loss i.e. of childhood experiences, their children being taken into care etc and then given no after support.'*