DRUG RELATED DEATHS 2019

FIFE ALCOHOL & DRUG PARTNERSHIP

A NOTE ON THIS REPORT

This report is intended to provide an overview of drug-related death within Fife by examining trends and themes which may be used to influence strategic decision making. It does not replace any internal or external reports completed by any national or local partner organisations.

Authors

Phillip Heaton
FIFE ADP POLICY OFFICER

Sarra Naylor
FIFE ADP DATABASE SUPPORT COORDINATOR

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PREFACE

Drug-related deaths (DRD) in Scotland have been rising over the last 5 years culminating in 1264 deaths in 2019. This is the largest number of deaths ever recorded in Scotland and accounts for an increase of 6% over the 2018 figures.

The information contained within this report is obtained from a number of sources such as Police Scotland Sudden Death Reports, pathology reports, internal NHS Fife and Fife Council databases, and feedback from ADP funded specialist services across the statutory and third sector. Statistical data described within this report has been taken in part from the National Records of Scotland report of Drug Related Deaths in Scotland 2019 along with local data analysis undertaken by the ADP Drug Death Database Coordinator.

DEFINITION OF A DRUG-RELATED DEATH

To ensure parity across any national and local comparisons, the definition of drug-related death used within this report is the same as that used by the National Records of Scotland. Briefly, the definition used is:

The 'baseline' definition for the UK Drugs Strategy covers the following cause of death categories (the relevant codes from the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision [ICD10], are given in brackets):

a) deaths where the underlying cause of death has been coded to the following sub-categories of 'mental and behavioural disorders due to psychoactive substance use':

(i) opioids (F11);
(ii) cannabinoids (F12);
(iii) sedatives or hypnotics (F13);
(iv) cocaine (F14);
(v) other stimulants, including caffeine (F15);
(vi) hallucinogens (F16); and
(vii)multiple drug use and use of other psychoactive substances (F19).

b) deaths coded to the following categories and where a drug listed under the Misuse of Drugs Act (1971) was known to be present in the body at the time of death (even if the pathologist did not consider the drug to have had any direct contribution to the death):

(i) accidental poisoning (X40 – X44);
(ii) intentional self-poisoning by drugs, medicaments and biological substances (X60 – X64);
(iii) assault by drugs, medicaments and biological substances (X85); and
(iv) event of undetermined intent, poisoning (Y10 – Y14).[1]

More Details on the definition of drug-related death used, including exceptions, exclusions and examples of other definitions as well as how the data in this report was gathered can be found in the appendices.

SUMMARY OF DEATHS IN FIFE - DATA, ANALYSIS & TRENDS

In 2019 there were 81 drug-related deaths recorded in Fife.

This is an increase of 26% from 2018 when 64 deaths were recorded.

Fig 1 shows the rate of increase in drug-related deaths within Fife between 2009 and 2019:

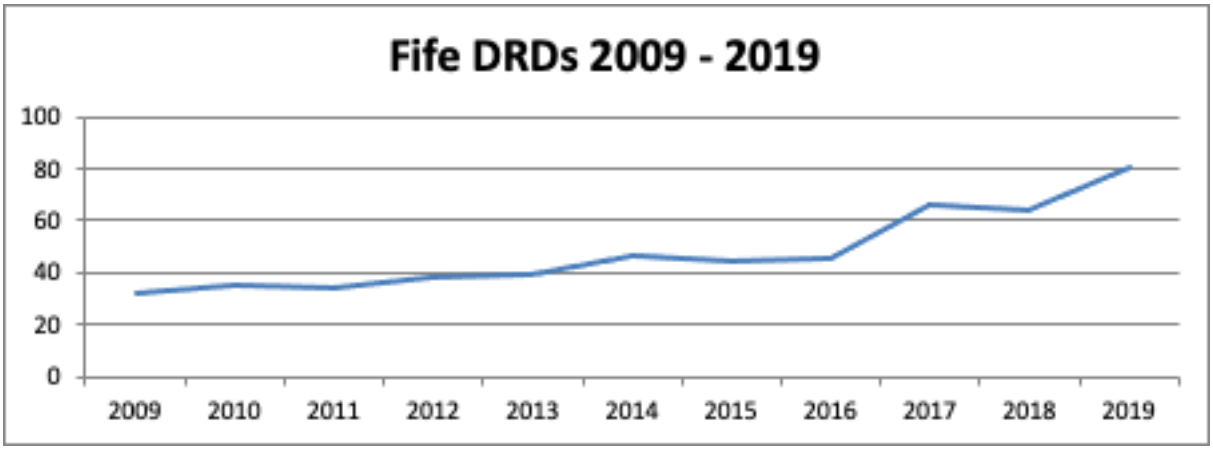


Fig 1

The overall picture of drug-related deaths is that they are increasing each year. There was a small decrease in 2018 from the previous year but 2019 figures are the highest ever recorded in Fife.

This acceleration rate and number of DRDs is not atypical to or an unusual situation solely in Fife and is occurring across the country as a whole.

LOCATION OF DEATHS

Previous years have shown that the majority of drug-related deaths are clustered around areas of higher deprivation. 2019 is no different and when compared to Scottish Index of Multiple Deprivation (SIMD) data, the two datasets overlap considerably. This applies to 2020 SIMD data as much as 2016 data.

Fig 3 shows a heat map of 2019 drug-related deaths.

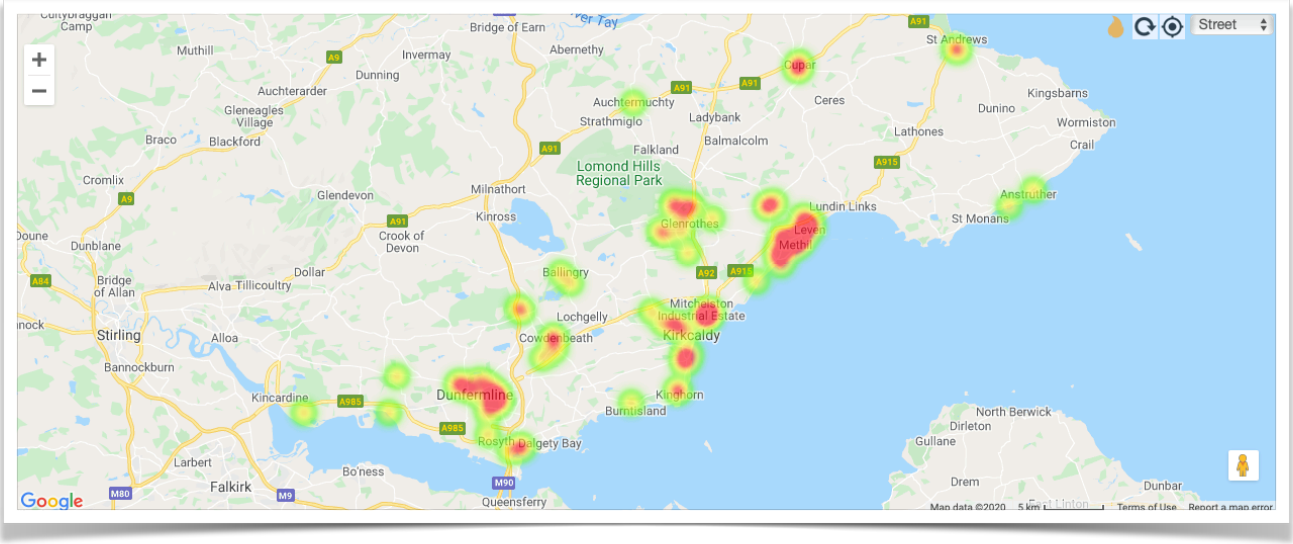
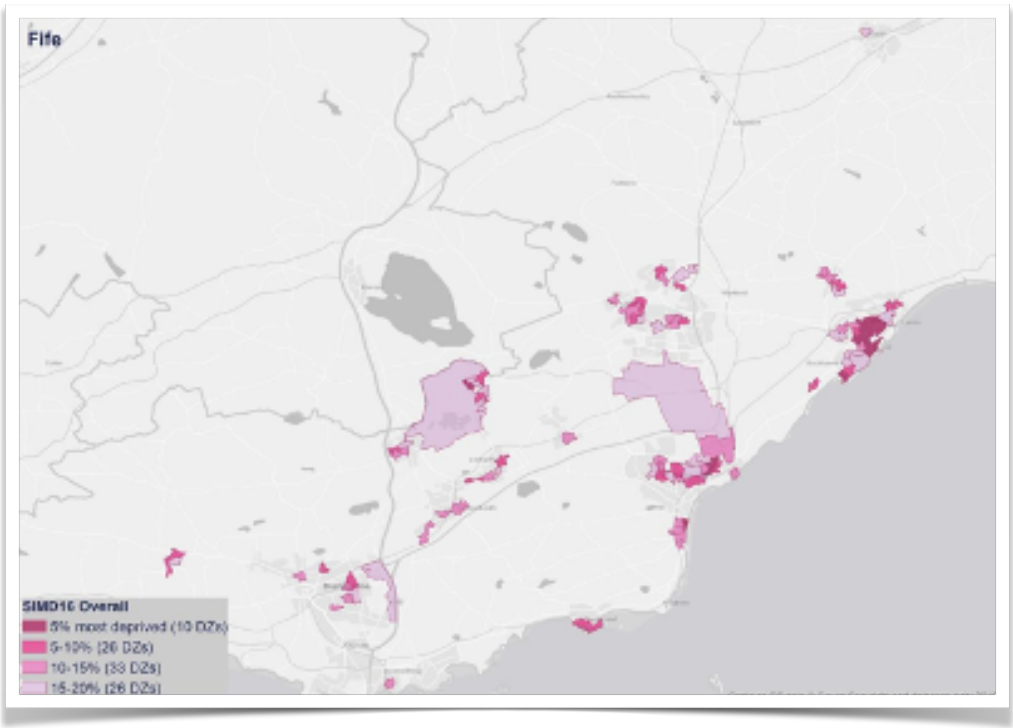


Fig 3

It is clear from the maps that high numbers of deaths occur in areas such as Leven, Methil, Glenrothes, Kirkcaldy and Dunfermline and is evident that these areas require special focus when devising strategies and service provision locality planning intended to reduce drug-related deaths in Fife.

The map below is taken from the SIMD 2016 data and shows the areas in Fife of highest deprivation. Note how the SIMD data mirrors the death clusters.



During 2018, Fife ADP Support Team conducted a targeted piece of work within the Gallatown area of Kirkcaldy based on reports of a number of clustered deaths within that area. This work was successful in developing links with local key workers and a harm reduction response both for people who use drugs as well as their families and friends.

The benefits of locality focussed work has been acknowledged and forms part of the ADP Strategy 2020-23. To address the high rate of drug-related deaths within the Levenmouth area, Fife ADP Support Team are engaging with the Levenmouth H&SCP Core Group to develop a locality based response which will be reflected in the Levenmouth plan.

Deaths within the Dunfermline area are also particularly high. This area also has a high number of near-fatal overdoses and the ADP Support Team are working to address this by liaising with homelessness organisations in the area to educate and equip staff and introduce a wider naloxone distribution programme. Again, this work is still in its infancy and will be reported to the ADP as it progresses.

AGE

It is clear from the chart below (Fig 6) that the most deaths for males and females occurred in the 35-44 age range. This is consistent with national trends and we can compare this to nationally available data for the five year period between 2014 - 2018.

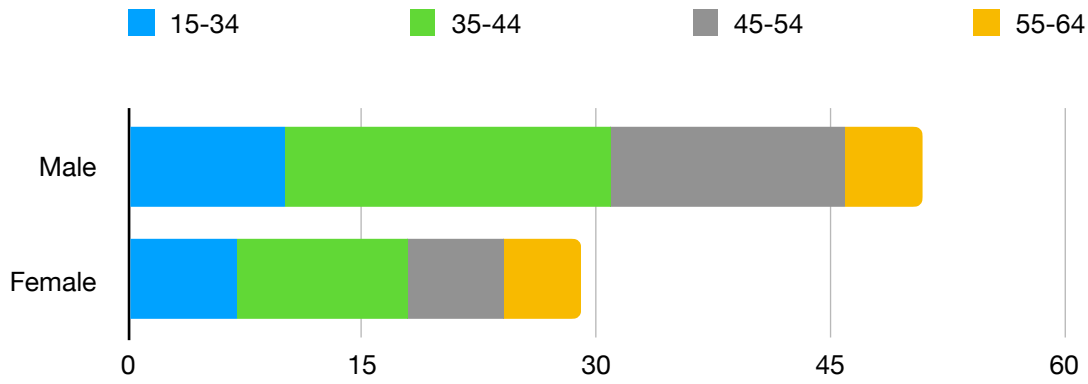


Fig 6

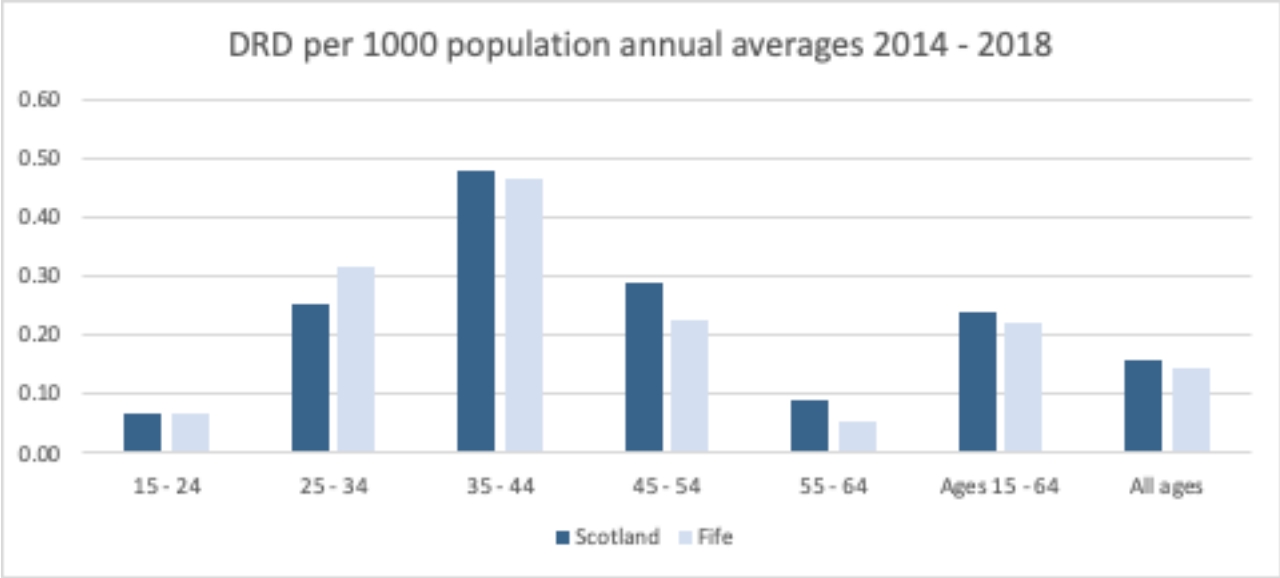


Fig 7

However, an interesting development with the 2019 figures is the increase in deaths amongst the 45-54 age range. It has long been noted that deaths are increasing within an older population due to associated medical problems such as co-occurring respiratory and heart related diseases and it is therefore no surprises that this age group is also incurring an elevated death rate.

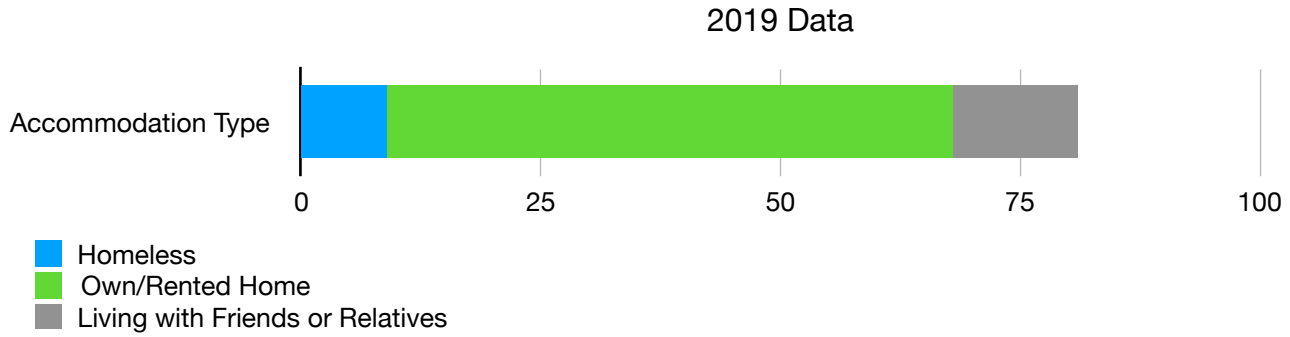
Another important point to note is the rise in female deaths in 2019. Again, this is consistent with national figures and further investigation into the potential causes of this rise need to be addressed. Fife ADP Support Team are working with Fife Violence Against Women Group to deliver a peer to peer research paper to speak to women about their experiences of the treatment and support system of care to explore issues with access and retention. This work will commence in 2021/22. Fife ADP Support Team also plan to produce a report focussing on female drug deaths over the last 3 years.

ACCOMMODATION

When considering the housing status of people who suffered a drug-related death, it is important to acknowledge that in many cases the living arrangements varied frequently and lifestyles could be described as “chaotic”.

Fig 8 and the accompanying table, shows that the overwhelming majority of deaths occurred to people who had their own accommodation. This definition includes housing which is owned or rented (but is not intended to infer place of death).

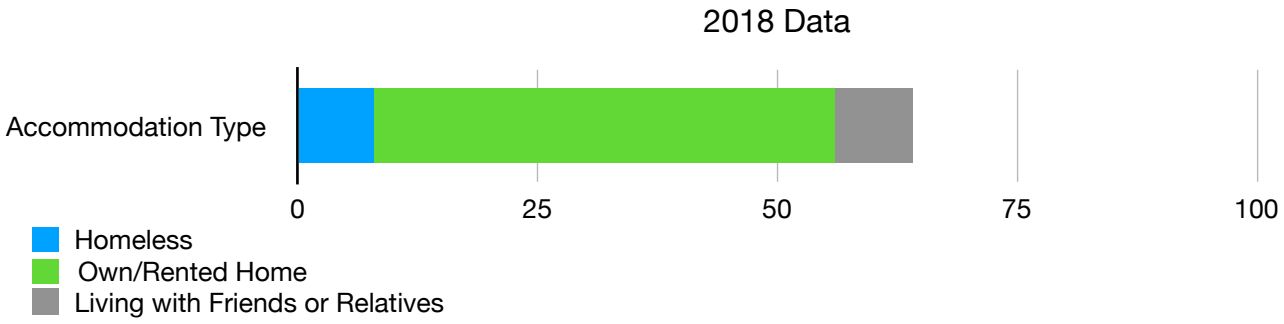
It must also be acknowledged there is a significant number of people, about a third, who had an unstable accommodation status and lived either with friends, relatives or in homeless/supported accommodation.



	Homeless	Own/Rented Home	Living with Friends or Relatives
Accommodation Type	9	59	9

Fig 8

Again, if we compare this data to 2018 (Fig 9), we find a similar pattern:



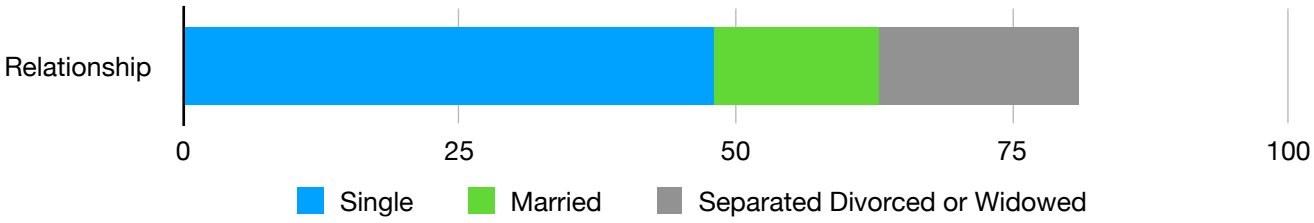
	Homeless	Own/Rented Home	Living with Friends or Relatives
Accommodation Type	8	48	8

Fig 9

RELATIONSHIPS

The relationship status of the person at the time of death was also considered, since it provides some indication of the level of social support potentially available to them.

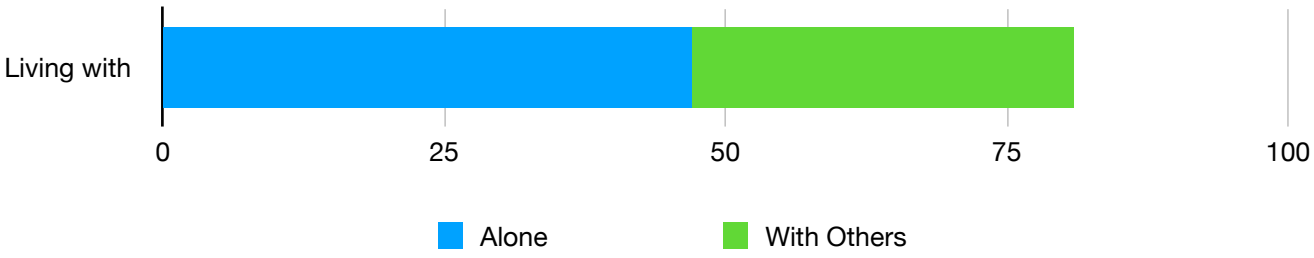
To determine the person's relationship status was not straightforward . If the individual was in a relationship with a partner at the time of death, they were classified as "*in a relationship*". If there was no partner mentioned in the six months prior to death, they were classified as "*single*". However, a single individual could arguably be classified as being in a relationship depending on the nature of their change of circumstance and several individuals had separated just prior to their death. More fluid "on-off" type relationships also made determining relationship status difficult.



	Single	Married	Separated Divorced or Widowed
Relationship	48	15	18

Fig 10

It is also pertinent to explore living arrangements, given accommodation status and relationship status it is unsurprising to find the majority of drug-related death fatalities lived alone at the time of death as can be seen in Fig 11:

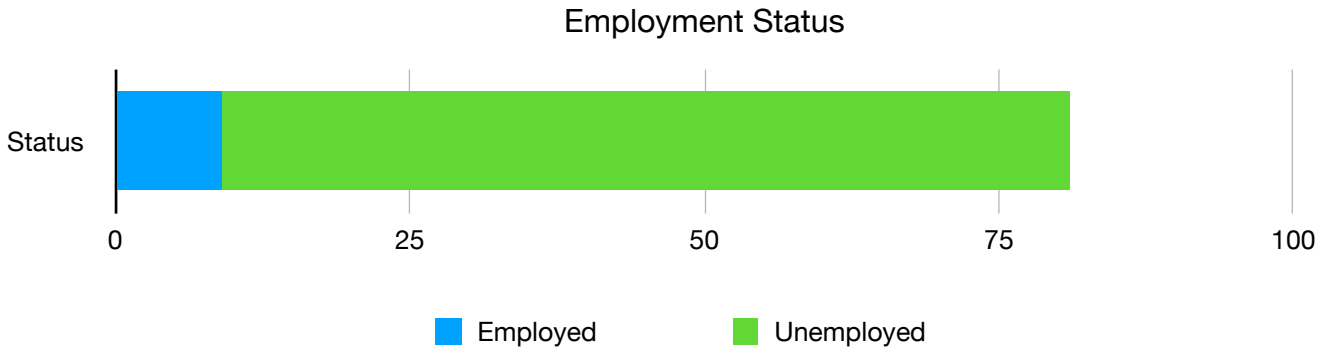


	Alone	With Others
Living with	47	34

Fig 11

EDUCATION & EMPLOYMENT

As in previous years, the overwhelming majority of the DRD cohort were unemployed at the time of death. Due to the way the data was collected, it was difficult to ascertain any nuance at this time. Therefore any potential disability related conditions have not been separated out from the main definition of "unemployed".



	Employed	Unemployed
Status	9	72

Fig 12

SIGNIFICANT LIFE EVENTS PRIOR TO DEATH

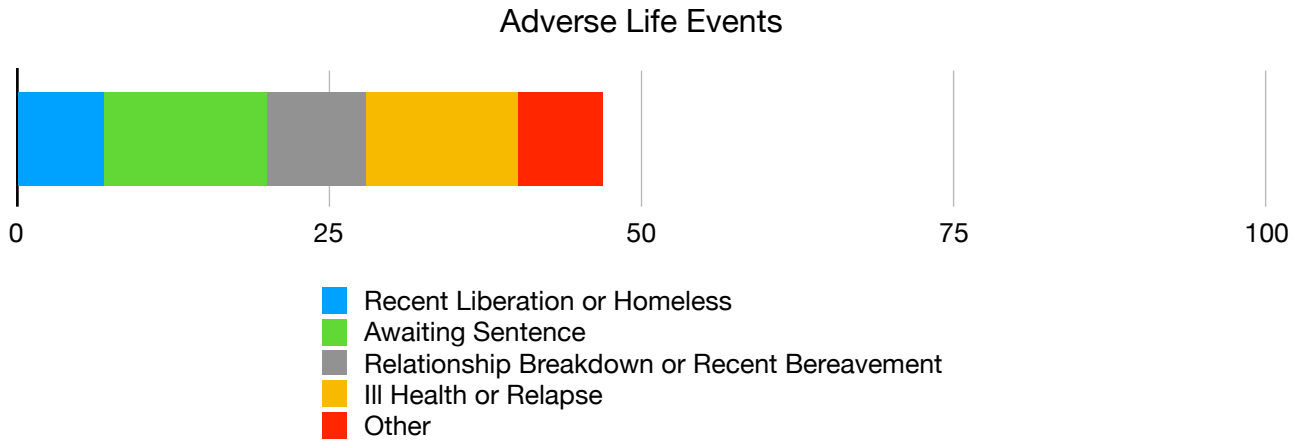
Given the information available, this report is unable to comment on events such as Adverse Childhood Experiences or other traumatic events which may have occurred in the early or informative years of the cohort in any meaningful way. Whilst such events were mentioned in some reports, it was not a feature of the reporting format and as such would not provide an accurate representation that any conclusions could be drawn from. There is evidence to show that ACE's do feature in chronic substance use

and it may be useful for more work to be carried out to identify the level at which ACE's feature in Fife's drug-related deaths.

There are, however, several recent adverse life events which happened in the six months prior to death that can be reported on with more confidence.

Significant characteristics of Fife's drug-related deaths are that people are single, live alone and are unemployed. This isolation can lead to loneliness and the potential for people to spend long periods of time with little or no human interaction. It is acknowledged that loneliness in itself can reduce life expectancy. That coupled with high risk behaviour can increase incidents of fatal overdose.

48% of those who suffered a drug-related death had experienced a significant adverse life event in the six months prior to death. Fig 13 highlights the primary events recorded for that cohort.



Recent Liberation or Homeless	Awaiting Sentence	Relationship Breakdown or Recent Bereavement	Ill Health or Relapse	Other
7	13	8	12	7

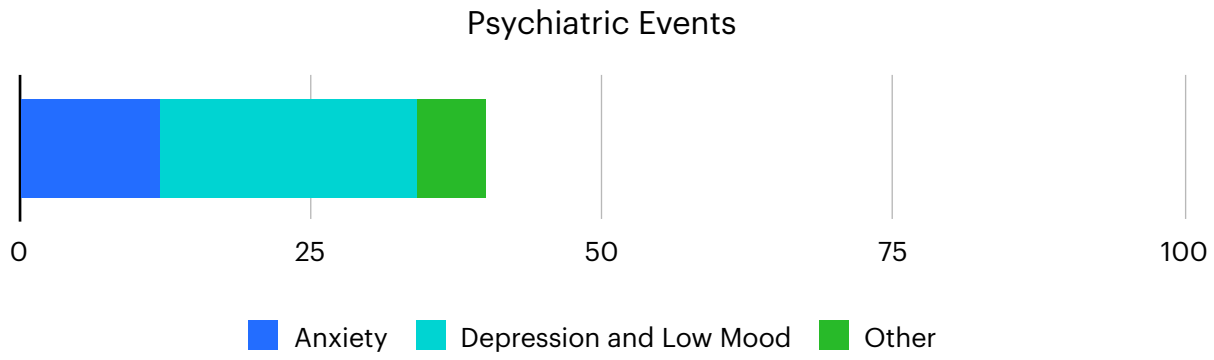
Fig 13

In some cases, the drug-related death fatalities' siblings, parents or other family members were substance users. The adverse life events experienced by drug-related death fatalities convey a sense of vulnerability, which may have led to the formation of coping by means of substance use and therefore impacted negatively upon their abilities to manage adversity in their adult lives.

At a basic level, the above information provides an indication of the level of instability of these individuals in their lives. Their personal histories show that these drug-related death fatalities experienced abuse, sexual/physical and/or emotional, significant losses/life events, which may have in turn been precipitating, maintaining and/or consequential factors of their substance use.

PSYCHIATRIC & MEDICAL PROBLEMS

42% of drug-related deaths fatalities had recorded or diagnosed mental health problems such as anxiety and depression.



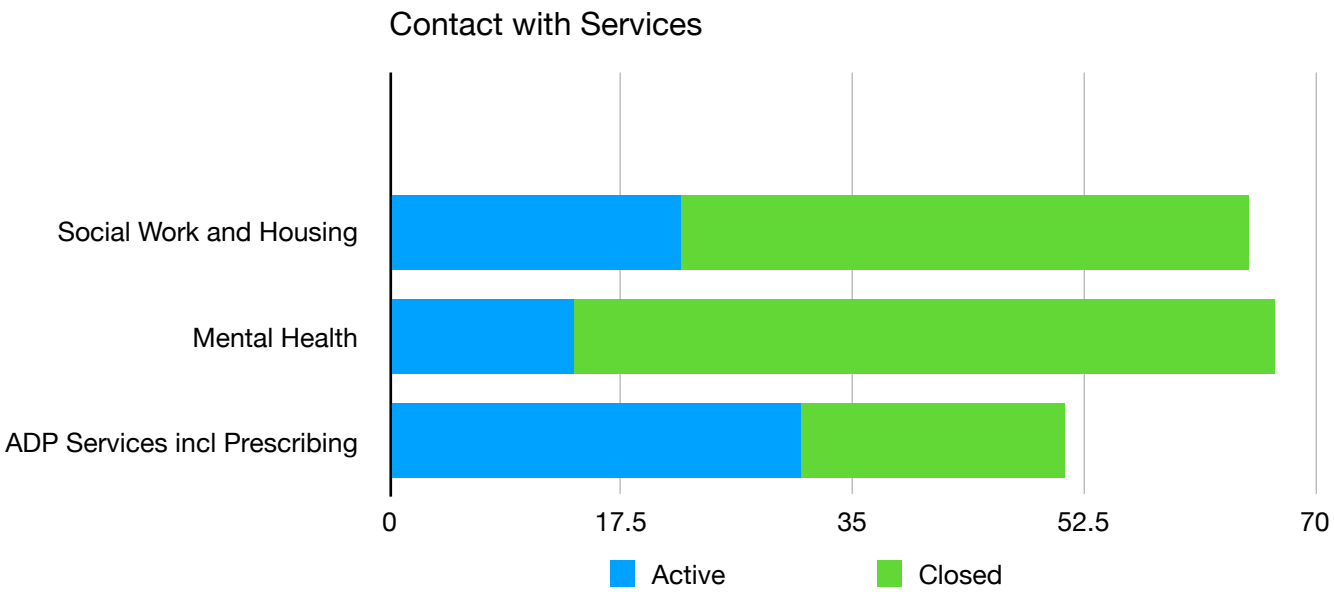
Anxiety	Depression and Low Mood	Other
12	22	6

Fig 14

A similar percentage (47%) of the cohort had recorded physical health problems in the 6 months prior to death. Notably, Hepatitis C and respiratory illnesses were among the illnesses recorded most frequently. These types of illnesses, especially respiratory and cardiac, would increase the likelihood of succumbing to opioid overdose due to the mechanism of opiate type drugs and how they act upon the body.

CONTACT WITH SERVICES

Fig 15 shows the numbers of people who were engaged with or discharged from services at the time of death. This data is gathered from service feedback and is to be used as a guide only.



	Social Work and Housing	Mental Health	ADP Services incl Prescribing
Active	22	14	31
Closed	43	53	20

Fig 15

It is evident that a large number of drug-related death fatalities are, or have at some point, engaged with the system of care available. In particular, the high rate of involvement with and discharge from social work and mental health services may be an area which requires further investigation which may also include any follow up discharge contact procedures or aftercare provided by these services.

When considering treatment, it is important to also consider the number of people who were in receipt of Medication Assisted Treatment (MAT) such as methadone and buprenorphine at the time of death. Fig 16 shows figures split by gender.

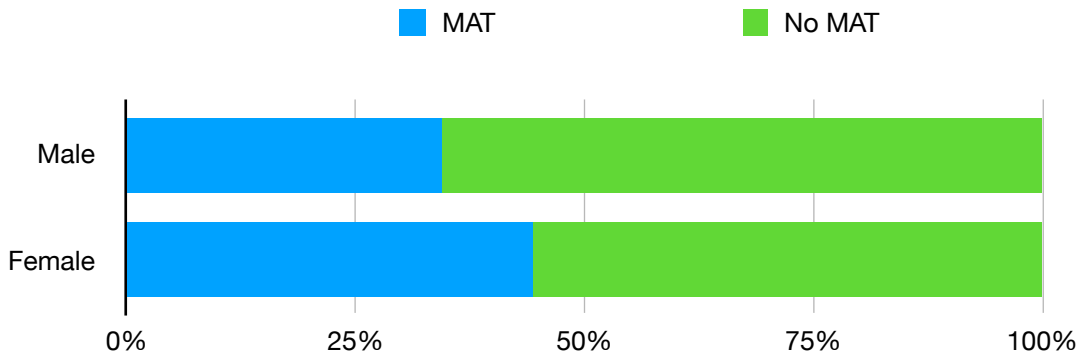
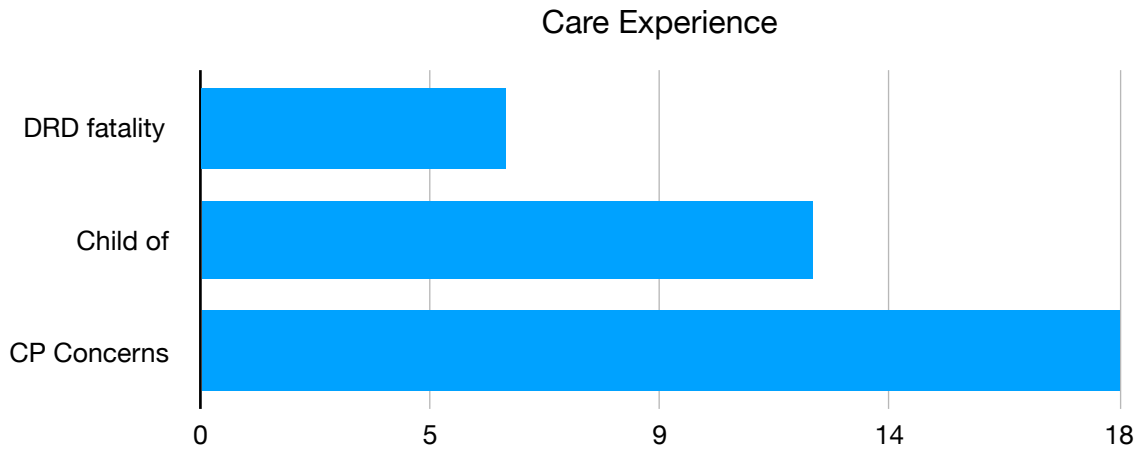


Fig 16

From the data, it can be determined that 45% of females were in receipt of MAT, whilst only 34% of males were. It should be noted that MAT is a known evidence based protecting factor against drug-related death.

CARE EXPERIENCED

It is acknowledged that Adverse Childhood Experiences (ACEs) have a significant impact on substance use later in life. When looking at the 2019 drug-related deaths, it is important to understand how ACEs have impacted upon the fatalities as well as their children. Experience of the care system can have some relevance here although this is not intended to be representative of all ACEs which this cohort may have experienced, it can be indicative of a wider set of circumstances in which we would expect to feature in this topic.



DRD Fatality	Child of	CP Concerns
6	12	18

Fig 17

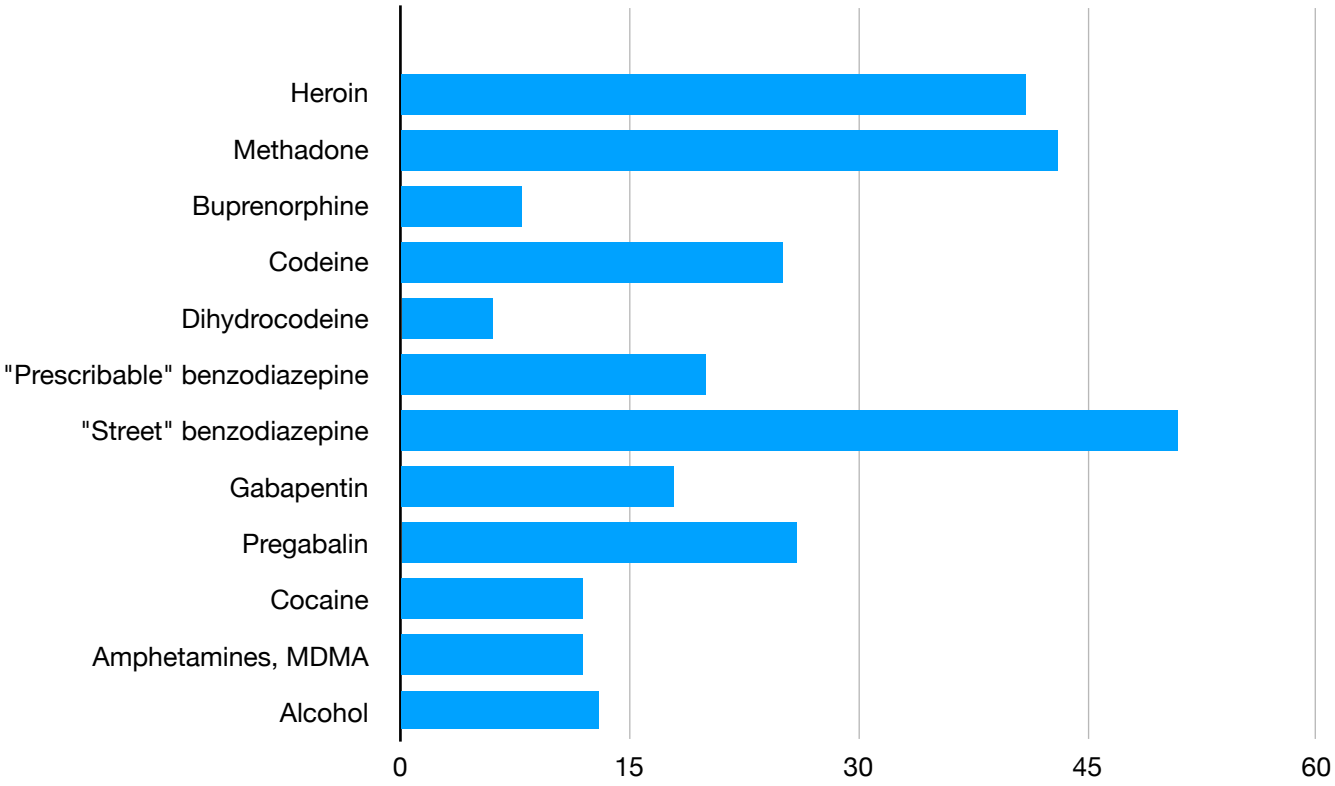
From the data received, it is evident that a significant number of the children of DRD fatalities were involved with the child protection system in some way although it beyond the scope of this report to investigate these circumstances in detail.

TOXICOLOGY

Toxicology reports generally include a reference for the "therapeutic" and "fatal" ranges of a substance, based on existing literature available to the toxicologist. However, these are often based on relatively small sample sizes, and do not consider the possibility of poly-drug use. The latter is particularly important, as the majority of drug-related deaths in Fife occurred as a result of multiple substances.

An individual's own tolerance to a substance should also be considered when interpreting toxic substance levels as this will vary depending on the history of illicit drug use in any particular individual.

The actual amounts of the drugs observed in drug deaths fatalities in Fife are often lower than the published fatal and even therapeutic ranges of any given drug. This highlights the importance of the cocktail effect, and the above values continue to raise questions about the clinical utility of the designated 'fatal' and 'therapeutic' levels. Furthermore, as the age of individuals who die of a drugs death is increasing, personal underlying pathology may make the individual more susceptible to death at a lower level of substance exposure.



Drug	Numbers	Percentage
Heroin	41	51
Methadone	43	53
Buprenorphine	8	10
Codeine	25	31
Dihydrocodeine	6	7
Traditional Benzo	20	25
Non-traditional Benzo	51	63
Gabapentin	18	22
Pregablin	26	32
Cocaine	12	15
Amphetamine, MDMA (Ecstacy)	12	15
Alcohol	13	16

Fig 18

Fig 18 shows all substances which were present in the toxicology results of the drug-related death fatalities in Fife, 2019. The graph shows the percentage of fatalities who were found with each substance in their toxicology results. In cases multiple substances were present due to poly-drug use and so the total numbers involved will be greater than the total of drug-related deaths.

As in 2018, benzodiazepines including traditional (those which can be prescribed but may have been diverted) and non-traditional or "street valium" type substances, were the most common substances present in drug deaths in 2019. Gabapentinoids were also present in a significant amount of toxicology results

CONCLUSIONS AND RECOMMENDATIONS

It is difficult to give a simple answer to why drug-related deaths are increasing. The fact that the situation is mirrored across Scotland does give context. Organisations and agencies across the country are working in partnership with bodies such as the Drugs Death Taskforce, SDF and the Scottish Government to develop new and innovative approaches to this problem as well as ensuring established methods such as effective harm reduction messages and naloxone provision are maximised. It is noble but idealistic to hold abstinent recovery as a goal for all and whilst this should certainly be part of an effective treatment response, harm reduction messages, optimum dose MAT, low-threshold prescribing, and active support for people who choose to continue to use drugs should be implemented.

Connectedness across ADP teams is to be encouraged and successful local initiatives replicated where possible to best effect. National organisations such as the Scottish Ambulance Service and Police Scotland also have critical roles to play and local links to facilitate frictionless partnership working are to be encouraged and developed which should extend to simplified information sharing procedures across sectors where possible.

Fife ADP has already done a huge amount of work to increase partnership working across Fife and it is not necessary to list the plans of the ADP here, suffice to say this work needs to be nurtured and developed to fully embed the work of the ADP into divisional workplans; drug-related deaths are a global responsibility for all services and not limited to ADP funded services.

In conjunction with a high quality treatment service, an equally high quality aftercare provision should be encouraged. People disengage from services for a number of reasons and safety of that individual should be paramount when this takes place and fast routes of re-engagement to services should be standard.

APPENDICES

OVERDOSE PREVENTION & DRUG DEATH MONITORING GROUP

The Fife Overdose Prevention & Drug Death Monitoring Group (OPDDMG) is a multiagency strategic group reporting to the Fife Alcohol & Drugs Partnership (ADP). It combines the previous Overdose Prevention Group and the separate Drug Death Monitoring Group, and its aim is to make a major contribution to the reduction of drug-related deaths (DRDs) and near-fatal overdoses (NFOs) in Fife. The group will identify, support and develop initiatives that improve the quality of services and reduce the risk of drug-related death and near-fatal overdose in vulnerable people.

AIMS AND OBJECTIVES

The principal aim of this report is not to scrutinise individual drug deaths but to look at trends in terms of substances used, demographics, gender, age, and service engagement to gain an overview of the current picture affecting people in Fife. All data is taken from Police Scotland sudden death reports, pathology reports, and service responses.

This report will be discussed by the OPDDMG to develop recommendations and an action plan developed with SDF input which will be reported to the ADP for consideration.

OPDDMG MISSION STATEMENT

The mission statement of the Fife OPDDMG is to facilitate a "Fife wide multi-agency approach to understanding and preventing drug-related deaths."

DRUG DEATH TASKFORCE

In 2019, the Minister for Public Health and Sport, supported by the Cabinet Secretary for Justice established the Drugs Death Taskforce to tackle the rising number of drug deaths in Scotland. From the DDTF website, the primary role of the group is to:

"Co-ordinate and drive action to improve the health outcomes for people who use drugs, reducing the risk of harm and death.

The taskforce will specifically:

- Examine and publish evidence of the triggers of drug deaths and what we have learned in Scotland about how they can be prevented

- Collate and publish good practice about what has worked in other parts of the UK and internationally to prevent death and harm arising from drug use

- Work with partners to identify, spread and sustain good practice in Scotland

- Identify specific barriers in the planning, commissioning and delivery of addiction services in Scotland

- Review whether the Misuse of Drugs Act 1971 affects the provision of a strengthened and consistent public health approach to drug use, recognising that this is reserved to the UK Parliament and any changes will require the agreement of the UK Parliament

- Identify the extent to which the availability of appropriate programmes and treatment options limit the use of diversion from the criminal justice system or the use of constructive sentencing options within the criminal justice system

- Identify the full range of support services which help to reduce harm and identify deficiencies in the delivery framework, availability and provision of such services

- Make recommendations for changes in current health and social care practice and on how a public health approach to drugs might be more fully realised across all relevant services and in the justice system"

The DDTF has introduced a number of funding streams and policy changes to facilitate freer distribution of naloxone, development of the new MAT Standards to increase low-threshold access to opioid substitution therapy (OST) such as methadone and buprenorphine, and the promotion of new medications such as Buvidal, which NHS Fife introduced during 2020/21 as a prescribing option for those at higher risk of harm, amongst other work streams.

Fife ADP has been and is actively engaging with the DDTF in all it's work streams to improve the system of care in Fife as well as developing local initiatives based on

national evidence to reduce the number of near-fatal overdose situations and drug-related deaths. Some of these initiatives such as the NFO project in partnership with ADAPT and Scottish Ambulance Service, and naloxone distribution changes which were established during 2019 will be outlined in this report.

More information on the DDTF can be found on the Scottish Government website:

https://www.gov.scot/groups/drug-deaths-task-force/

OTHER ADP WORK STREAMS

It is worth briefly mentioning some of the other work streams currently in development and supported by the ADP Support Team to reduce drug-related deaths. More information on any of these projects can be provided by the ADP Support Team.

Navigator Project - This project, being developed with SACRO, will offer advice, signposting and harm reduction information including naloxone kits within the Kirkcaldy police custody suite.

Prison Peer Mentoring - Recently liberated prisoners are at a high risk of drug-related death due to reduced tolerance for their drug of choice and varying strengths of drugs compared to those accessible within the prison system. Phoenix Futures, with direction and support from the ADP Support Team, have developed a team of peer mentors to reduce this risk by engaging with prisoners at the point of liberation and immediately prior.

Levenmouth Recovery Cafe - Funding was awarded to Restoration to develop a Recovery Cafe and increase capacity focussed on the Levenmouth area. This has been successful with approximately 7% of Restoration membership now coming from this area.

DEFINITION OF A DRUG-RELATED DEATH

The definition of a DRD is complex, with individual studies adopting specific definitions, which vary depending upon the focus of the study.

The NRS definition includes instances in which toxicological findings indicate the presence of a controlled substance, but where this substance may not necessarily have been a factor contributing to the individual's death.

Any deaths directly resulting from the overdose of a drug listed under the Misuse of Drugs Act 1971 and relevant amendments in the year 2017 have been included and considered in this report. In 2014, tramadol and zopiclone became controlled substances under an amendment to this Act, similarly, due to their rapidly increasing usage and contributions to DRDs, the UK Government plans to make gabapentinoids controlled substances following a public consultation in 2019.

The ICD-10 inclusion and exclusion criteria of what constitutes a drug-related death presented below are used by various national investigations into drug-related deaths, e.g. The National Investigations into Drug-Related Deaths 2003, Drug-related Deaths in Scotland in 2016 (National Records for Scotland) and Drug Misuse Statistics Scotland (Information Services Division, 2008). Subsequently, this report adopts that definition. A full explanation of the definition NRS uses to classify DRDs can be found here: *https://www.nrscotland.gov.uk/files/statistics/drug-related-deaths/drd2016/html/drug-related-deaths-2016-annex-a.html*

Inclusion criteria: ICD-10

Drug-related deaths, where the underlying cause of death has been coded to the following sub-categories of 'mental and behavioural disorders due to psychoactive substance use';

a)

i. opioids (F11)
ii. cannabinoids (F12)
iii. sedatives or hypnotics (F13)
iv. cocaine (F14)
v. other stimulants, including caffeine (F15)
vi. hallucinogens (F16); and
vii. multiple drug use and use of other psychoactive substances (F19)

b) Deaths coded to the following categories and where a drug listed under the Misuse of Drugs Act (1971) was known to be present in the body at the time of death:

i. accidental poisoning (X40-X44);
i. intentional self-poisoning by drugs, medicaments and biological substances (X60—X64);
1. assault by drugs, medicaments and biological substances (X85) and
2. event of undetermined intent, poisoning (Y10-Y14)

Exclusion Criteria

A. deaths coded to mental and behavioural disorders due to the use of alcohol (F10), tobacco (F17) and volatile substances (F18)
B. deaths coded to drug abuse which were caused by secondary infections and related complications (e.g. septicaemia)
C. deaths from AIDS where the risk factor was believed to be the sharing of needles;
D. deaths where a drug listed under the Misuse of Drugs Act was present because it was part of a compound analgesic or cold remedy, e.g.:
    - Co-proxamol: Paracetamol, dextropropoxyphene
    - Co-dydramol: Paracetamol, Dihydrocodeine
    - Co-codamol: Paracetamol, codeine sulphate

All three of these compound analgesics have, particularly co-proxamol, been used in suicidal overdoses

GUIDE TO DATA COLLECTION FOR THIS REPORT

Step 1.

A suspected Drug-related death occurs in Fife, police attend and carry out investigation into the circumstances surrounding the death. The length of the investigation depends upon the individual circumstances and can vary from a few days to several months. Police Scotland also request toxicology from the Procurator Fiscal.

Step 2.

Police Scotland informs NHS Fife via the secure drug-related death e-mail address. ADP Support Team email relevant agencies to inform them of suspected DRDs in order they may complete internal or outstanding paperwork.

Step 3.

Agencies check records to see if the individual has accessed their respective services. If the individual is known to a particular agency, the Drug-related Death Questionnaire is completed by that agency and returned to the ADP Support Team.

If the individual is not known to the agency, a nil return is sent.

The Forensic Medicine Unit, Laboratory Medicine Edinburgh Royal Infirmary send post-mortem/toxicology reports of all deaths where the individual was a known drug user to the secure drug-related death e-mail address.

Step 4.

ADP Support Team enters all collected data into ISDs NDRDD.

Step 5.

Three times a year, NRS publish interim drafts of data they hold on DRDs to date. Fife ADP Support Team cross reference this data with locally held data which has been submitted to ISD NDRDD and inform NRS of any additional or missing information.

NRS publish their report approximately six months after the year end. The NRS report runs from January to December.

ABBREVIATIONS USED IN THIS REPORT

ADP - Alcohol & Drug Partnership

DRD - Drug-related Death

SIMD - Scottish Index of Multiple Deprivation

OPDDMG - Overdose Prevention & Drug Death Monitoring Group

ACE - Adverse Childhood Experience

SDF - Scottish Drugs Forum

MAT - Medication Assisted Treatment

NFO - Near-fatal Overdose

DDTF - Drug Death Taskforce

NRS - National Records of Scotland

ISD - Information Services Division (NHS)

NDRDD - National Drug-related Death Database

Author contact information:

Phillip Heaton, Policy Officer, Fife ADP, Email: phil.heaton@fife.gov.uk

[1] National Records of Scotland, Drug-related Deaths in Scotland in 2019 Report.