

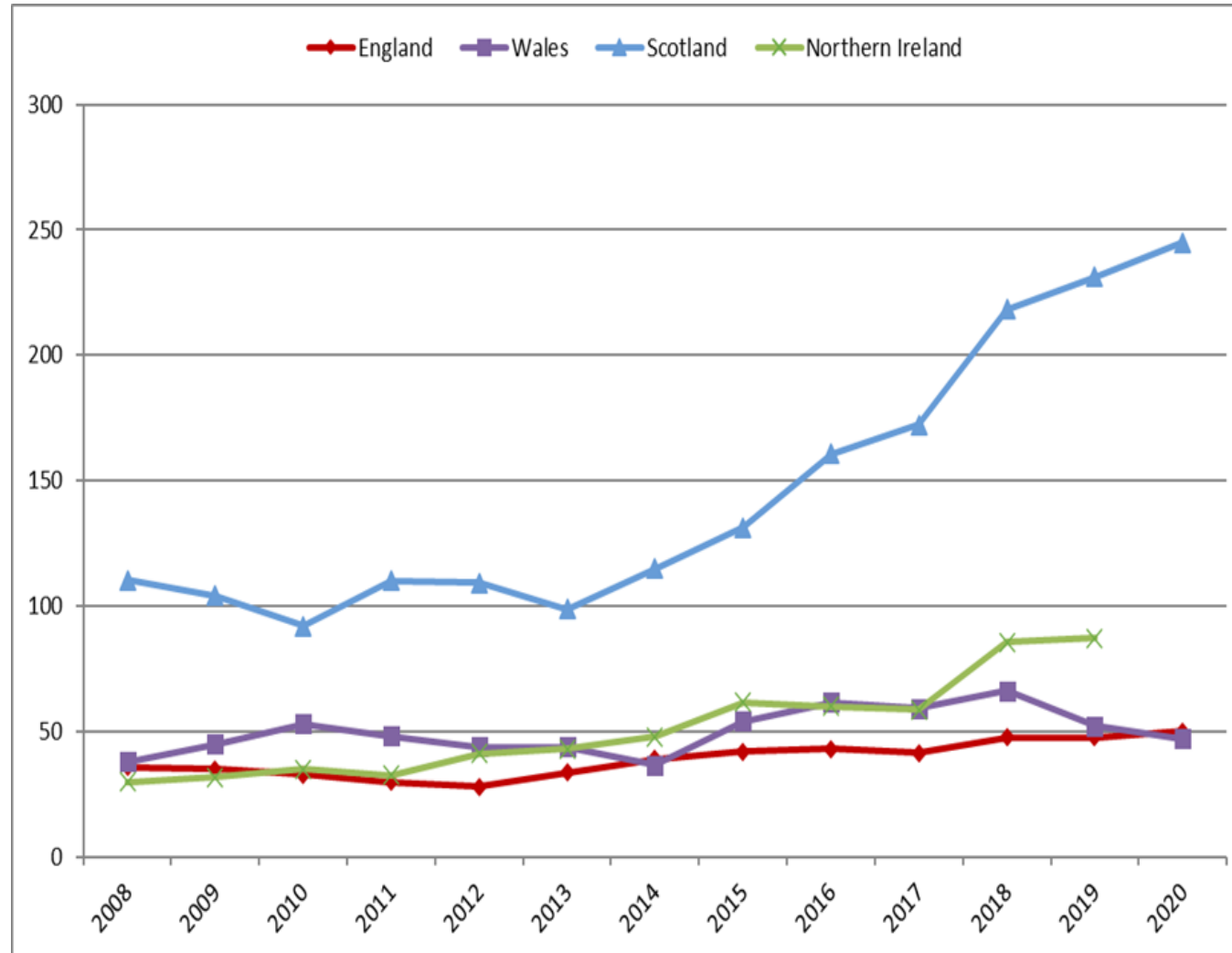
Reducing Drug Related Deaths: Are National Policy Approaches working for those at highest risk? Learning from Scotland

Catriona Matheson

Professor in Substance Use, University of Stirling

Independent Consultant Drug Related Death, Aberdeen City Alcohol and Drug Partnership

The Rise of Drug Related Deaths

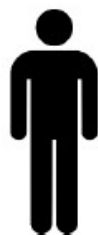


Summary: drug misuse deaths in Scotland in 2022

2022 drug misuse deaths **1,051**

Change relative to 2021 **↓ 21%**

2022 drug misuse death rate age standardised, per 100,000 **19.8**



66%
Males

2021: 70%



34%
Females

2021: 30%

Average age
45 years

2021: 44 years



More than one substance implicated

79%

2021: 83%



Opiates/opioids implicated

82%

2021: 84%



Benzodiazepines implicated

57%

2021: 69%

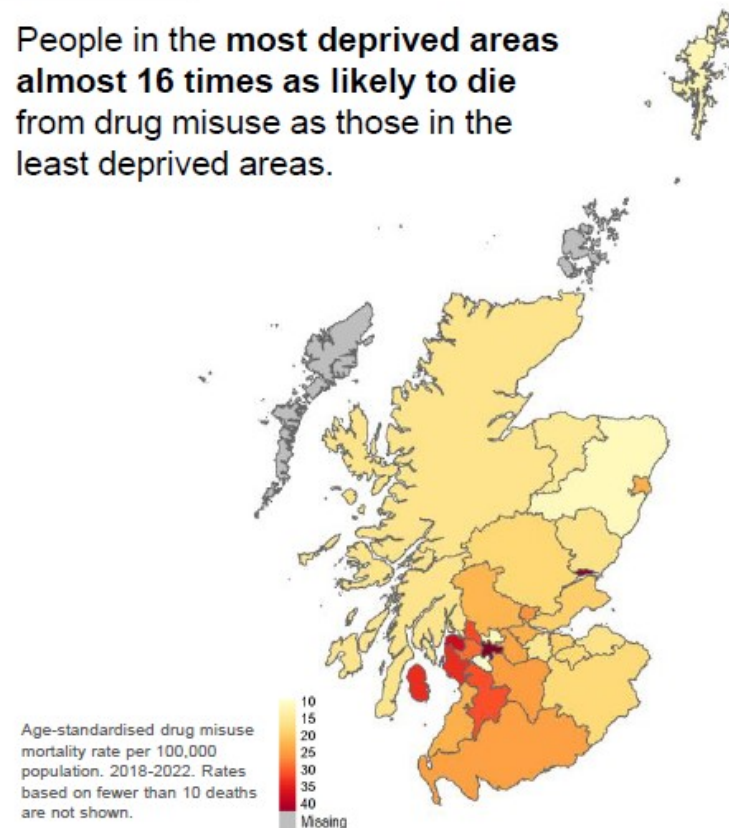


Cocaine implicated

35%

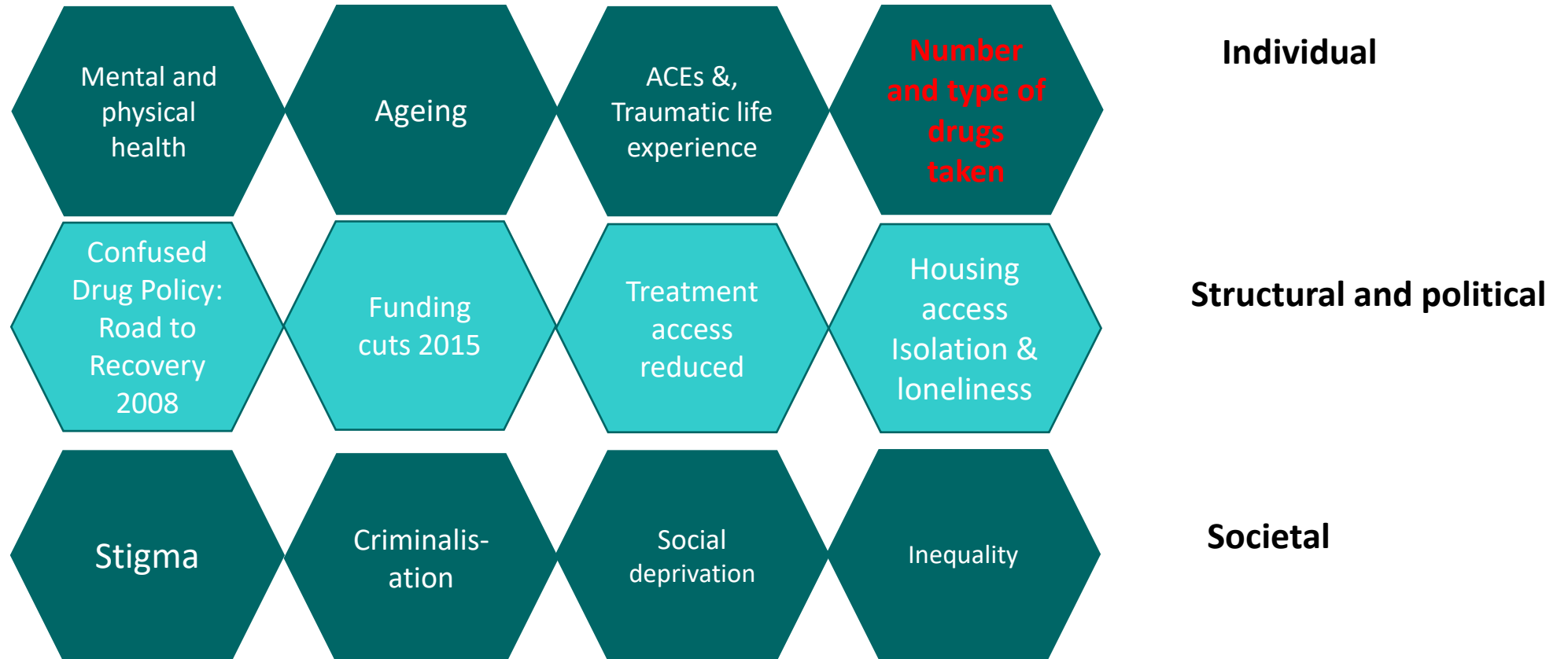
2021: 30%

People in the most deprived areas almost 16 times as likely to die from drug misuse as those in the least deprived areas.



Key Drivers of Drug Deaths

Key Drivers of Drug Deaths in Scotland – the Scottish Evidence



References:

Fitzpatrick S., Bramley G., Hard Edges Scotland. June 2019.

Matheson C., Hamilton E., Wallace J. Liddell D. (2018) Exploring the health and social care needs of older people with a drug problem, *Drugs: Education, Prevention and Policy*, DOI: 10.1080/09687637.2018.1490390.

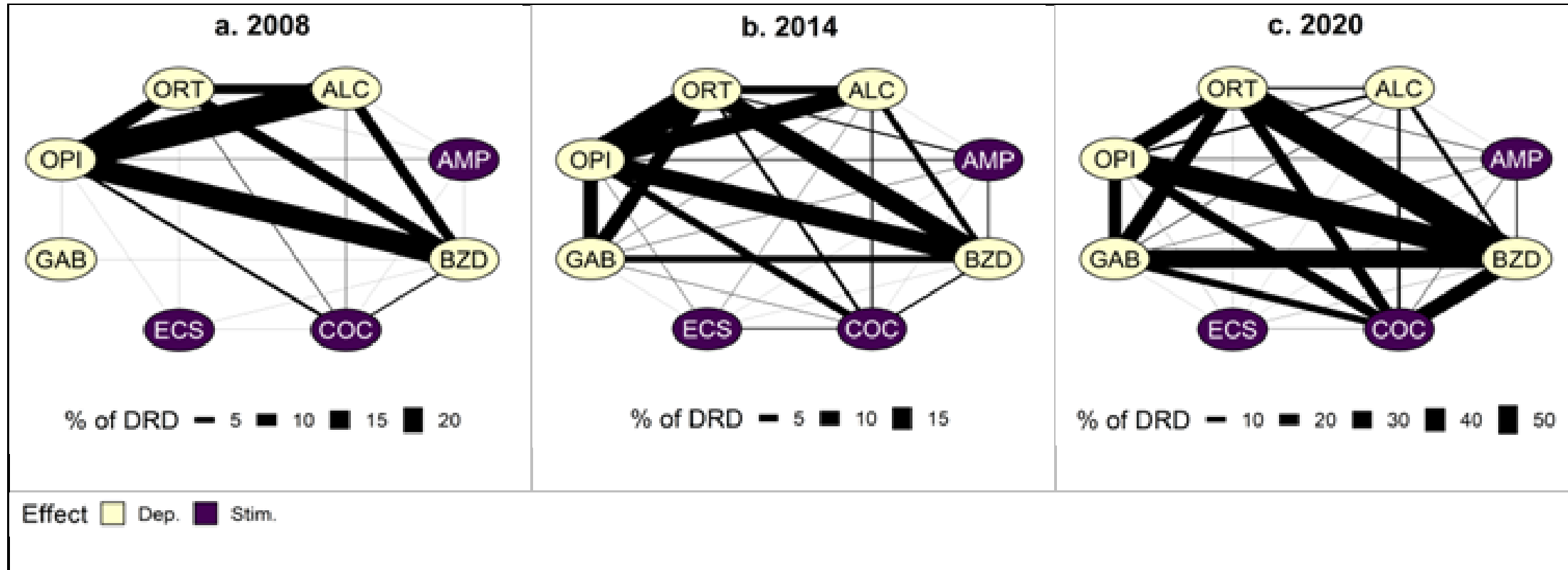
Tweed E., Rodgers M. Taking away the Chaos. The Health Needs of people who inject drugs in Glasgow. NHS GGC.

Tweed EJ, Miller RG, Schofield J, Barnsdale L & Matheson C (2020) Why are drug-related deaths among women increasing in Scotland? A mixed-methods analysis of possible explanations. *Drugs: Education, Prevention and Policy*.

Hamilton E. (2018) A Theory of Isolation and Loneliness in older men who inject drugs in Glasgow. Masters thesis University of Glasgow.

Van Amsterdam et al (2021) Explaining the Differences in Opioid Overdose Deaths between Scotland and England/Wales: Implications for European Opioid Policies. *European Addiction Research*. DOI: 10.1159/000516165

Change in polydrug combinations



ORT: methadone & buprenorphine

OPI: opiates (heroin/codeine etc)

ALC: alcohol

GAB: gabapentinoids

BZD: benzodiazepines

AMP: amphetamines

COC: cocaine

ECS: ecstasy

Description of at Risk Group

Learning from Local Drug Death Review

50 cases reviewed

Review of Deaths against a Risk Matrix

| |
|---|
| Immediate Situation |
| Any transition of care in the last month from a residential setting? -Res rehab, inpatient (mental health/ICU), prison |
| Living alone and overdosed/died at home? |
| Using more than 3 substances? -alcohol/ benzodiazepines/ cannabis/ cocaine/ crack cocaine/ gabapentinoids/ opiates/ solvents/ synthetic opioids |
| Using benzodiazepines or alcohol with opiates (including prescribed)? |
| Any of the following physical health conditions? -Cardiovascular / respiratory disease (asthma or COPD)/liver disease/ kidney disease |
| Any of the following prescription medications? -Opiate replacement treatment/antidepressants/antipsychotics/pain medication/ sleep medication |
| In last 12 months* |
| Recent trauma including domestic abuse, sexual abuse, assault? |
| Significant recent life events including bereavement or removal of child? |
| Deterioration in financial situation e.g loss of income, rent arrears, drug debt? |
| Deterioration in mental wellbeing (self-report or observed)? |
| Recent overdose? -self report/ ambulance call or A&E attendance |
| Self-harming behaviour? |
| Changes/major challenges (negative) in housing situation? (including cuckooing) |
| Evidence of self-neglect? -observed/reported by other agencies e.g. pharmacy, housing |
| Health and Wellbeing Factors |
| Lack of supportive family - (parents/partner/siblings) |
| Early life trauma (include parental substance use/neglect/ abuse) |
| Any mental health conditions? |
| Other chronic health problem e.g. chronic pain? |
| Inability to stabilise on medication assisted treatment? |
| Frequent missed doses |
| Long history of substance use (>10 years) |
| Age over 35 years? |

Key emerging themes/risks - >70% of cases

- Any of the following prescription medications - OAT/antidepressants/antipsychotics/pain medication/ sleep medication
- Using more than 3 substances? -alcohol/ benzodiazepines/ cannabis/ cocaine/ crack cocaine/ gabapentinoids/ opiates/ solvents/ synthetic opioids
- Long history of substance use (>10 years)
- Age over 35 years
- Any of the following physical health conditions? -Cardiovascular / respiratory disease (asthma or COPD)/liver disease/ kidney disease
- Using benzodiazepines or alcohol with opiates (including prescribed)
- Co-occurring mental health condition

The National Response

National Response

- Establishing a Drug Death Taskforce: July 2019 by the Minister for Public Health and Sport, supported by the Cabinet Secretary for Justice.
- Mission: *“Identify and advise on an evidence-based strategy, and its component parts, that can successfully tackle Scotland’s unique challenge.”*
- Evidence based emergency response grounded in public health

Interventions to reduce the risk of opioid related deaths (EMCDDA, 2017)

Interventions to reduce the risk of opioid-related deaths

**Reducing fatal
outcome of overdose**

**Supervised
drug
consumption**
Immediate first-aid
in drug emergencies

**Take-home
naloxone
programmes**
Improved bystander
response

**Reducing risk of
overdose**

**Retention
in opioid
substitution
treatment**
Reduce drug use
and injecting

**Overdose
risk
assessments**
In treatment
facilities and
prisons

**Overdose
awareness**
Knowledge of risk
and safer use

**Reducing
vulnerability**

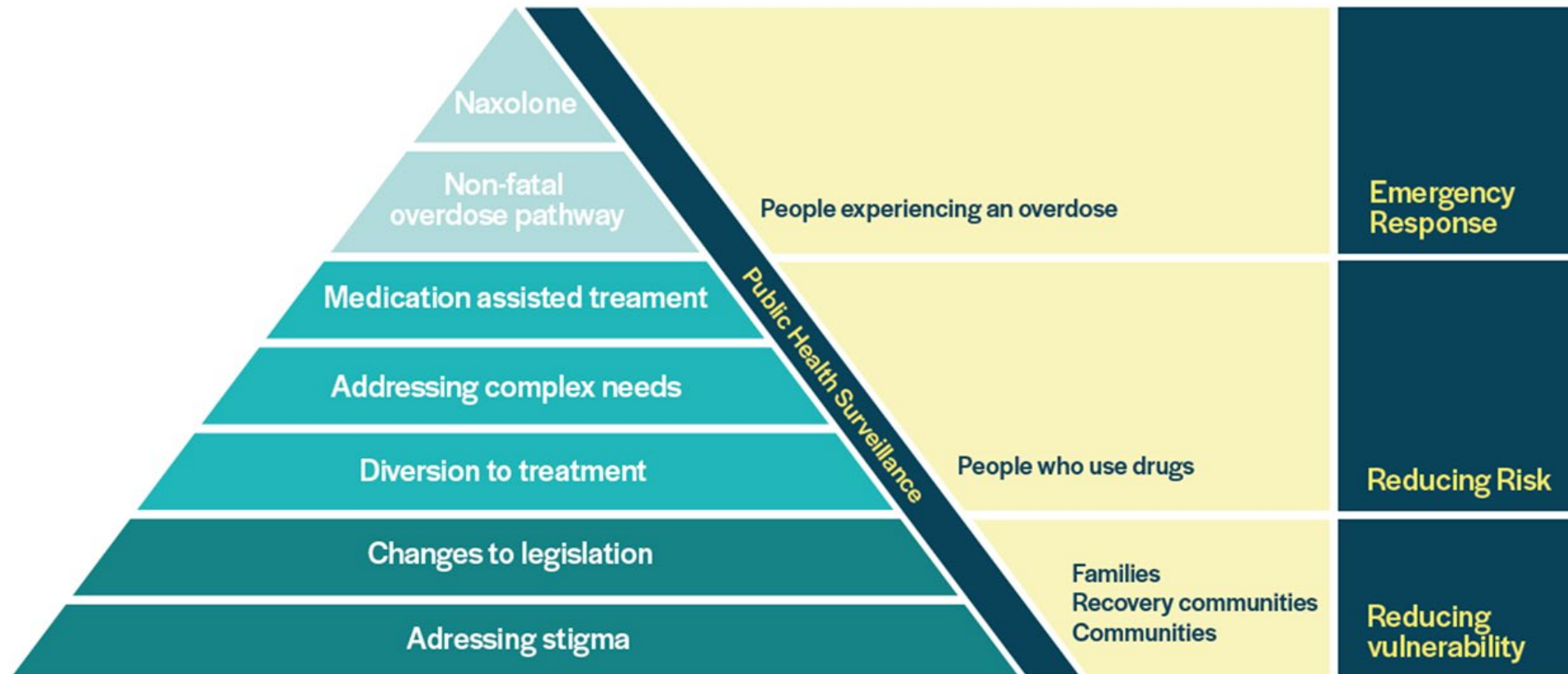
**Outreach
and
low-threshold
services**
Accessible
services

**Enabling
environment**
Removing
barriers to service
provision

**Empowerment
of drug users**
Enabling drug
users to protect
themselves

**Public health
approach**
Recognition of
wider impact

STRATEGIC EVIDENCE BASED APPROACH



Focused on what was legally possible

Evidence Based Services (Drug Deaths Taskforce)




Maximise naloxone distribution



Non-fatal overdose pathways outreach to the most vulnerable e.g. those experiencing a non fatal overdose



Increase ready access to quality drug treatment – Medication Assisted Treatment Standards

RADAR 
Rapid Action Drug Alerts and Response
Briefing paper: Scotland's Drugs Early Warning System

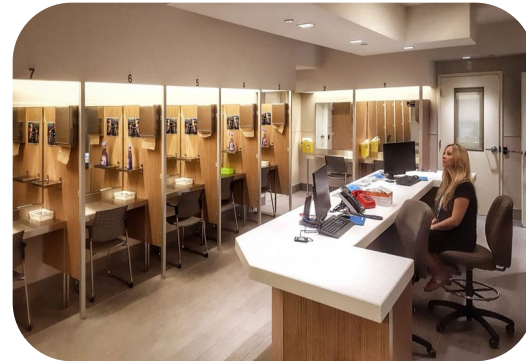
This briefing reflects agreed consensus to optimise drug-related public health surveillance in Scotland. Members of the Operations Group (including representation from Alcohol and Drug Partnerships (ADPs), Scottish Government, Police Scotland, services, voluntary organisations, and community members including lived and living experience) gave consensus on the 27th of January 2022 to use the approach detailed in this paper and it will now be progressed by Public Health Scotland (PHS). This critical work is a priority of the Drug Deaths Task Force and links to the Scottish Government's National Drugs Mission.

RADAR is an early warning system that mobilises data collection streams and multi-agency networks to enhance our ability to detect and assess threats, allowing for quick and targeted action to reduce drug-related harm.

Enhanced surveillance



Drug checking



Supervised 'safe' consumption facilities - or remote supervision using technology



Stabilisation facilities for those most at risk



Maximise Naloxone Distribution



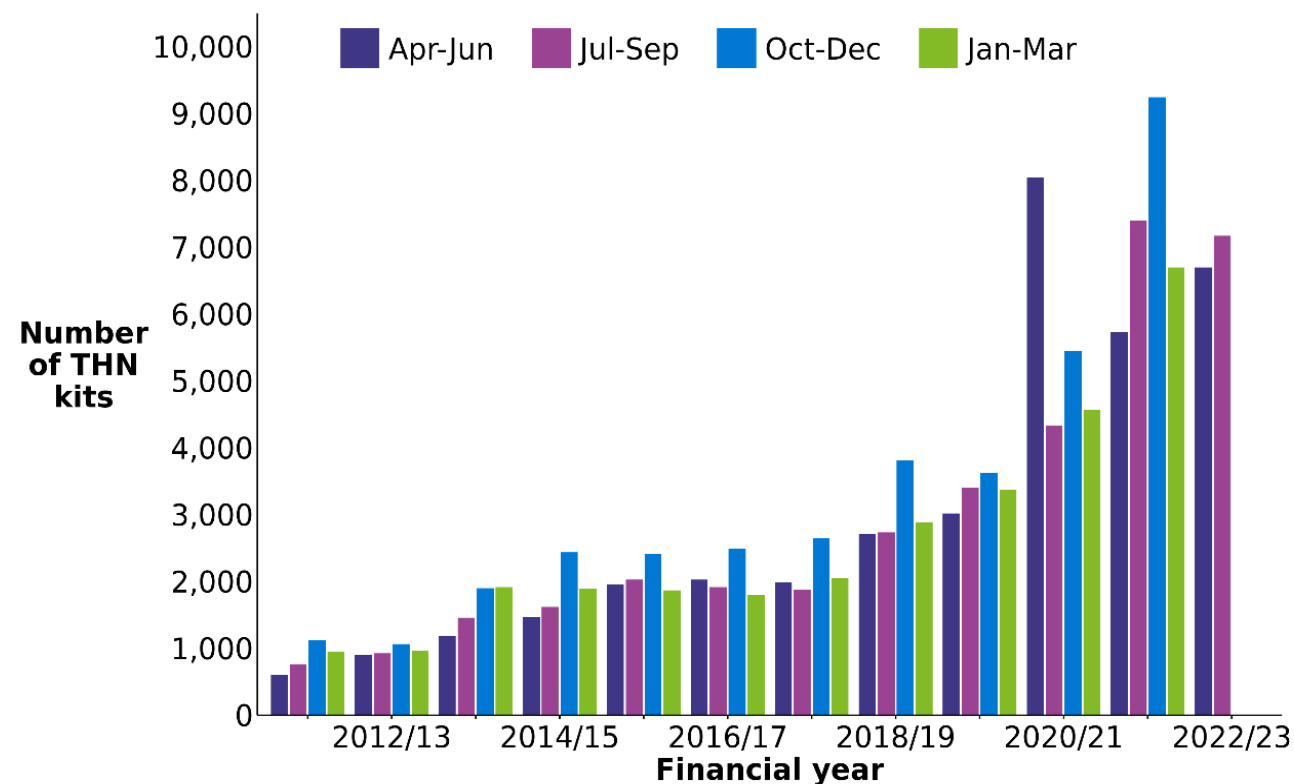
percentage reach to those at risk up from 49% to 67.5% (ISD)

Police naloxone rollout
153 administrations between March 2021-March 2022
(4 sudden deaths)

Naloxone on release from prison: 1,929 THN kits issued in prisons in 2022/3, a 14% increase from 2021/22
A total of 12,412 THN kits since 2011

All community pharmacies stock naloxone for use

Ambulance take home naloxone across Scotland – 2518 kits by mid 2023



Source: Public Health Scotland

Take home naloxone: THN

Non Fatal Overdose Intervention

Evidence – Scottish Data

- Over half of people who die had previously experienced a non-fatal overdose
- Among those who had previously overdosed, 70 (16%) were known to have overdosed at least five times prior to their death.
- Of those who had experienced a previous overdose, 24% (105) had overdosed within six months of death

(NRS 2016 data)

Response

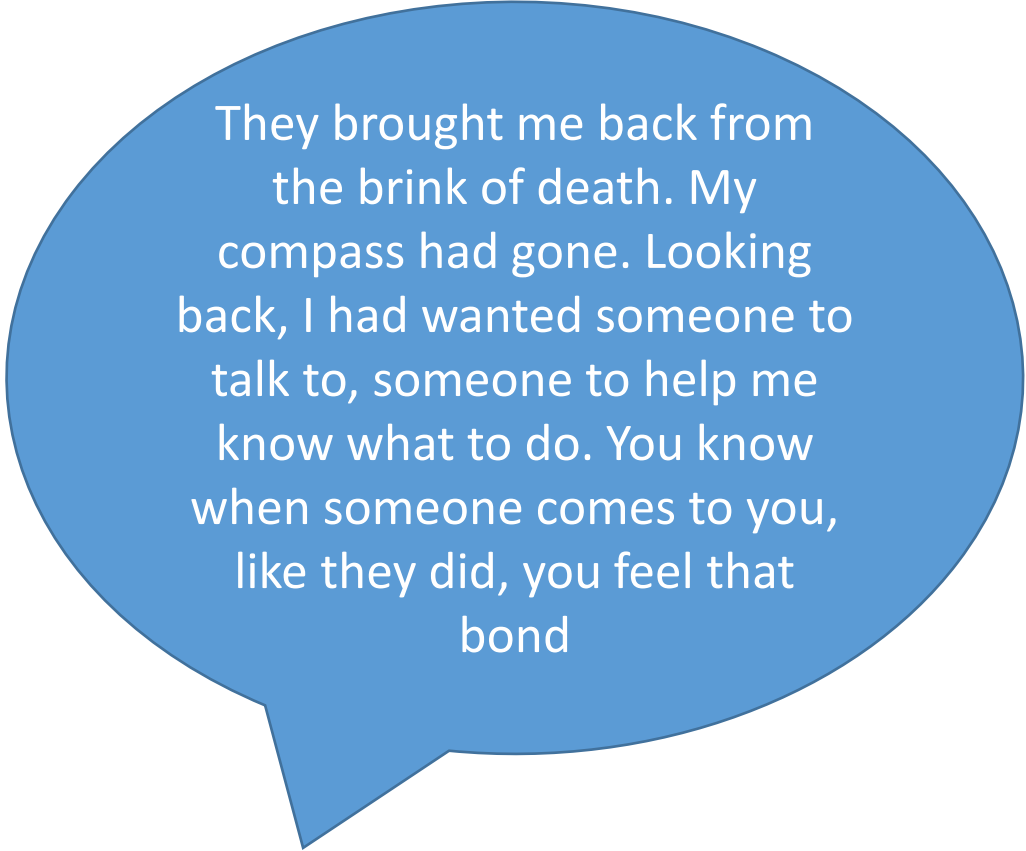
- Scottish Ambulance Service
- 7214 incidents in 12 months (Aug 21 – July 22)
- 40% not in treatment

Overdose response teams

- **Crisis intervention/ assertive outreach** visit people and provide support and link to services. – still to be evaluated

Overdose response teams

- Third sector/statutory service
- Make contact – ideally within 24 hours
 - Home visits
 - Overdose prevention advice
 - Naloxone
 - MAT referral
 - Injecting equipment provision
 - info & contact



They brought me back from the brink of death. My compass had gone. Looking back, I had wanted someone to talk to, someone to help me know what to do. You know when someone comes to you, like they did, you feel that bond

Medication: Opioid Agonist Treatment

- Methadone
- Buprenorphine – sub lingual or long acting injection (weekly or monthly)
- Diamorphine assisted treatment

- Strong evidence base Scottish cohort data found those off OAT were 3.37 times more likely to die than those on OAT. (McAuley et al, 2023)



Medication Assisted Treatment

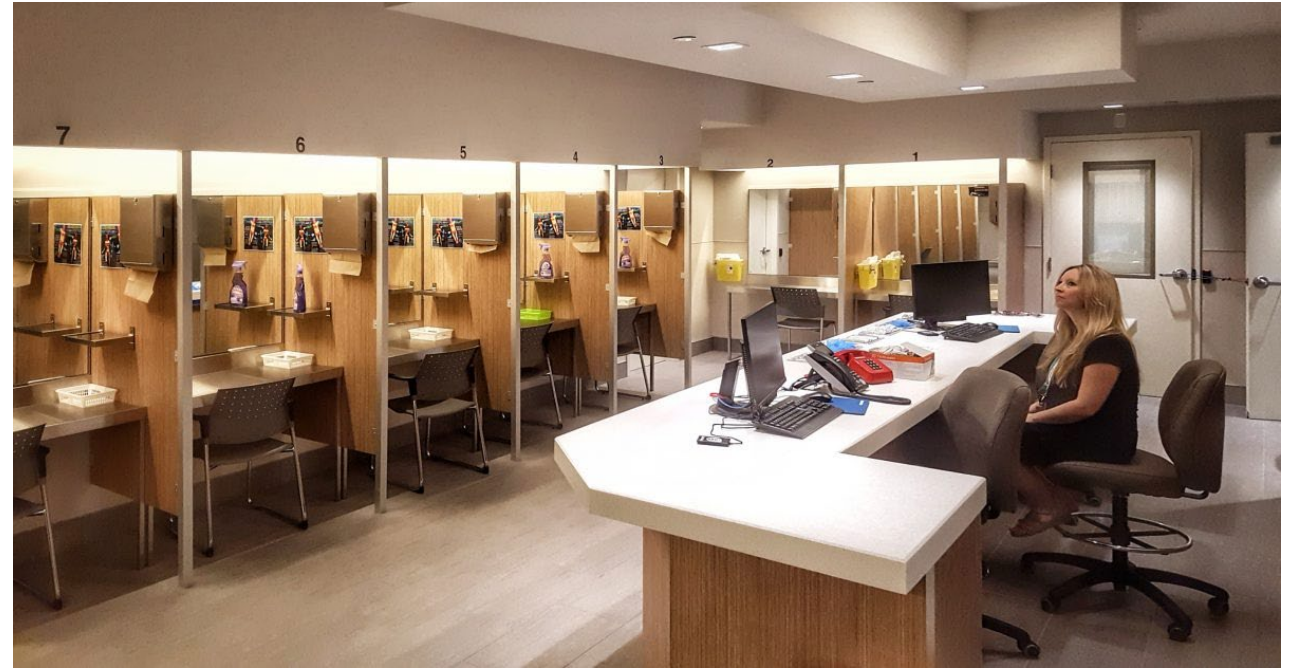
evidence based treatment standards

Medication-Assisted Treatment (MAT) is the use of medication, such as opioids, together with any psychological and social support, in the treatment/care of individuals who experience problems with drug use.

1. All people accessing services have the option to start MAT from the same day of presentation.
2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.
3. All people at high risk of drug-related harm are proactively identified and offered support to commence, re-commence or continue MAT.
4. All people are offered evidence based harm reduction at the point of MAT delivery.
5. All people will receive support to remain in treatment for as long as requested.
6. The system that provides MAT is psychologically and trauma informed (Tier 1); routinely delivers evidence based low intensity psychosocial interventions (Tier 2); and supports the development of social networks.
7. All people have the option of MAT shared with Primary Care.
8. All people have access to advocacy and support for housing, welfare and income needs.
9. All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery.
10. All people receive trauma informed care.

Safe Drug Consumption Facilities

- Pilot starting in Glasgow soon!
- Widely used in Canada, Australia, Europe



Drug checking and surveillance

- Wedinos – postal service
- Festivals in the UK
- First fixed site in Bristol 2024
- Licences recently submitted for fixed sites in Scotland –but too slow!



Digital Solutions



- Supported by the *i4i Innovation fund* and *Digital Lifelines Scotland*

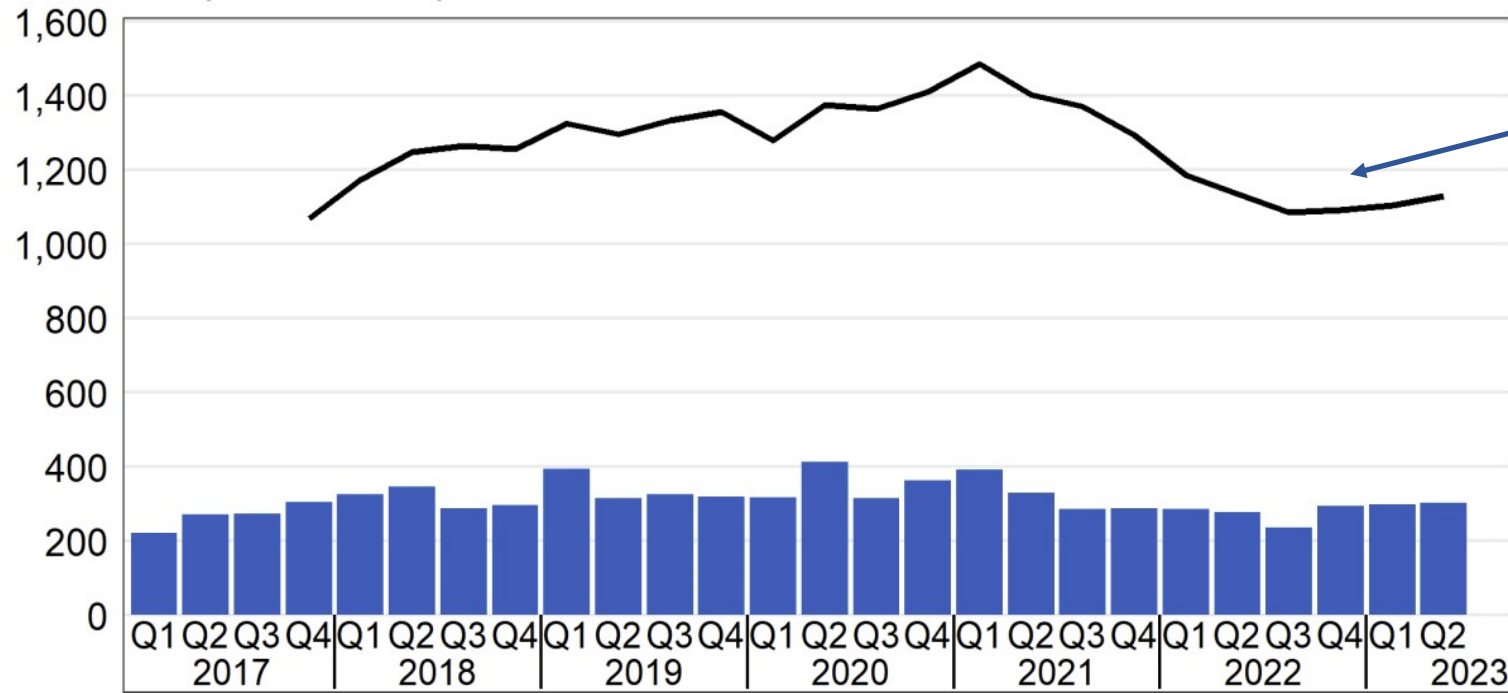
Digital means of connection crucial to keep people connected – covid smartphones, tablets, data packages

Use of responder applications to connect people at the point of risk to a supporter network/ naloxone apps to connect carriers to situations

Use of monitors, room sensors and wearable devices to detect signs of overdose

Are national approaches working
for those at highest risk?

Where are we now?



New emerging drugs
e.g nitazenes, new
benzodiazepines
(bromazolam)

Note: Q1 is January to March, Q2 is April to June, etc
Source: Police Scotland

■ Police Scotland suspected drug deaths — Rolling annual suspected drug deaths (sum of last 4 quarters)

Local Issues and Response

- Polypharmacy and Poly drug use!!!
- Managing deterioration
 - Linking into broader services, assertive outreach, housing, adult social protection and Police
- Physical health deterioration: respiratory and cardiovascular disease
 - Health screening/ anticipatory care – estimating the size and needs of the at risk group locally
- Communicating with the at risk population

Challenges

- New emerging drugs e.g. fentanyl, nitazenes, synthetic cannabinoids, new benzodiazepines Can we keep up?
- **Politicisation**
 - Evidence based approach overlooked – talking the talk of evidence but...!
 - Ongoing legal restrictions
- **Workforce challenges**
 - Chronic understaffing in treatment services
 - Time to deliver psychosocial support
 - GP and clinical psychologist numbers insufficient
- Insufficient investment in clinical services (in Scotland)
- Research takes time and requires funding (Drugs Mission a positive sign)

Summary

Why?

High risk combinations
of multiple substances
Physical resilience
reduced Mental health
poor - more risky drug
use

Response

Considerable efforts
across services to
respond, Successes so
far: naloxone, overdose
response teams MAT
standard

Still need

Drug checking, medical
stabilisation, health
checks

and...

Need to reach out,
communicate better...
and give hope