December 2020

Drug Related Deaths in Scotland
TPS Position Statement

Scotland recorded **1,264** drug related deaths (DRD) in 2019, 6% more than in 2018 (1187 recorded). The number has more than doubled in the last 5 years and is **almost three times that of the UK as a whole**. A DRD is recorded when drugs are implicated in, or potentially contributed to, the cause of death. This number does not include deaths from suicide, from illnesses or infections related to drug use, from accidents or incidents that occurred while the person was using drugs; it really is just the tip of the iceberg.

What we know:

Risk of a drug related death increases when people have other support needs in addition to their problematic drug use – The Staying Alive Report showed us that people experiencing homelessness are 7 times more likely to die of drug related issues than the general population. In the six months before their death, 60% of people had a specific psychiatric disorder recorded one in ten (11%) had been in prison. Poor physical health can also put people at greater risk of DRD, with blood-borne viruses in particular being associated with a higher risk of accidental overdose.

A near-fatal overdose is an indicator of a future DRD. Over half of drug related deaths reported in 2016 (54%) had previously experienced a non-fatal overdose. Among this number, 24% had overdosed within 6 months of their death, 15% within the last 3 months, and 16% were known to have overdosed at least five times prior to their death.

Meaningful connection reduces risk of both overdose and non-overdose deaths. Staying Alive highlighted connection to services as a protective factor against DRD – one barrier to engagement is labelling people as 'hard to reach' when we need to consider how we've made those services 'hard to engage with. We must also recognise that other, less formal meaningful connections – to peers, to family, to community – are valuable and important protectors.

Naloxone is effective in preventing opioid overdose deaths – 56% of DRDs occur when others are present; with the right support those people might have been able to intervene. The take-home naloxone programme aims to give people the means to help themselves and others in the event of an overdose by providing kits and training in the community and to people leaving prison. The percentage of opioid-related deaths in people within 4 weeks of leaving prison has reduced by almost a third, and we've seen over 1,500 overdose reversals in the community using take-home kits. In 77% of DRDs the person had been in drug treatment, in prison or police custody or discharged from hospital in the six months prior to death; this contact was a harm reduction opportunity.

Stigma increases risk – It can impact a person's self-esteem and their mental health. It can limit their willingness and ability to engage with support services and to sustain positive changes. People need to feel valued, that their life is important and worth protecting. The way a person is treated by a service matters. The way that we talk about drug use and people who use drugs, matters. Communities that show compassion and provide opportunities for people to grow and develop, matter.

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Our legal framework is preventing action – The crisis we are experiencing has driven fresh thinking and new approaches in other countries – Portugal's decriminalisation and diversion programmes, Safer Consumption Rooms in Canada and drug testing schemes in the Netherlands, for example. There is a clear evidence base to show that these approaches can deliver significant improvements, but the Misuse of Drugs Act (1971), reserved to Westminster, stands in the way of us attempting to create our own evidence based responses.

Key Asks:

Recovery is only possible if people survive. **Keeping people alive should be an explicit priority** that is clear and visible in leadership at the Scottish Government, ADP and local authority level.

We support Glasgow HSCP's case for **Safer Consumption Rooms**. We urge the UK Government to make the necessary legislative changes to allow this evidence-based approach.

We must make more of the powers we do have to challenge current practice and invest in:

- Increased **assertive outreach** – taking the support to where people are
- Better **integration and communication between all parts of the system**, at national and local level, in strategic planning and service delivery, to coordinate efforts, share resources and make the most of every opportunity to prevent and reduce harm
- New forms of evidence-based support and treatment that make services more accessible and relevant – **low-threshold prescribing, heroin-assisted treatment (HAT) and drug testing services** have all been shown to improve engagement
- Faster access to **substitute prescriptions** – a range of options for medication, and associated support, as well as a priority response to non-fatal overdoses
- Open access, residential **stabilisation services** that give people at greatest risk a place of safety and peer-led support to encourage engagement
- An approach to treatment that upholds the **Human Rights** of the people who need it – we must move away from punitive approaches that limit access for those who "fail" to meet the standards and expectations set by the system; we cannot punish people for their illness

The **Naloxone programme should be expanded** to include public sector workers most likely to encounter someone at risk, such as police officers and paramedics. We should invest in the development of easier administration methods, learning in particular from the evaluation of the intra-nasal approach.

Commitments in the Government's drug & alcohol strategy to tackle stigma need to be progressed and connected to similar commitments in the Ending Homelessness Together Action Plan and Mental Health framework. But we can't only look at these work areas - we need to take a **whole system, and whole population approach to understanding and tackling the stigma that puts people at risk and makes it harder to access support and treatment**

We need **a legal and policy framework that is evidence based and effective** in preventing and reducing harm. It should not be an issue of politics; it should be an issue of what will work. This demands commitment, bravery and leadership from our elected officials.