SDF Scottish Drugs Forum

Drug-related deaths in Scotland

MSP Briefing

Scottish Drugs Forum

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Background

As has again been evidenced in the latest drug-related deaths statistics from the National Records of Scotland (Dec 2020), preventable drug overdose deaths in Scotland represent a deepening public health crisis.

This briefing describes the current situation and the steps that can be taken to begin to reverse the tragic and appalling loss of life. There are wider long-term issues we need to address around access to mental health services, housing, education and training, welfare and family support. These deaths result from and represent structural issues that result in health and economic inequalities in Scotland. However, in the context of the current discussion, this paper focuses on urgent actions that can be taken now.

1. The challenge Scotland faces

1.1 - Scale of problem drug use

The root causes of problem drug use can be complex but are not mysterious. In Scotland, the closest statistical correlations are between problem drug use and poverty and deprivation; problem drug use and trauma and adverse circumstances in childhood and early adulthood; and problem drug use and mental health issues. Despite attempts to depict it as such, problem drug use is not a result of poor decision-making, a lifestyle choice or the result of hedonism 'gone wrong'.

Scotland has a very high rate of people with a drug problem in comparison with the rest of the UK and other countries. The official estimate of the number of people with a problem involving opiates and / or benzodiazepines has not really changed in 15 years. In 2006 the estimate was 55,328 and the latest estimate is 55,800 to 58,900 in 2015/16. In other words, for every person who dies or becomes abstinent, there is a new person with a problem.

There is an ageing population of people over 35 amongst whom the vast majority of deaths occur; but there are young people with a similar profile to their older peers – childhood trauma, experience of the care system, etc. – joining the population of people with a drug problem. Drug deaths are rising in both groups. The median age of death is 42.

1.2 - Drug overdose deaths

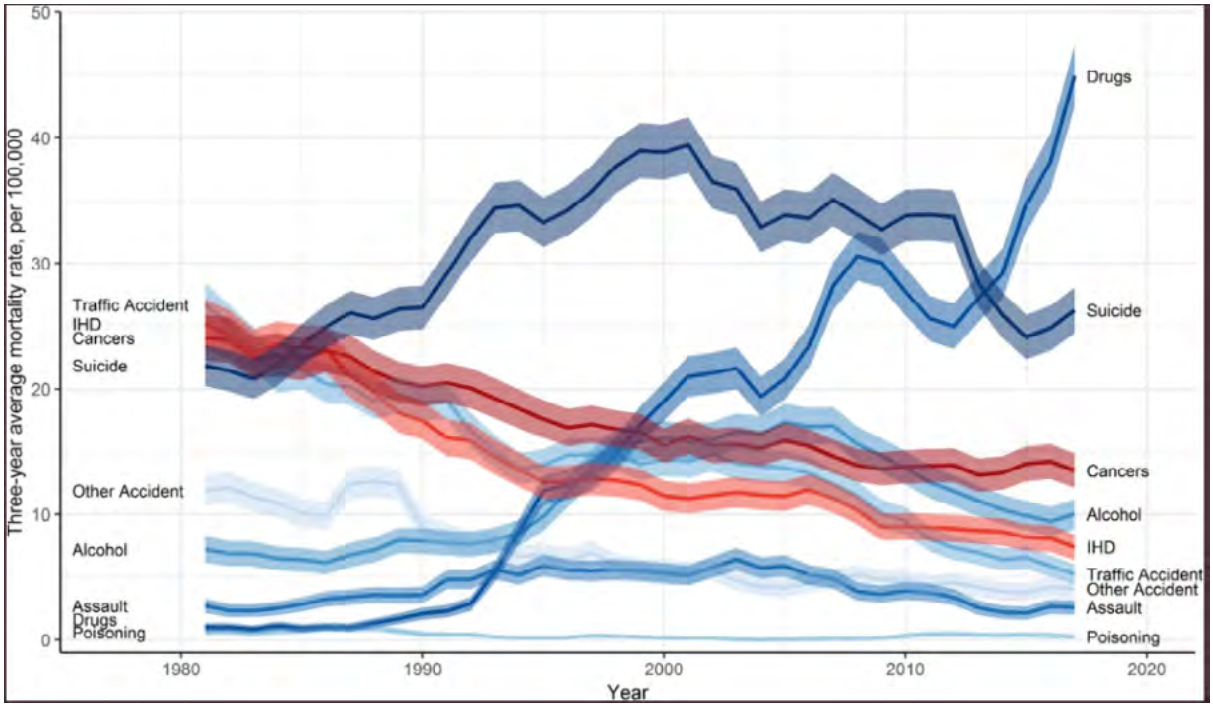
A 'drug-related death' is defined as a death caused by an overdose of drugs. Other deaths as a consequence of drug use are not included in the annual statistics.

Records began in 1996 and there has been a general trend for the number of deaths to increase. Scotland has reported record high numbers of drug overdose deaths in each of the last 6 years.

Scotland has a very high rate of overdose deaths – the highest per head of population in Europe.

Under devolution, Scotland has enjoyed success in reducing other causes of premature death – suicide, cancers, alcohol, ischaemic heart disease, accidents, and physical assault. This success is

not shared in relation to drug overdose deaths. The 2019 figure is almost four and a half times the figure for 1999.



Alik et al. (2020). Deaths of despair: cause-specific mortality and socioeconomic inequalities in cause-specific mortality among young men in Scotland

Of the 1,264 deaths in 2019:

- 94% were in people who had taken more than one substance
- 86% involved an opiate or opioid (heroin, for example)
- 70% involved benzodiazepines (mainly illegally imported and / or manufactured versions of pharmaceuticals)
- 29% involved cocaine
- 77% of people were over 35 with vast majority between 35-54 years of age
- The number of people under 35 had been around 200 each year but now closer to 300.

It seems that the 2020 figure, due to be released in July 2021, is likely to be at least as high as 2019.

2. Treatment systems in Scotland

2.1 - Treatment engagement

Being in treatment is the best evidenced service response to prevent overdose deaths. Scotland needs to increase the number of people in treatment. Scotland needs to be better at attracting people to treatment.

Scotland has a very low rate of people in treatment – 35-40% of people who would be protected from death and other harms by being in treatment are actually in treatment. This compares with 60% in England.

2.2 - Treatment retention

Scotland is very poor at retaining people in treatment. The evidence is that people are not 'parked' in treatment but that they have relatively short treatment episodes and they are frequently disengaged or pushed out of treatment. There is heightened risk of overdose when discharged from any service (prison, hospital, residential rehabilitation or drug treatment) particularly when this is unplanned.

The statistics available are shocking. For example, the Dundee Drugs Commission found that the Integrated Substance Misuse Service had 452 unplanned discharges amongst approx. 1,300 patients in a single year. SDF's own research show that people are often not in treatment long enough to benefit from the protection it offers.

Unplanned discharges often reflect a lack of therapeutic relationship between service providers and people using the service. The culture of some services and some service providers is punitive. Large caseloads, rigid appointment systems and 'policing' people's behaviour are common practice. People experience the treatment system as stigmatising in itself and much of the treatment regime as stigmatising – especially witnessed consumption of medication in community pharmacies and regular routine urine or saliva testing.

Ending unplanned discharges and ensuring that people who drop out of treatment, for whatever reason, are followed up and supported should be key priorities.

The culture of treatment delivery needs to change. It will not change itself and there is a need for 'patient voice' and advocacy as well as support to third sector and other non-treatment services working with people who are in treatment.

2.3 - Treatment access

Treatment is hard to access. Typically, motivation fluctuates and so people need to be engaged at the moment they present – waiting is not an option for many people. People become demotivated to change, can disengage and even die while waiting.

Treatment needs to be attractive and offer what people want, when they want it; and it needs to respond to changes in what people want over time - substitution prescription, support to address immediate health or social issues; support with longer term mental or physical health issues etc. Treatment should be a gateway to other supports that people want. Currently services are focussed on immediate crisis and often poorly engaged with other mainstream services.

Providing same day access to opioid substitution treatment (OST) when people present for help should be a national priority.

2.4 - Treatment choice

There is a lack of choice in treatment and empowerment of people to make choices about their treatment.

Given that 86% of deaths involve opiates, treatment for this group should be a focus. Opioid substitution treatment is the World Health Organisation recommended treatment. There is a substantial and overwhelming evidence for this as a protective factor against overdose deaths as well as other outcomes. There have been two Government commissioned reviews into opioid

substitution treatment in the last 15 years. These were broadly unnecessary and we do not need another.

In Scotland, we have stigmatised this treatment – we now need to destigmatise and promote OST as a protective treatment which will be suitable for many of the people most at risk of drug-related death.

Like other NHS patients, people should be empowered to make informed decisions about the medication (diamorphine, methadone or buprenorphine), the formulation and the dose that will best support them.

Heroin-assisted treatment should be developed and available across Scotland. It is currently only available in a pilot project in Glasgow supporting fewer than 20 people.

The response to the pandemic has seen far more people no longer needing to attend a pharmacy each day for the supervised consumption of their medication. This innovation has for years been resisted by large parts of the treatment system. It is now obvious and demonstrable that this resistance was largely unnecessary. There are lessons here on the conservative culture of much of the wider NHS provision. The practice innovations enforced by the pandemic should be largely retained and built on in the development of better more attractive service provision.

2.5 - Models of care and accountability

Scotland delivers care and treatment in a system which in some respects compares poorly with other countries.

Treatment is delivered almost entirely by the NHS in dedicated services. There are different models across Scotland with shared care models (i.e. where care is shared between a GP and a specialist service) in place in Lothian and Glasgow and very centralised specialist provision in other places like Dundee, for example.

There are long-standing issues with regard to accountability of specialist provision in the NHS. The specialist voluntary sector is accountable to Alcohol and Drug Partnerships (ADPs) through a commissioning process. A similar approach with clinical provision has been adopted in England. The Scottish model tends to lead to a disconnect between NHS treatment and psycho-social support provided by the voluntary sector.

We need to ensure that appropriate accountability is built into the role and function of ADPs so that NHS treatment services are held accountable in a similar way to third sector organisations commissioned by ADPs.

2.6 - Residential rehabilitation treatment

For some people in some situations, residential rehabilitation will be vital and effective.

Scotland has relatively low numbers of residential rehabilitation spaces. However, the situation needs to be contextualised. The high and rising number of drug-related deaths cannot be attributed to the number of places in Scotland. The provision of residential rehabilitation places for people with a drug problem in Scotland has never been much over 600 people per year going into residential rehabilitation and is now considerably lower than that. In the face of almost 60,000

people with a drug problem, even doubling the current number of people going into residential rehabilitation will make little impact on drug-related deaths. It will also take time to increase capacity.

Even if it is expanded along with other service provision to ensure more people are in treatment overall, residential rehabilitation services will remain an important but small part of the treatment response to problem drug use in Scotland – as it is elsewhere in the UK and Europe.

3. The role of the Medication Assisted Treatment (MAT) Standards

MAT Standards have been developed and published (Nov 2020). These have the potential to address many of the issues with treatment access, retention and quality. However, implementation will have to be led and driven through services and planning structures far more vigorously than previous attempts at change. This cannot be left to the NHS alone.

As an immediate priority, Alcohol and Drug Partnerships could amend their current strategies to include implementation of MAT standards 1-5 (below). These are implementable as a priority. MAT Standards 6-10 address crucial longer term change in the service system landscape and the culture of services.

There is a need to devise a mechanism for local monitoring and reporting of MAT implementation. ADPs should be encouraged to highlight difficulties and share challenges and there should be national reporting on progress including the experiences of people using services or who could use services but are not.

The MAT Standards 1-5 are -

1. People have the option to start MAT from the same day of presentation.
2. People are supported to make an informed choice on what medication to use for MAT and the most appropriate dose.
3. People (in or out of drug treatment) at high risk of drug-related harm are identified, prioritised, contacted and offered support to commence or continue MAT or other treatment.
4. People can access evidence-based harm reduction at the point of MAT delivery
5. People receive support to remain in treatment for as long as requested.

4. Other measures to reduce drug-related deaths and harms

4.1 - Naloxone

Scotland has an excellent national 'take-home' naloxone programme that, with support, can be expanded and more effective.

Naloxone reduces fatal overdoses rates in people using opiates near, or in the presence of, other people who are themselves trained in naloxone administration. Naloxone provision has been a success in saving lives. The support of the Lord Advocate has allowed non-specialist services to supply naloxone has been an important change as well as peer supply.

Wider distribution to non-specialist services has been delivered as a response to the pandemic. This is a platform for further development and this opportunity should not be wasted. Police distribution could be extended immediately beyond the pilots and supply should be maximized through the new role for Scottish Ambulance Service in community provision of naloxone.

4.2 - Drug Consumption Rooms (DCRs)

Scotland has no drug consumption rooms. These can impact on drug-related deaths in providing a place to inject safely to people who otherwise would be involved in street injecting. It should be noted that prevention of drug-related deaths was not the primary concern of the Glasgow proposal for a consumption room which was developed to respond to street injecting and an outbreak of HIV.

Clearly one DCR in Glasgow for a city centre population of 500 people involved in street or public injecting will make little impact on deaths among a population of almost 60,000 people with a drug problem.

SDF and others have always maintained that the legal impasse can be addressed within Scotland and DCRs in Scotland provision is possible. An immediate priority would be to address the legal issues and ensure provision for each of Scotland's cities and towns where there is evidence of street or public injecting

4.3 - Decriminalisation

While this might not immediately impact significantly on drug-related deaths, it is important as part of an approach, like that in Portugal, that encourages social inclusion rather than exclusion. It may also support the necessary cultural and attitudinal change and address the stigmatisation of people with a drug problem which is a significant issue that contributes to drug-related deaths.

The Lord Advocate has agreed that the existing legal framework allows recorded police warnings for cannabis possession for personal use. This could be extended to cover all substance. The element of individual police officers' discretion should be removed.

5. The drug strategy in Scotland

There is a perception that the drugs field is fractious and that all evidence is contested. This is a mischaracterisation that has impeded progress in terms of policy development, consultation and advice to the responsible Minister. The real issue is whether Scotland follows the international evidence base for 'what works' and achieves the outcomes achieved elsewhere or instead entertains the notion that our situation is unique and exceptional; resistant to practical solutions effective elsewhere and therefore requires some 'alternative' or 'radical' action. The latter path, followed under the previous drug strategy The Road To Recovery (2008 – 2018), is arguably a significant contributory factor to our present situation.

There is a significant issue with the current drug strategy. Rights, Respect, Recovery (November 2018) It mentions drug-related deaths only to say that these should be reduced and has no coherent strategy for reducing deaths. As has been demonstrated by events and developments subsequent to its publication [i.e. record drug-related deaths announced in July 2019 and

December 2020; the establishment of the Drug Death Task Force in July 2019; the establishment of a new post of Minister for Drugs Strategy in December 2000] that strategy is inadequate.

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