

LJMU Annual Conference on Drug-related Deaths
28 March 2025

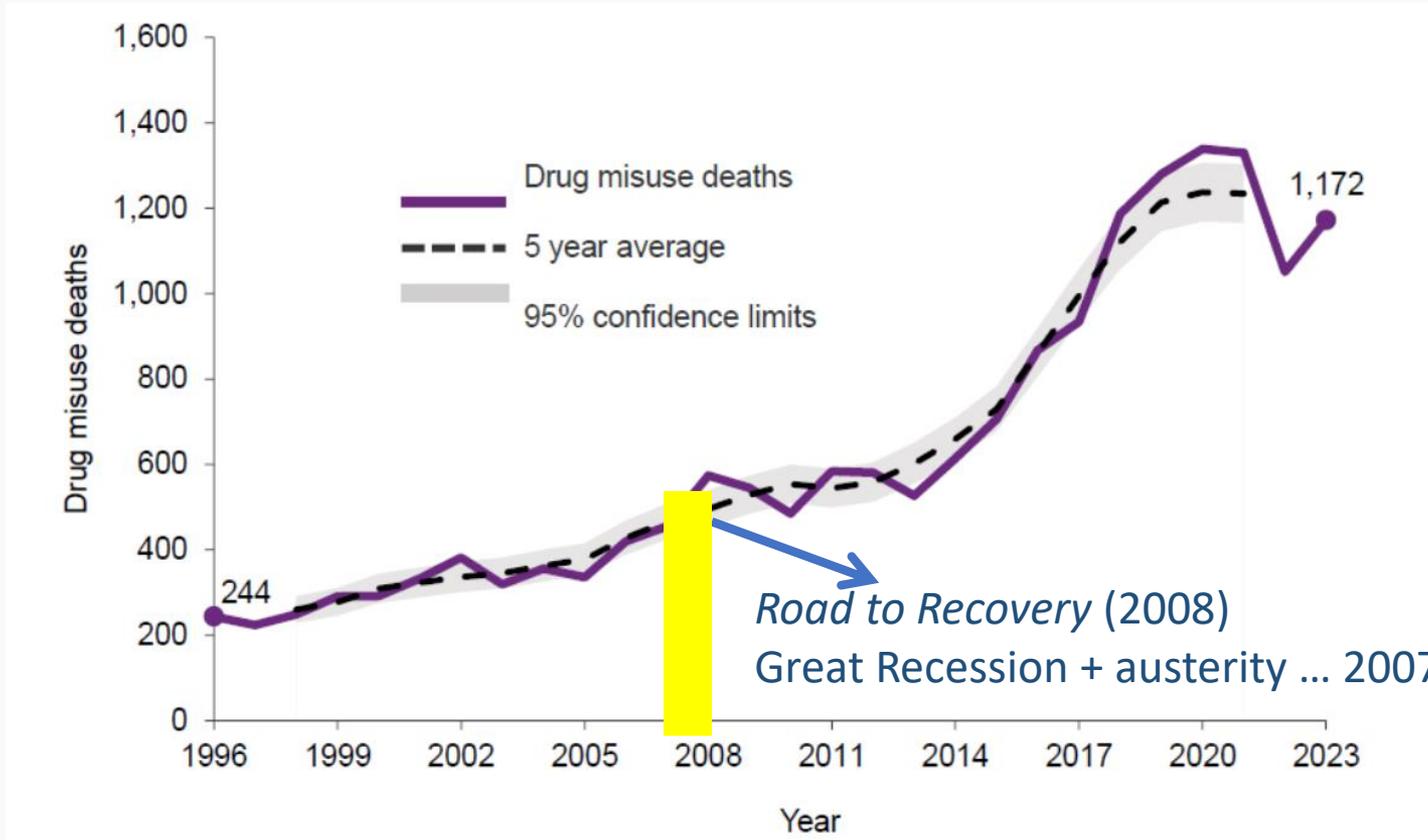
**Social (structural & systemic) Determinants
of drug-related deaths**

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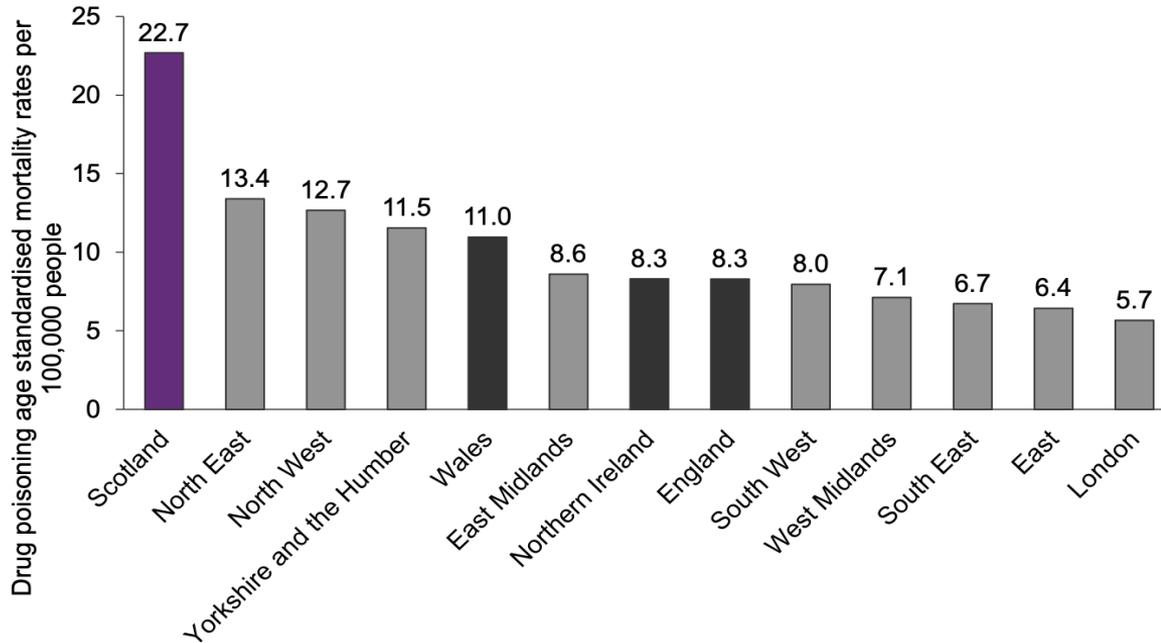
Drug-misuse deaths, Scotland, 1996 to 2023



(Source: NRS: 2024)

Comparisons within the UK (rates per 100,000 population)

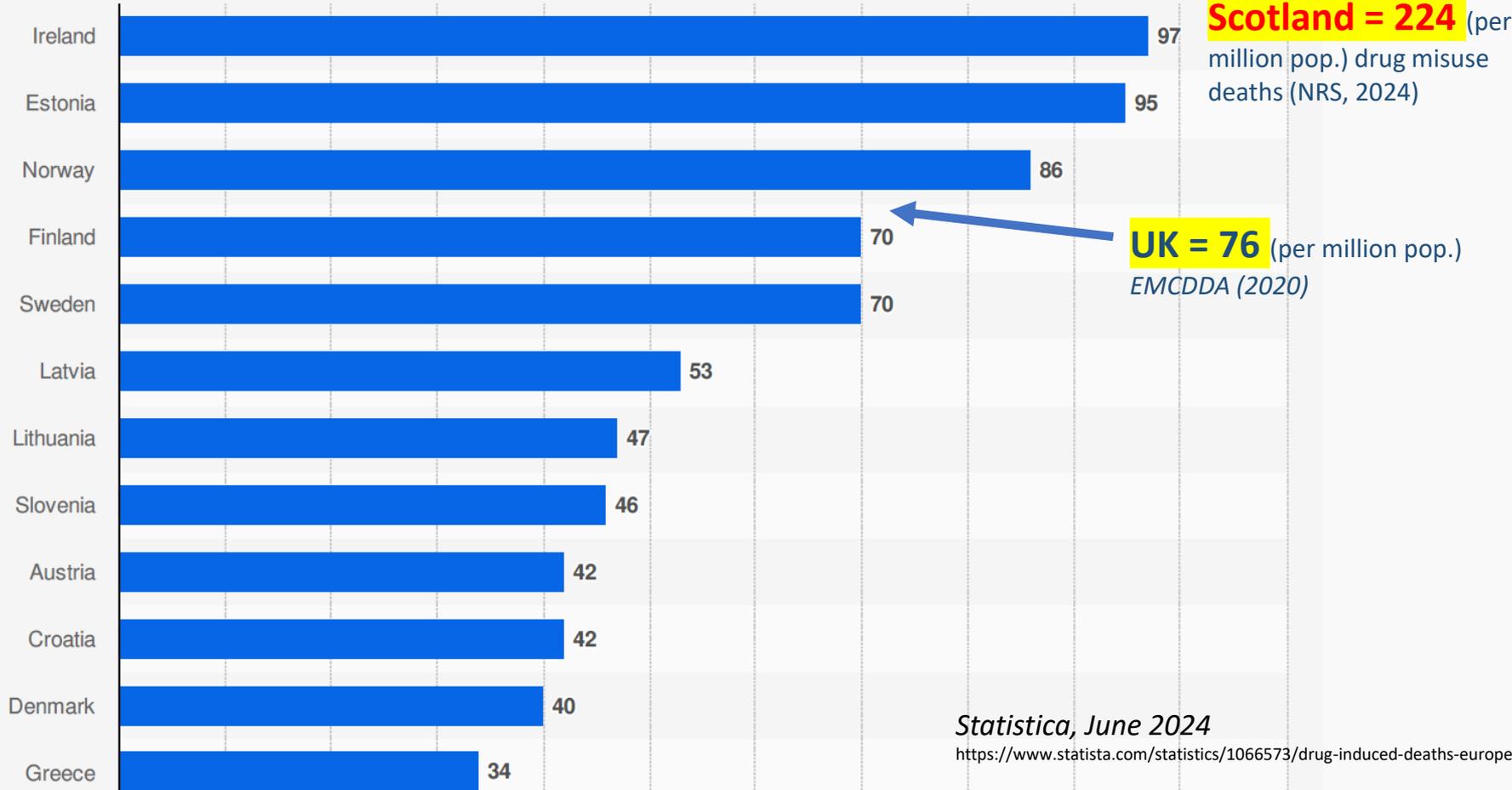
Figure 9: Drug poisoning deaths, age standardised mortality rates, UK countries and regions, 2022



Drug poisoning death rate is used to compare within UK. This definition includes deaths where the drug is not known and are higher than 'drug misuse deaths' which are counted only when the drug is known. Figures for drug misuse deaths are considered to be underestimates.

Drug induced deaths (directly caused by illegal drugs) Europe 2022

(per million population) 1 of 2 slides



Background

- Scottish context of deep health and income inequalities concentrated in areas of deprivation over a long period of time (see Walsh & McCartney).
- Inequalities in drug deaths greatest in areas with large and relatively deprived urban centres (e.g. Glasgow, Dundee) (Finch et al. 2023).
- People in the most deprived areas are 16 times more likely to die from drug overdose than those in the least deprived (NRS, 2024).
- Accumulation of multiple sources of deprivation plus experience of significant event in the six months prior to death (41% - ill health or a recent diagnosis (medical or psychiatric), bereavement, release from prison, homelessness or housing problems. PHS, 2024).
- Drug deaths are the biggest single contributor to mortality in 15-44 year olds (Miall et al. 2022: 50).

Social (and Structural) Determinants of Health

- the conditions in which people are born, grow, live, work and age.
- shaped by the distribution of money, power & wider set of 'upstream' forces and systems shaping the conditions of daily life. The 'causes of causes' (Marmot).



Source: Dahlgren-Whitehead (1991)

Research Studies

1) Social autopsy of drug deaths among young people in Scottish region

Research team: Aileen O’Gorman PI, Stephanie Govenden, NHS Highland, Frances Matthewson, Highland Alcohol & Drug Partnership

Funder: Corra Foundation, Scotland

2) Understanding the role and potential of primary care in the prevention of drug deaths

Research team: Aileen O’Gorman PI, Anne Whittaker Co-PI, Betsy Thom, Kit Colliver, Roy Robertson, Stewart Mercer, Alison Munro, Andrea Mohan, Wez Steele, Joan Love.

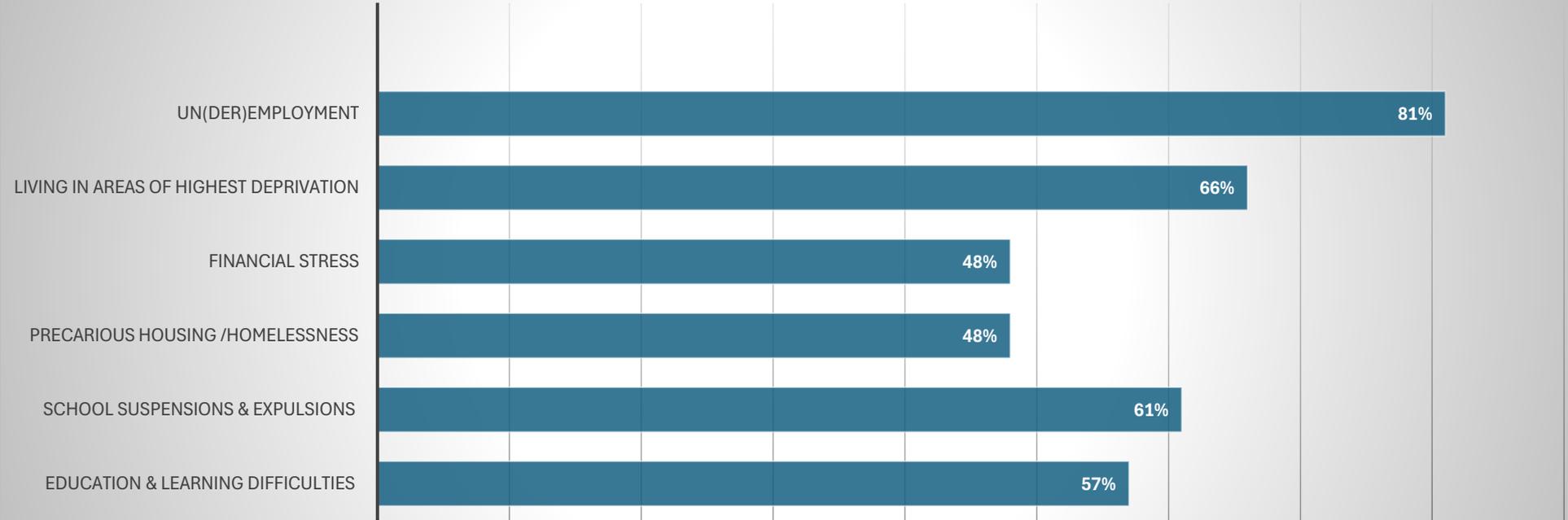
Funder: Drugs Deaths Taskforce, Scot Gov.

Good people doing good work but constrained by social, structural and systemic issues

Study 1: Health, drug use and cause of death

- 21 young drug-related deaths reviewed: 18 young men & 3 young women. Age range 16-25 years.
- A high proportion of the cohort had experience of mental ill-health (86%) and physical ill health/injuries (76%).
- Half of the cohort were IV users at the time of their death and regular polydrug users.
- The main causes of death recorded by the pathologist in the postmortem reports were multi-drug toxicity (n=13) and heroin toxicity (n=5).

Socio-economic factors



Context of young deaths

- Accumulation of adversities: high levels of mental and physical ill health; parental separation & care experienced; social work involvement; parental mental illness, AOD problems & violence in home.
- High levels of self-harm, suicide ideation, non-fatal overdoses, violent incidents, contact with Criminal Legal System – 52% in prison/custody
- Systems struggled to address their multiple complex needs, and young people, families & professionals struggled to navigate labyrinth of care.
- Young people disengaged and/or treatment was terminated when more person-centred wraparound low-threshold services were needed.
 - Just two young people were in treatment at the time of their death.

Young peoples experience of system of care

Services complex and fragmented

Mismatch between needs & services

Focus on brief interventions to motivate behavioural change, recovery & abstinence

Insufficient under-resourced services
Incapacity to address co-occurring mental health and substance use difficulties

Hard to reach, inflexible conditional system of care – often judgemental & punitive

Discharges for DNA

Archaic and dysfunctional referral system

Onus to self-refer and opt-in – they opted out

Over assessed: under-supported

Over policed: under-protected

Study 2: Case studies of 'shared care' system

- Primary care team:
- Secondary care substance use and mental health services
- Local services: (e.g. community pharmacists, health visitors, social work services, and third sector substance use agencies.)

Patients and families experience of system of care

People with complex health and social issues – not just drug use.

System challenging and engagement difficulty: particularly addiction and mental health services.

Stigmatising environments and attitudes (in ADRS, hospitals, pharmacies etc)

Poor relations and communication – experience of intrusive questions by health care workers

Services required people to be 'recovery ready', 'motivated' and 'stable' to access the service. Difficult especially if in crisis.

Services located in unpleasant, hard to access buildings

Professionals experience of system of care

Complex relationships between professionals

(issues of boundaries, different definitions of the problems and different interpretation of the patient's situation, different treatment approaches and goals and different views on appropriate action on patient care)

Tension between
recovery responses and
harm reduction
responses

Differences in prescribing
practices between
services

(affect on patient behaviour e.g.
placed on weekly pick up and
disengage)

Individualisation and
responsibilisation of
engagement issues

(lack of engagement attributed to
patient attitudes, behaviour, hard –
to-reach rather than hard to reach
services)

Structures and systems

- Evidence from case studies indicates **structural** issues: constraints imposed by lack of resources, commissioning and contracting processes, organisational structures, the location of services and the built environment.
- **Systemic issues** included lack of communication, shared information and collaboration across professional groups and agencies. Lack of specialist mental health support, underfunded complex systems of care – sometimes fragmented.
- Participants emphasised the cumulative impact of **socioeconomic deprivation and structural inequalities**, which shaped the environments in which drug use occurred, their health (multimorbidity & mental health) and constrained effective delivery of care (e.g. inverse care law).

Overall need to address ...

- high level of conditionality attached to health & social care services (e.g. social protection, housing, addiction services etc.)
- responses to complex, multiple, interdependent needs - especially mental ill health and drug use dependency.
- focus on individual behaviours rather than ‘causes of causes’ (SDHs do not arise by chance but outcome of political decisions leading to precarity of income and , housing, access to welfare and healthcare).
- implementation gap between policies and practice (how policy is enacted in practice)
- a whole system approach (intersectoral drug policy + health policy + social policy) and low-threshold harm reduction services.

Positive developments

- Scotland's National Mission on Drugs notes 'important to address inequalities and the wider social determinants of health'.
- EUDA mandate -- > a focus on socioeconomic determinants of drug use and drug-related harms and the implications for policies and responses.
- EU Network on social/structural determinants of drug-related deaths: exploring the for different rates of drug-deaths in Europe and internationally.
- ISSDP (www.issdp.org) pre-conference workshop in Manchester June 'Drug-related deaths: national and international challenges and perspectives' (workshop targeted at frontline professionals, service managers, commissioners and policy makers).

Look forward to hearing from you if you have any queries

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