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Substance Use, Grief, and Scotland's Drug Death Crisis: Exploring Lived Experiences

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Chapter 1

Grief and substance use: A thematic synthesis of qualitative research

Prepared in accordance with the author requirements for Journal of Loss and Trauma

Abstract

People who use substances (PWUS) are disproportionately affected by both death and non-death losses; and have vulnerabilities that can hinder the processing of the associated grief. While there is an established and growing quantitative research base demonstrating the complexities between grief and substance use, the qualitative literature base remains fragmented. This study aims to systematically review the grief experiences of PWUS to enhance understanding and inform service delivery. A systematic search of four electronic databases identified 18 studies, which were quality assessed using the Critical Appraisal Skills Programme (CASP) (2024). A thematic synthesis revealed three themes: Locked in Loss and Addiction, Defeated and Defended, and Routes to Recovery. Findings highlight the reinforcing relationship between grief and substance use, identify grief responses relevant to PWUS, and offer an aggregated insight into their grieving experiences. This has important implications regarding the integration and provision of grief-informed support in clinical practice.

Key Words: grief, bereavement, drug related death, substance use, child removal

Introduction

Grief in the context of substance use is attracting increased research attention due to the recognition that people who use substances (PWUS) face complexities in their grieving experience. PWUS are disproportionately affected by both death and non-death losses; frequently reporting upon estrangement from family members, the removal of children and traumatic deaths of significant others (e.g. overdose, suicide, murder) (Furr et al., 2015; McComish et al., 1999). Typically, the grief that accompanies bereavement and loss need not be pathologised. It is a universal and normative experience; accompanied by emotional, cognitive, physiological and behavioural changes to functioning which attenuate over time (Worden, 2018). However, research has found that PWUS face challenges in this process and are significantly more likely to experience complicated grief reactions than those without substance use difficulties (34% vs 5%) (Masferrer et al., 2017; Parisi et al., 2019).

While there is variation in the definition of complicated grief across diagnostic frameworks (e.g. American Psychiatric Association, 2013; World Health Organization [WHO], 2024a), it generally refers to a grief that deviates from the expected course. Unlike typical grief, which gradually lessens over time, complicated grief is characterised by prolonged, intense emotional distress that can interfere with health, social and occupational functioning and quality of life. It may manifest as chronic and persisting over time, delayed and emerging long after the loss, absent and inhibited or suppressed, or unprocessed and not emotionally integrated (Wilson et al., 2022). The increased prevalence of complicated reactions for PWUS indicates a heightened vulnerability to persistent and debilitating grief responses.

Emotion Regulation

For grief to be effectively processed and resolved, individuals must attend to and tolerate the intense emotional demands of longing, sadness, guilt, anger, emotional numbing and blame (Eisma & Stroebe, 2021; Stroebe & Schut, 2010). This process requires a degree of emotion regulation capacity which is the ability to tolerate, experience and engage with distressing feelings (Gross, 1998). However, PWUS are well evidenced to have deficits in emotion regulation capabilities as a consequence of neurobiological dysregulation, trauma and adverse childhood experiences (Stellern et al., 2022; Weiss et al., 2022). As grief presents as an overwhelming and often intolerable emotional state, PWUS may turn to substances for immediate and short-term relief from distress within the context of diminished emotion regulation capacities (Baker et al., 2004; Eisma & Strobee, 2021; Wong et al., 2013).

While the use of substances provides momentarily relief from painful and intense affective states, it simultaneously impedes upon the cognitive and emotional processing of grief

(Caparrós & Masferrer, 2021; Eisma & Stroebe, 2021). PWUS are more likely to rely upon less helpful coping strategies such as emotional avoidance, social withdrawal, and self-criticism (Caparrós & Masferrer, 2021). This can perpetuate distress and increases the risk of adverse outcomes, including premature mortality. Notably, following the loss of a child to an overdose, parents are significantly more likely to die from a drug death (Christiansen et al., 2020).

Stigma

Grief can be further complicated by the stigma surrounding substance use, operating on both micro and macro levels (McNeil, 2020). PWUS are often viewed as morally deficient or personally responsible for their circumstances, rather than as individual's navigating complex psychosocial and health challenges. This can lead to social distancing and diminished empathy from others, contributing towards exclusion and isolation (Hinshaw & Stier, 2018). The internalisation of this stigma can further compound emotional distress and lower self-esteem which can impeded upon treatment engagement (Da Silveira et al., 2018).

Structural stigma, including discrimination in healthcare, employment and housing, can reduce access to stabilising resources such as employment and valued activities (Russinova et al., 2011; Wesselman & Parris, 2021). Such losses are particularly detrimental in the context of grief, in which access to psychosocial supports is crucial in processing and recovery (Strobe & Schut, 2020). The Dual Process Model (DPM) (Stroebe & Schut, 2010) of coping with grief suggests that adaptive grieving involves oscillation between confronting the emotional experience of loss and engaging in restorative activities that foster recovery. For PWUS, both aspects of this process are disrupted; unhelpful coping strategies, diminished social support, and stigma disrupt the ability to process grief in a means conducive to resolution.

Disenfranchised Grief

Additionally, a significant theme in the addiction literature is that of disenfranchised grief, which occurs when loss is socially invalidated, dismissed, or unacknowledged due to stigma and societal perceptions (Thompson & Doka, 2017). The losses that accompany addiction, such as the overdose of significant others or the removal of children, are often perceived as self-inflicted which can reinforce blame and moral judgment (Feigelman et al., 2012; Turner & Stauffer, 2023). Subsequently, the emotional impact of such losses can be unacknowledged, unrecognised or dismissed (Lambert et al., 2021; Titlestad et al., 2021). Those experiencing stigmatised losses may be unable to express their grief, leading to isolation, prolonged distress, and limited access to support (Stout & Fleury-Steiner, 2023). The lack of recognition and

tailored support for these grief experiences may drive continued substance use, relapse, and disengagement from services (Duffy & Baldwin, 2013; Schlosser & Hoffer, 2022).

Current Evidence Base

Despite a robust quantitative research base evidencing the high prevalence of death and non-death losses for PWUS, and the complexities associated with the grieving experience, a qualitative insight regarding the lived experience for PWUS has yet to be obtained. While there is a recent research trend exploring the experience of being bereaved by a drug related death for PWUS, the wider research exploring the experience of grief within the context of substance use remains fragmented and lacks comprehensive synthesis. This presents a requirement to systematically review and integrate the available literature to provide an understanding of grief within this population and contribute to a more robust evidence base for this under research population. Doing so addresses the gap in the existing knowledge base; and ensures that the complex needs of this vulnerable and stigmatised group are understood and effectively supported.

Aim

The aim of this study is to conduct a systematic review and thematic synthesis of qualitative literature exploring the grief experiences for PWUS.

Review Question

What are the grief experiences for PWUS?

Method

Review Development and Registration

The Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) checklist (Tong et al., 2012) was used to guide the review (Appendix A). As per PRISMA guidelines, this systematic review protocol was registered with the International Prospective Register of Systematic Reviews (PROSPERO) on 11th December 2023. An update was submitted on 19th November 2024 (CRD42023491010).

Search Strategy

Following initial scoping searches, a specialist librarian consulted on the development of a search strategy using the SPIDER framework (Sample, Phenomenon of Interest, Design, Evaluation, Research Type). This was selected due to its applicability to qualitative research (Cooke et al., 2012). The full strategy (Appendix B) incorporated:

1. Key words related to the sample e.g. addiction, substance use
2. Key words related to the phenomenon of interest e.g. grief, bereavement
3. Key words related to the design e.g. qualitative studies
4. 1 AND 2 AND 3

Four databases (EMBASE, CINAHL, MEDLINE and PsychINFO) were searched from inception until 9 January 2025. These databases were selected following review of related research and librarian consultation. Search terms were adjusted per database. Google Scholar was used to complete a forward and backward citation check of eligible studies retrieved from database searches.

Eligibility Criteria

The SPIDER framework informed the inclusion and exclusion criteria.

Inclusion criteria:

1. Adults (aged 18 years and older).
2. Individuals who either:
   a) Have a diagnosis of substance use disorder.
   b) Engage in regular, problematic, or dependent substance use as identified or implied in the study (e.g. descriptions of impaired control, social impairment, risky use or withdrawal effects).
   c) Have received addiction treatment.
3. Studies exploring grief experiences in the context of substance use including reactions, help seeking behaviour, coping mechanisms, and support experiences.
4. Qualitative studies
5. Peer-reviewed qualitative or mixed-methods studies where qualitative findings are reported separately.

Studies were excluded on the basis of:

1. Non-English language publications.
2. Quantitative-only studies.
3. Unpublished, non-peer reviewed studies.
4. Studies focused on recreational substance use with no indication of problematic use or impact on functioning.
5. Studies focussing on third party experiences without exploration of the individual with problematic substance use.

Adolescents were excluded as their grief responses are evidenced to be different than that of adults due to their emotional and cognitive development (Griffin, 2010; Palmer et al., 2016). Including adolescents may have introduced variability to the findings which may not be reflective of the patterns of grief observed in adults as per the focus of this review. Recreational drug use refers to the non-habitual consumption of substances for social or leisure purposes, typically without causing significant harm or impairing daily functioning. In contrast, problematic drug use involves patterns of substance use that lead to negative consequences, such as physical, psychological, or social harm, and often aligns with the diagnostic criteria for substance use disorders (Okruhlica & Sieroslawskil, 2006).

Only studies with a rigorous qualitative methodology (e.g. thematic analysis, grounded theory, narrative analysis) that provided rich participant data with direct quotes, in-depth theme development, and contextualised experiences within the context of substance use were included. Since this review was the first within the research area, it was deemed appropriate to exclude studies that had not undergone peer review to uphold methodological rigour. As such, the decision was made to exclude unpublished studies (such as dissertations and theses) to mitigate potential risks associated with the inclusion of studies that may not have met the same level of scrutiny in terms of design, sample size, or analysis methods. By focusing on published literature, the review aimed to provide a robust and reliable synthesis of the evidence.

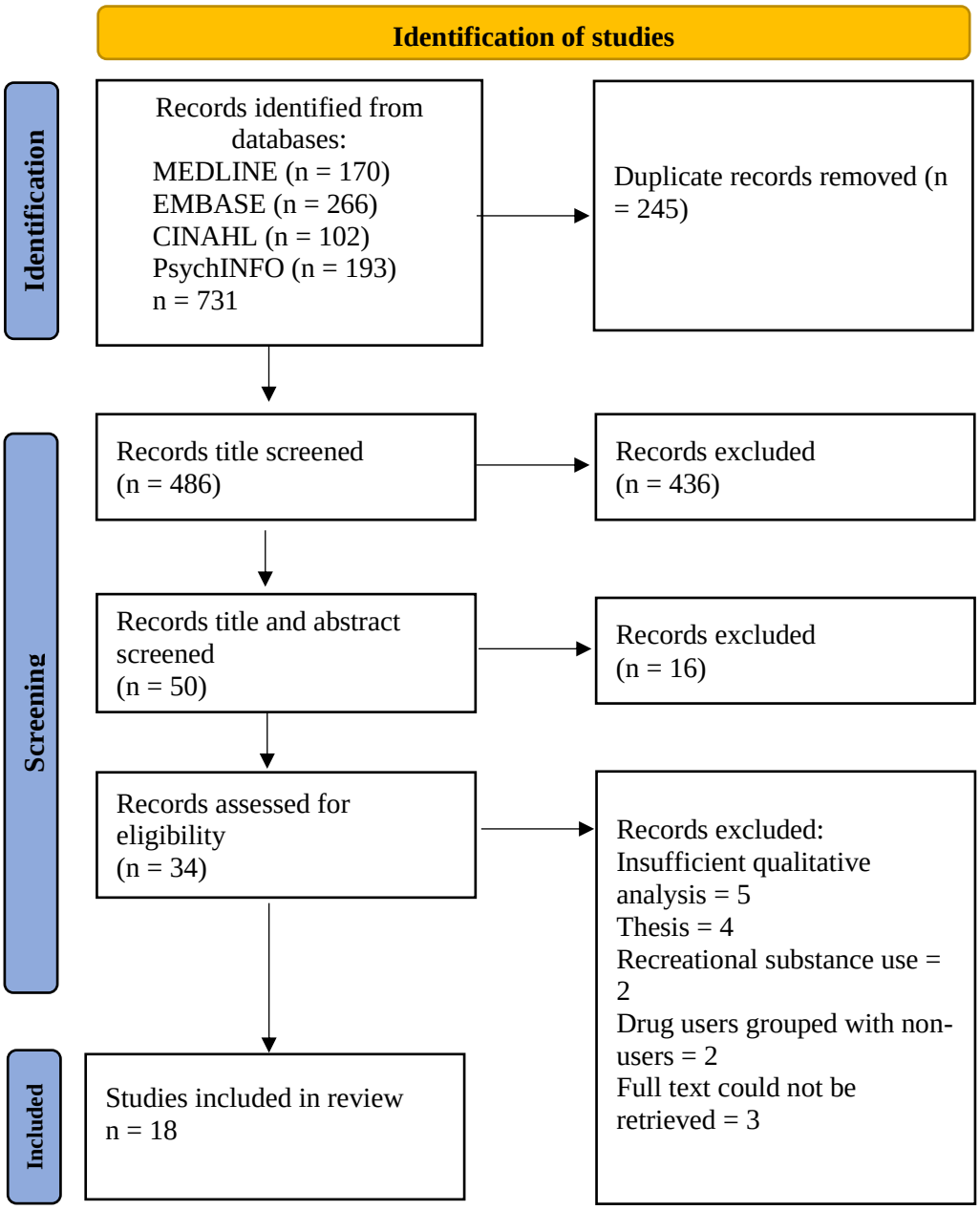
No geographical restrictions were applied.

Study Selection

The process of study selection is shown in Figure 1. Database searches returned 731 articles, which were imported into Rayyan (https://www.rayyan.ai/) to support screening. De-duplication removed 245 articles, and title/abstract screening excluded a further 452. The remaining 34 articles were assessed for eligibility using the exclusion and inclusion criteria. A Trainee Clinical Psychologist co-reviewed 15% of the articles (n = 5), achieving 90% inter-rater agreement. Disagreement related to the inclusion of Scott et al. (2017) and pertained to whether the study adequately explored the intersection of grief and substance use. Concurrently, the paper was excluded. The final synthesis included 18 studies. A backward and forward citation search was conducted using Google Scholar; no further eligible studies were uncovered.

Figure 1

PRISMA Flow Diagram – process of identification to inclusion.



Data Extraction

A summary of study characteristics of the 18 studies is provided in Table 1.

Table 1

Study and Participant Characteristics

First Author; country	Aim of study	Participants (N; gender; age range (average); ethnicity; substances)	Method, Analysis & Theoretical Framework	Key Themes	CASP Rating
Creighton (2016) Canada	Explore alcohol use in young men grieving the death of a friend.	N = 57 Gender = 100% men Age = 19–35 (not reported) Ethnicity = 39 White (68%), 18 Black/Other (32%) Substances = alcohol (100%)	Semi-structured interviews Thematic analysis Hegemonic and multiple masculinities framework	Dull the pain Purge sadness Troubled drinking	High
Daniulaityte (2011) United States	Explore psychosocial stress and implications on drug use.	N = 19 Gender = 100% women Age = 23–47 (37.2) Ethnicity = 10 Black (52%), 9 White (48%) Substances = crack cocaine (100%)	Semi-structured interviews Thematic analysis Not reported.	Stress-drug link Failed motherhoods Abated grief	High
Ehrmin (2002) United States	Explore care needs of women in transitional housing for substance use.	N = 12 Gender = 100% women Age = 23–44 (not reported) Ethnicity = 100% Black Substances = crack cocaine (67%), heroin (17%), alcohol (16%)	Semi-structured interviews; Ethnographic Culture care diversity and universality theory	Numbing pain Emotional pain sources	Moderate
Etherington (2007) United Kingdom	Understanding connections between problematic drug use and loss.	N = 1 Gender = woman Age = 31 Ethnicity = not reported Substances = alcohol, cannabis	Semi-structured interviews Life story research Narrative theory and social constructivism	Early loss experiences Drug death in social network Recovery motivation	High

Grundetjern (2018) Norway	Explore motherhood in the context of drug use.	N = 21 Gender = 100% women Age = range not reported (36) Ethnicity = 100% White Substances = amphetamines (62%), heroin (24%), cocaine (14%)	Semi-structured interviews; Grounded theory Emergent theory developed from the data.	Grieving mothers Detached mothers Motherly dealers	High
Janzen (2017) Canada	Understand the lived experience of mothers in recovery after losing child custody.	N = 4 Gender = 100% women Age = 18–30 (not reported) Ethnicity = not reported Substances = crack cocaine (100%)	Semi-structured interviews Interpretative phenomenological analysis (IPA) Interpretative framework	Betrayal Soul ache Reclamation	High
Kelly (2021) Canada	Understand the opioid crisis from the perspectives of PWUS.	N = 33 Gender = 70% men, 18% women, 12% transgender Age = 22-66 (45.5) Ethnicity = 17 White (52%), 16 Indigenous (48%) Substances = illicit drugs	Semi-structured interviews; Thematic analysis Not reported.	Opioid crisis trauma Community response Stigma	Moderate
Kenny (2015) United States	Understand the impact of child custody loss on women who use drugs.	N = 19 Gender = 100% women Age = 18–62 (39) Ethnicity = 58% White, 42% Black/Indigenous Substances = crack cocaine (42%), cannabis (32%), opioids (32%), alcohol (26%)	Semi-structured interviews Thematic narrative analysis Post-structuralist feminist framework	Separation Suffering Remembrance Survival	High
Lamonica (2020) United States	Understand the experiences of women who used	N = 28 Gender = 100% women Age = 28–63 (not reported)	Semi-structured interviews; Grounded theory Ecological systems theory	Regaining motherhood Agency interactions	High

	opioids and lost custody of their children.	Ethnicity = 61% White, 39% Black/other Substances = opioids (100%)			
Macmadu (2022) United States	Explore the impact of overdose of a social network member for PWUS.	N = 25 Gender = 15 men (60%), 10 women Age = 33-50 (38) Ethnicity = not reported Substances = heroin (52%), fentanyl (56%), crack cocaine (76%), benzodiazepines (48%)	Semi-structured interviews; Thematic analysis Protection motivation theory	Risk behaviours Protective behaviours	High
O'Callaghan (2024) Ireland	Explore how stigma influences grief for PWUS.	N = 6 Gender = 4 men (66%), 2 women Age = not reported (over 18) Ethnicity = 100% White Substances = not reported	Semi-structured interviews; IPA Not reported	Stigma shaping grief Forged connections Isolation and death as an escape	High
Roberts (1999) United States	Understand factors influencing drug use.	N = 32 Gender = 100% women Age = 21–52 (34) Ethnicity = 100% Black Substances = crack cocaine (65%), heroin (35%)	Semi-structured interviews; Grounded theory Feminist perspective	Experiencing loss Managing loss	High
Russell (2025) United Kingdom	Understand mothers' experiences of child removal and support.	N = 12 Gender = 100% women Age = 28–49 (38) Ethnicity = 83% White, 17% other Substances = not reported	Semi-structured interviews; IPA Phenomenological framework	Safe/Unsafe Changing identity Loss No way to win	High
Schlosser (2022) United States	Understand the impact of drug death	N = 30 Gender = 22 men (73%), 8 women	Semi-structured interviews; Thematic analysis	Death saturation	Moderate

	in opioid users' social networks.	Age = 20–68 (39) Ethnicity = 83% White, 17% Other Substances = 100% opioids	Not reported	Responsibility Interrupted mourning	
Selseng (2023) Norway	Explore how losing a friend or partner to a drug related death influences drug use.	N = 13 Gender = 7 women (54%), 6 men Age = 21–54 (not reported) Ethnicity = not reported Substances = not reported	Semi-structured interviews; Narrative analysis Narrative identity theory and dual process model	Managing grief Silence Responsibility Life transformation	Moderate
Selseng (2024) Norway	Explore experiences of support for bereaved PWUS.	N = 13 Gender = 7 women (54%), 6 men Age = 21–54 (not reported) Ethnicity = not reported Substances = not reported	Semi-structured interviews; Thematic analysis Not reported.	Lack of acknowledgment Social isolation Support barriers	High
Smith (2009) United States	Explore chronic sorrow as a relapse trigger in women who use substances.	N = 12 Gender = 100% women Age = 26–41 (33) Ethnicity = 58% White, 42% Black Substances = crack cocaine (50%), methamphetamine (25%), alcohol 17%), benzodiazepines (17%), marijuana	Semi-structured interviews; Content analysis Grief theory	Mothering loss Blocking feelings Relapse triggers Loneliness	High
Wojtkowiak (2019) Netherlands	Understand the experience of drug related death bereavement for PWUS.	N = 10 Gender = 100% men Age = 27–55 (not reported) Ethnicity = not reported Substances = heroin (50%), crack cocaine (50%)	Semi-structured interviews; Grounded theory Meaning making model	Inhibition of emotion Fragmented grief Social exclusion Acceptance of death	Moderate

Quality Appraisal Process

The Critical Appraisal Skills Programme (CASP) (2024) was used to assess quality of the included studies due to its suitability for novice researchers completing qualitative research within health and social care (Long et al., 2020; Nadelson & Nadelson., 2014). The CASP evaluates study validity, quality, and relevance to practice and research using 10 questions.

The first author rated all included studies using the CASP grading system developed by Butler et al. (2016). This grading system was employed to facilitate clearer comparison between studies and increase the rigour of quality assessment. Criteria was scored as 1 (met), 0.5 (unclear), or 0 (not met), with total scores categorising studies as low, medium or high quality.

A Trainee Clinical Psychologist independently rated five studies (28%), achieving 90% inter-rater agreement. Disagreements pertained to whether sufficient consideration had been given to the ethical implications of completing sensitive research in the context of substance use; and if there had been consideration given to the relationships between the researcher and the participants. This was deemed particularly important in the context of PWUS being a disempowered and stigmatised group. Discrepancies were resolved through discussion until consensus was reached. No studies were excluded based on quality rating. Overall quality rating of each study is provided in Table 1, with individual item ratings in Appendix C.

Synthesis Method

Thematic synthesis was the most suitable method for the current review as it facilitates the integration of data from a range of qualitative methods, accommodates cross-disciplinary perspectives, and is well suited to novice reviewers (Flemming & Noyes, 2021).

The synthesis followed the three-stage approach outlined by Thomas and Harden (2008). Studies were imported into Dedoose software (https://www.dedoose.com/) and coded from ‘Results’ onwards. Participants’ accounts and author interpretations were coded conceptually. While coding only participant accounts may have minimised bias; upon consideration of the novelty of the review and the high degree of avoidance within the research population, it was deemed appropriate to synthesise author interpretations as well. It was considered this would provide a contextual understanding of the data.

The studies were coded in no particular order; subsequent studies were coded into pre-existing codes and new codes were created when required. Codes were then inductively grouped into descriptive themes which were interpreted to develop higher-order analytical themes and

subthemes. Emerging themes were reviewed by a Clinical Psychologist and Consultant Clinical Psychologist, with academic and clinical expertise within drug and alcohol services, to enhance rigour of the synthesis.

Theoretical Position and Reflexivity

This systematic review adopts a critical realist and interpretivist perspective. Interpretivism facilitates the exploration of the personal experiences of participants (Schwandt, 2000); while critical realism acknowledges that structural factors such as stigma, trauma, and access to support will influence experience (Maxwell, 2012). While the review is grounded in this perspective, a reflective stance was employed to consider epistemological diversity across the included studies with reference to similarities and differences in interpretations.

Reflexivity was maintained throughout to consider positionality. The researcher, a Trainee Clinical Psychologist, had prior clinical experience with complicated grief and prior research experience in qualitative methods. These factors may have contributed to the development of the research question and interpretation of the studies. Efforts were made to avoid pathologising normative grief reactions. Additionally, the researcher had recently conducted her own study exploring the perspectives of PWUS which may have increased her sensitivity to ethical issues and influenced her CASP assessment.

Results

Study and Participant Characteristics

In total, 18 studies were included in the review representing the grief experiences of 334 participants. While the studies from Selseng et al. (2023; 2024) used the same participant sample; both were included as they had distinguishable focusses that were relevant to the research question. The majority of participants were women (58%). Some studies omitted details regarding participants' ethnicity; however, where reported, participants were predominantly identified as either Black or White. This indicates limited ethnic diversity across the sample. Age ranged from 18 to 63 years. Substances ranged and included heroin, crack cocaine, alcohol, and benzodiazepines.

Six studies explored the experience of loss and grief generally (Creighton et al., 2016; Daniulaityte & Carlson, 2011; Ehrmin, 2002; Etherington, 2007; Roberts, 1999; Smith, 2009). Seven studies explored grief related to drug death (Kelly et al., 2021; Macmadu et al., 2022; O'Callaghan & Lambert, 2024; Schlosser & Hoffer, 2022; Selseng et al., 2023; Selseng et al., 2024; Wojtkowiak et al., 2019). Five studies explored the experience of grief following the

removal of children (Grundetjern, 2018; Janzen & Melrose, 2017; Kenny et al., 2015; Lamonica & Boeri, 2020; Russell et al., 2025). Studies were published between 1999 and 2025; with the majority published within 10 years of the review (n = 13). The studies exploring grief following drug death were, primarily, the most recent studies which is reflective of a research response to the global drug death crises (WHO, 2024). Studies were conducted in the United States (n = 8), Canada (n = 3), Norway (n = 3), the United Kingdom (n = 2), Ireland (n = 1) and the Netherlands (n = 1). All studies collected data using semi-structured interviews although, analysis approaches varied.

Quality Assessment Results

All studies were of good quality. They presented clear aims and rationales. All studies adopted an appropriate research design and data collection method. Consideration of ethical issues was present in all studies and was evidenced by the provision of ethical approval statements. However, no studies appeared to consider how obtaining informed consent may be more difficult within the context of substance use or made reference to how they could manage potential distress.

Some authors considered their role as a researcher (Ehrmin, 2002; Etherington, 2007; Lamonica & Boeri, 2021; Macmadu et al., 2022; O'Callaghan et al., 2024; Russell et al., 2025; Selseng et al., 2024) and made appropriate accommodations to encourage participation. Few studies explicitly discussed researcher positionality and its influence on data interpretation, although O'Callaghan and Lambert (2024) and Russell et al. (2025) addressed it by use of a reflexive journal.

While most studies (n = 14) focused on individuals already engaged in harm reduction or treatment; Ehrmin (2002), Kenny et al. (2015), Lamonica and Boeri (2020), and Roberts (1999) recruited participants who were not necessarily engaged with services. This provides perspectives of those disconnected from care. All studies provided rich data, using direct quotes and supporting interpretations. All studies contribute meaningfully to practice and research.

Given that all papers were assessed as good quality, the quality appraisal did not significantly influence the analysis or findings. This consistency in quality allowed for a more confident synthesis of the evidence, ensuring that the conclusions drawn were based on robust and reliable studies.

Thematic Synthesis Results

Three themes and nine subthemes emerged from the analysis (Table 2). The prevalence of themes across studies is outlined in Appendix D.

Table 2

Thematic Synthesis Themes and Subthemes

Theme	Subtheme
Locked in Loss and Addiction	Intrinsically interwoven
	Regulate, escape, numb
	Fear-based changes
	But how could I stop?
Defeated and Defended	Disenfranchised grief, disenfranchised lives
	Addiction overshadows grief
	Avoidance disrupts help-seeking and providing
Routes to Recovery	I can't care about me, but I can care about you
	Care, support and purpose

Locked in Loss and Addiction

This theme explores the relationship between grief and substance use.

Intrinsically interwoven

Across all studies, participants' described life histories replete with cumulative loss, trauma, and adversity. Losses included parental figures, family members, children (through removal or death) and peers. These losses were often accompanied by feelings of abandonment, shame, guilt, and worthlessness (Daniulaityte & Carlson, 2011; Ehrmin, 2002; Etherington, 2007; Janzen & Melrose, 2017; Kenny et al., 2015; Macmadu et al., 2020; O'Callaghan & Lambert, 2024; Roberts, 1999; Russell et al., 2025; Schlosser & Hoffer, 2022; Selseng et al., 2023; Smith, 2009; Wojtkowiak et al., 2019).

These emotional states were often described as ongoing, rather than a single event, with grief evolving into a persistent experience. This conceptual understanding of grief (as persistent rather than episodic) was key across the studies and was consistently linked to an increase in substance use as a coping mechanism. (Daniulaitye & Carlson, 2011; Ehrmin, 2002; Etherington, 2007; Grundetjern, 2018; Kelly et al., 2021; Macmadu et al., 2020; O'Callaghan & Lambert, 2024; Roberts, 1999; Schlosser & Hoffer, 2022; Selseng et al., 2023; Wojtkowiak et al., 2019). Across studies, grief led to increased substance use to cope, substance use

exacerbated instability and contributed to secondary losses. This intensified emotional distress and reinforced dependence on substances:

> *Women experienced failed relationships and continued physical, sexual, and emotional abuse. Inability to trust a partner were cited as common problems leading to the failure of relationships. Increased drug use by one or both partners developed as a means of dealing with problems. Violence and abuse ensued under the influence of drugs. Loss of control over drugs usually resulted in loss of child custody. Ongoing loss was described by Julie, a 40-year-old heroin user: 'When I was 18, mom died. My older brother is gay. Never see him; never knew my father. I loved my daughter's daddy. He left after she was born. [Social services] took her away when she was a baby. She grown now, and I've not seen her since she's adopted. It still hurts'. (Roberts, 1999, p. 627)*

Over time, the number of losses created emotional stagnation in which grief could not be processed (Macmadu et al., 2022; O'Callaghan & Lambert, 2024; Wojtkowiak et al., 2019). This fostered feelings of hopelessness and fatalism (Jenzen & Melrose, 2017; Kenny et al., 2015; Macmadu et al., 2020; O'Callaghan & Lambert, 2024; Schlosser & Hoffer 2022; Selseng et al., 2023; Roberts, 1999; Wojtkowiak et al., 2019). To cope, emerged a 'neutral death acceptance' (Wojtkowiak et al. 2019). This was characterised not by an active desire to die, but an ambivalence towards living as participants contended with insurmountable emotional pain (Jenzen & Melrose, 2017; Kenny et al., 2015; Macmadu et al., 2020; O'Callaghan & Lambert, 2024; Schlosser & Hoffer 2022; Selseng et al., 2023; Roberts, 1999; Wojtkowiak et al., 2019).

Regulate, escape, numb

Across all studies (except Kelly et al., 2021), and irrespective of the source of grief, participants described an escalation of, or relapse into, substance use after loss. Substances were used to regulate the intensity of grief, 'I guess the drug use has actually increased to suppress pain and feelings' (Schlosser & Hoffer, 2022, p. 6); numb distressing emotions, 'I not only relapsed but I doubled the use…the hole, the empty spot…there was this big gaping hole that can't be filled, but you try to fill it with drugs' (Smith et al., 2009, p. 408); or escape an intolerable reality:

> *In the early aftermath of separation, almost all women described trying to numb and detach from memories of what had occurred. Women almost universally explained responding to suffering through increased use of drugs (e.g., cocaine, heroin, opioids and cannabis) and alcohol. Women also described binging as a strategy for immediate sedation from pain. (Kenny et al., 2015, p. 1162)*

Across studies, participants' accounts highlight that the destabilising nature of loss led to a reliance on substances to provide short-term relief from emotional pain.

Fear-based change

A small subset of studies (Macmadu et al., 2022; O'Callaghan & Lambert, 2024; Schlosser & Hoffer, 2022; Selseng et al., 2023), found that a minority of participants immediately adopted safer using practices in the aftermath of loss. This was always in response to a drug death however, this was not a consequence of improved coping, but rather an avoidance behaviour in the context of witnessing traumatic deaths, 'Just, you don't wanna overdose. You don't wanna risk having that happen to you' (Macmadu et al., 2022, p. 8).

While the initial shock of the death functioned as a 'wake-up call' (Macmadu et al., 2022), without alternative coping mechanisms, long-term recovery was not sustainable:

> *I thought it would be enough for me to like, 'Okay, this is it. I gotta get my shit together,' and whatever. And it was for a year and a half. It was enough for me to kind of think about it every day and use it to benefit, but it wasn't—it wasn't enough to keep me sober. (Schlosser & Hoffer, 2022, p. 6)*

In the authors' interpretation, this change was seen as a temporary avoidance strategy rather than a sustainable coping mechanism, as the underlying grief remained unresolved.

But how could I stop?

Participants in seven studies (Creighton et al., 2016; Kenny et al., 2015; Janzen & Melrose, 2017; O'Callaghan & Lambert, 2024; Selseng et al., 2023; Selseng et al., 2024; Roberts, 1999), lacked confidence in their ability to cope with grief without the numbing effect of substances. Some framed substance use as an act of self-preservation to prevent suicide:

> *If it weren't for beer, I'd be dead. (…) if I had to sit alone in my head with the aftermath without that ability to escape and that distraction of a TV show, um, it would have been beyond my capacity to deal (Kenny et al., 2015, p. 1162)*

Alongside a diminished belief that they could cope without substances, some participants described that in the face of loss, drugs and alcohol provided solace:

> *That's our coping skill. That's our friend. (…) When anything was going wrong, who was there for me? By continuing [with cocaine], by going down the road after my kids [were] gone, I didn't pick up the phone and call my treatment centre. I picked up the phone and called my drug dealer. (Janzen & Melrose, 2017, p. 241)*

Across four studies (Etherington, 2007; Kelly et al., 2021; O'Callaghan & Lambert, 2024; Roberts, 1999), participants described substance use providing connection and community; with recovery presenting further loss:

> *Junkies give me more help but want me to stay on the shit. I gotta have my crowd. They're the most important. I'd miss them. Can't quit and give up my friends. No one to talk to at home. (Roberts, 1999, p. 629).*

Defeated and Defended

This theme highlights how grief remains unrecognised and unsupported among PWUS. Stigma and avoidance create barriers to meaningful support.

Disenfranchised grief, disenfranchised lives

Participants reported social isolation in the aftermath of loss, with grief often unacknowledged, minimised or dismissed (Ehrmin, 2002; Daniulaityte & Carlson, 2011; Janzen & Melrose, 2017; Kelly et al., 2021; Kenny et al., 2015; Lamonica & Boeri, 2020; O'Callaghan & Lambert, 2024; Roberts, 1999; Russell et al., 2025; Schlosser & Hoffer, 2022; Smith, 2009; Wojtkowiak et al., 2019).

For some, grief was actively dismissed as services and family members failed to recognise them as bereaved individuals (Selseng et al., 2024). The authors' interpretation of these accounts emphasised how such dismissal reinforced feelings of disenfranchisement and made it more difficult for these individuals to access support for their grief. Other experiences of stigma and disenfranchisement were more passive, there was a sense that it had not been considered that they would be impacted by death (Kenny et al., 2015; Russell et al., 2015):

> *He was visiting a close friend, spending the night there, and found him dead from an overdose the following day. Stian said that he called the police (…) After Stian had quickly explained what had happened, one policeman said: 'yes – you can just go' (Selseng et al., 2024, p.430).*

The author's interpreted the indifference in response as reflecting a sense of social devaluation for PWUS as grieving individuals (O'Callaghan & Lambert, 2024).

Addiction overshadows grief

Indeed, across six studies (Creighton et al., 2016; O'Callaghan & Lambert, 2024; Roberts, 1999; Russell et al., 2025; Schlosser & Hoffer, 2023; Selseng et al., 2024), drug use overshadowed grief in service responses which reinforced the notion that substance use, rather than loss, was the primary issue requiring intervention: 'The clinic is busy, it's full, so

sometimes the appointment would be just in, get your script [prescription] and out the door again. So there was, you know, minimal supports offered and available' (Russell et al., 2025, p. 8). Without opportunities to be supported to process grief, substance use became the primary coping mechanism:

> *Because Randy and his friends did not have an opportunity to talk about the death of their friend, they tried to find other ways to cope. He said his drinking went from an "occasional night out or brief bender" to heavy drinking on a daily basis. (Creighton et al., 2016, p. 58)*

Avoidance disrupts help-seeking and providing

When grief was unseen, dismissed, or overshadowed by substances use, individuals were left to process their losses in isolation (Creighton et al., 2016; Macmadu et al., 2022; O'Callaghan & Lambert, 2024; Selseng et al., 2024; Wojtkowiak et al., 2019). This could result in blocked grieving and the intensity of unresolved grief could lead to individuals becoming emotionally detached:

> *The detached mothers' almost nonchalant way of describing the event, and laughing instead of crying, may have been a defence mechanism resulting from having lost a child (Grundetjern, 2018, p. 405).*

The incongruent reaction is interpreted as an attempt to emotionally distance herself from her pain. For many participants, avoidance became the primary coping strategy, making it difficult to engage in grief processing or recovery, 'I got into this treatment program. I felt like I was in the hot seat. They made me write down everything I do wrong. I left. I couldn't take it.' (Roberts, 1999, p. 629).

Across three studies (Schlosser & Hoffer, 2022; Selseng et al., 2024; Russell et al. 2025) participants referenced the internal conflict of desiring support but struggling to articulate their needs:

> *I would love to be able to just come and go like 'Look I am feeling like s*** and need somebody to talk to', but I just really struggle with that. I mean maybe just now my barriers have come down a wee bit, but I still feel that I can't open up like with [addiction worker]. (Russell et al., 2025, p. 5)*

When interacting with services, this made it difficult for grief to be recognised: 'Several of the bereaved mentioned that typical situations they encountered were helpers asking, 'How are you?' or 'Are you okay?' The bereaved answered in the affirmative, and thus the follow-up

ended' (Selseng et al., 2024, p. 434). Thus, unexpressed and unacknowledged grief reinforced avoidance-based coping and emotional detachment.

Routes to Recovery

This theme explores how social connection, caregiving and purpose support recovery from grief-driven substance use.

I can't care about me, but I can care about you

Within the context of disenfranchisement and diminished self-worth, it was difficult for participants to reduce or stop using substances. However, across six studies (Etherington, 2007: Lamonica & Boeri, 2020; Macmadu et al., 2020; Schlosser & Hoffer, 2022; Selseng et al., 2023; Roberts, 1999), caring for someone else could be a motivating factor, 'As a disincentive to using heroin intravenously, she had her children's names tattooed on her arm' (Lamonica & Boeri, 2020, p. 11). The participants account reflects how caregiving and motherhood can serve as a protective factor against substance use.

For others, witnessing the ripple effect of grief on loved ones prompted reflections on the potential consequences of their own death:

> *If I continue to do drugs, and I die, it's actually not about me, because it is those left behind who have to live with my death. So, perhaps it's okay to live life a bit for someone else too. (Selseng et al., 2023, p. 466).*

While self-compassion remained blocked, the recognition of the impact upon others fostered a sense of responsibility and reason to live. As participants were socially isolated and emotionally disconnected, acts of caregiving became an avenue towards meaning and recovery:

> *I belong in life and I can make a difference, even if it's just little (…) for another lady that probably is going to come in here needing the room that I paint, she can use it. Little things like that with my recovery that keep me going, for another person, to help them out, that is much more. (Janzen & Melrose, 2017, p. 245)*

The authors interpreted these small acts as a means of reconnecting to a sense of purpose and belonging.

Care, Support and Purpose

Participants who developed greater control over their substance use did so when they had some form of love, support or stability in their lives (Creighton et al., 2016; Daniulaityte & Carlson,

2011; Etherington, 2007; Jenzen & Melrose, 2016; Kenny et al., 2015; Lamonica & Boeri, 2020; Roberts, 1999; Russell et al., 2025). It was noted that having a structured job (Creighton et al., 2016; Daniulaityte & Carlson, 2011; Janzen & Melrose, 2017; Kenny et al., 2015; Lamonica & Boeri, 2020), children to care for (Etherington, 2007; Janzen & Melrose, 2017; Kenny et al., 2015; Roberts, 1999; Russell et al., 2025), supportive workers (Janzen & Melrose, 2017; Russell et al., 2025; Selseng et al., 2023), and support from peers and community members (Daniulaityte & Carlson, 2011; Roberts, 1999; Russell et al., 2025), could support recovery. This was considered essential for emotional processing:

> *I have support people now that I call when I'm going through something (…) even if I was to take a drink, my problem would still be there. So if something is bothering me very badly, I pick up the phone and talk about it. (Daniulaityte & Carlson, 2011, p. 6)*

When these supports were in place, participants were more likely to adopt harm reduction practices (Lamonica & Boeri, 2020; Macmadu et al., 2020; Roberts, 1999). When these relationships and supports either did not exist or failed, substance use escalated as a means of coping with grief. The authors emphasised that emotional and social support networks were essential for preventing relapse and supporting long term recovery.

Discussion

This review is the first comprehensive synthesis of qualitative literature exploring the grief experiences of PWUS. Eighteen studies were analysed, producing three themes: Locked in Loss and Addiction, Defeated and Defended, and Routes to Recovery. Despite variability in study contexts, the findings are cohesive; offering an aggregated insight into the grief experience for PWUS.

Regulation of Grief

This synthesis provides substantive evidence that increased substance use is a grief response for PWUS and identifies grief as a relapse trigger. These findings contextualise quantitative reviews demonstrating substance use as an emotion regulation strategy (Stellern et al., 2022; Weiss et al., 2022; Wong et al., 2013). As postulated by the DPM, coping with grief is a complex regulatory process characterised by a fluctuating pattern of confrontation and avoidance (Stroebe & Schut, 2010). From this perspective, substance use serves as an accessible, albeit harmful, means of navigating this regulatory process. This reinforces the role of substance use a broader regulatory strategy and offers a destigmatising understanding.

Additionally, this review clarifies psychological mechanisms that may underpin substance use as a grief response and offers intervention targets. Namely, attempts to down-regulate the intensity of grief, substance use to avoid distressing thoughts, emotions and memories, and appraisals regarding one's ability to cope without the numbing effect of substances. Further, the finding that initial substance control is unsustainable following loss evidences the importance of interventions that equip individuals with helpful coping strategies to support recovery (Caparrós & Masferrer, 2021).

The synthesis illustrates that cumulative loss leads to emotional overload and appears to disrupt the regulation of grief (Stroebe & Schut, 2016). Within the synthesis, this contributed to emotional detachment and neutral death acceptance. While participants did not actively seek death there were consistent reports of ambivalence towards life (Wojtkowiak et al., 2019). This may reflect a coping response, whereby persistent exposure to loss fosters fatalism and apathy. The prevalence of this finding across studies spanning over 25 years provides evidence of this being a significant feature of the grief experience for PWUS.

This has implications for intervention delivery. Ambivalence towards life diminishes self-care while bolstering powerlessness to change (Butler et al., 2015). This is compounded by limited restoration opportunities (Russinova et al., 2011; Wesselman & Parris, 2021). This suggests that PWUS may be less responsive to grief support that focuses on future orientated goals. The finding that connection to, and concern for, others can motivate individuals to adopt safer using practices and engage in recovery suggests that grief interventions with a relational and values based approach may be more beneficial (Lamonica & Boeri, 2020; Paton et al., 2022). Given the dearth of validated grief interventions for PWUS (Parisi et al., 2019), this presents an avenue for clinical implementation and ongoing research.

Social Support and Meaning

While the importance of social support in recovery is well evidenced (Best et al., 2015; Tracy & Wallace, 2016), this synthesis illuminates the protective role of social support, meaningful relationships, and purpose in mitigating grief related distress. The finding that caregiving roles, such as parenting or supporting peers, can instil a sense of value, meaning, and self-worth corroborates the literature evidencing the restorative power of peer support roles for those in recovery (Scannell, 2021). This has particular relevance within the current global drug related mortality crises, which has resulted in a grieving population of PWUS (Dyregrov et al., 2020; WHO, 2024b). Findings from the synthesis suggest that crises recovery may be dependent upon social connection and caregiving opportunities; to manage grief related distress and the associated drug use.

Disenfranchised Grief

This synthesis aligns with literature evidencing the association between substance use and disenfranchised grief (Titlestad et al., 2019); while being the first to collate the evidence regarding the impact for PWUS. Across studies, grief was consistently unrecognised and unsupported. Participants described being positioned as drug users rather than grieving individuals, leading to their emotional needs being overlooked. This was evidenced in the oldest (Roberts, 1999) and most recent (Russell et al., 2025) studies, suggesting the disenfranchisement of grief for PWUS is a persistent systemic issue.

To address this, frontline staff require training to deliver grief-informed care, particularly given that grief may not be verbally expressed (Russell et al., 2025; Schlosser & Hoffer, 2022; Selseng et al., 2024). Further research is also required to examine how stigma perpetuates the disenfranchisement of grief for PWUS and how this may be dismantled in service delivery and guiding policies.

Strengths, Implications and Future Directions

This review is the first to systematically synthesise qualitative literature on the grief experiences for PWUS, providing evidence to support the recognition and validation of grief within drug and alcohol services. The methodological rigour of the included studies enhances the credibility of the synthesis.

The consistency of themes across 25 years of research highlights the persistent challenges of addressing grief needs for PWUS. This has individual implications, supporting the notion that those accessing treatment are likely to have unaddressed grief needs requiring clinical attention (Furr et al., 2015; Parisi et al., 2019). Also, within the context of global public health, these findings hold urgent clinical and policy relevance (WHO, 2024b). By collating the experiences of this stigmatised group, this synthesis enhances clinical awareness and reinforces the need for grief-informed care in services. The synthesis also provides avenues for such care: caregiving and peer support opportunities. Future research should prioritise the development and integration of grief-informed care into service delivery and clinical practice.

Limitations

Due to the ambiguity of ‘loss’ as a construct, the search strategy prioritised specificity, potentially omitting relevant studies. Limiting the review to English language studies has resulted in a synthesis that predominantly reflects Western experiences of grief. Future research should explore variance in the intersection of grief and substance use across cultures. This is

important as minority groups experience significant structural barriers that can block their access to care (Mantovani & Evans, 2019).

Although the studies were methodologically robust, the exclusion of dissertations and grey literature may have omitted valuable insights. As PWUS are under represented in research, future reviews should incorporate unpublished studies.

Conclusion

This review has collated the experiences of a highly stigmatised, complex, and often silenced community to offer an understanding of their grief experiences. The findings illustrate the complex relationship between grief and substance use; and reinforce the need for grief-informed approaches in services. This review found evidence of the intervening potential of caregiving and meaningful relationships in mitigating distress and substance use. This highlights community belonging, relational support and purposeful activity as being integral to grief-informed care. Importantly, diminished grief recognition remains a systemic issue and ongoing research is required to understand how this may be dismantled.

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Chapter 2

‘It’s mental health, not just a drug problem’: understanding and responding to Scotland’s drug death crisis

Prepared in accordance with the author requirements for Contemporary Drug Problems

Plain Language Summary

Over the last 25 years, Scotland has been facing a drug death crisis, with more deaths than anywhere else in the United Kingdom or Europe. Most research has focussed on understanding the causes for the crisis and finding ways to prevent deaths. Harm reduction strategies have been introduced, which aim to keep people safe when they use drugs. These include providing supervised places to use drugs and access to overdose-reversing medication.

Little research has looked at how the crisis has impacted people who use drugs or if they find harm reduction strategies helpful. Understanding this is important as people who use drugs are likely to know someone who has died from a drug death and are more likely to die themselves. This research aimed to understand how Scotland's drug death crisis affects people in treatment for drug use and what they think about harm reduction.

Six people were interviewed about their experiences and views. The interviews were analysed using a method called interpretative phenomenological analysis, which helped the researchers understand how people are coping.

An important finding was that grief is a big part of the crisis and that people will use drugs to cope with their feelings, so the crisis keeps going. The people interviewed called for opportunities to talk about their difficulties, money to be invested in the places they live, and trusting relationships with professionals.

Abstract

Scotland is in the midst of a drug death crisis. The research that influences policy, treatment, and intervention in relation to the crisis is largely quantitative and has sought to establish risk factors and response strategies. While necessary, there is no known research that has explored the impact of the crisis, or how harm reduction methods are being received, by those at risk of a drug death in Scotland. Interpretative phenomenological analysis was used to understand the impact from the perspective of six individuals currently receiving treatment for illicit drug use, and who are therefore more likely to be vulnerable to, or impacted by, drug death in Scotland. Four group experiential themes emerged: Relentless Loss, Impact on Drug Use, Opposing Priorities, and Connection, Stability, Support. The analysis provides evidence of a maintaining mechanism of the crisis: unacknowledged and unsupported grief. Participants emphasise the need for interventions that go beyond drug treatment; calling for emotional support, community investment, increased opportunities, and consistent, long-term relationships with workers. Findings are discussed within the context of current policy guidance and service delivery.

Key Words: drug misuse death, addiction, grief, harm reduction, living experience, qualitative

Introduction

Scotland has been experiencing a disproportionately high number of drug misuse deaths (DMDs). That is: a death caused by the use of, or poisoning from, a controlled substance which is found in the body (National Records of Scotland [NRS], 2024). Most recent data estimates there to be 277 DMDs per 1,000,000 of the Scottish population, placing rates at nearly three times higher than the rest of the United Kingdom, the highest in Europe and one of the highest in the world (Audit Scotland, 2024; NRS, 2024). Strikingly, in 2020 there were 650 COVID-19 related deaths for individuals aged 15-64 years; comparative to 1339 DMDs for the same age group (NRS, 2021a and b). Subsequently, DMDs within Scotland have been recognised as a public health emergency leading to a national effort to understand and mitigate this tragedy (Scottish Government, 2022a).

The research that influences policy, treatment, and intervention in relation to the DMD crisis is largely quantitative and has sought to establish relevant risk factors and response strategies. From these findings, the increase in DMDs has been attributed to a complex interplay of socioeconomic deprivation, poly drug use, cohort effects and service disinvestment (Audit Scotland, 2024; Scottish Drugs Death Task Force, 2022a). Comparative to the rest of the United Kingdom, Scotland has experienced significant historical economic and political hardship. Deindustrialisation in the 1970s and 1980s led to high rates of unemployment, compounded by housing policies that fragmented communities (Walsh et al., 2021). Additional political mandates of the time bolstered austerity in Scotland and the impact was reflected in elevated rates of drug use, alcohol harm, and suicide (Parkinson et al., 2017; Parkinson et al., 2018). Subsequent disinvestment to public services, alongside the rise and access of benzodiazepines (particularly street derivatives) and gabapentin to the Scottish drug market have resulted in a complex and multifactorial explanation for the increased rates of DMD in Scotland (van Amsterdam et al., 2021).

Alongside quantitative risk factor research has been a political, public, and media agenda for harm reduction methods to reduce the number of DMDs (Carver et al., 2023; Nicholls et al., 2022). The Scottish Government established the Drugs Death Taskforce to identify measures to reduce drug use, harm, and deaths. Their final report advised upon the implementation of six evidence based harm reduction and intervention strategies: near-fatal overdose pathways, substance specific out-of-hours support, supervised drug consumption facilities, naloxone provision, assertive outreach, and drug-checking services (Table 3) (Scottish Drug Deaths Taskforce, 2022b).

Table 3

Proposed Harm Reduction Strategies within the National Response

Harm Reduction Strategy	Scottish Drug Death Taskforce Recommendations
Near fatal overdose pathways	Emergency care should be available for every person who experiences a near fatal overdose.
Substance specific out-of-hours support	A near fatal overdose should be seen as a medical emergency requiring 24/7 care with out-of-hours referral points.
Supervised drug consumption facilities	Supervised drug consumption facilities should be implemented to provide a supervised space for people to use drugs safely and be supported into treatment pathways.
Naloxone provision	Naloxone is an opiate antagonist treatment which can be administered to reverse the effects of opiate overdose. There is a national effort to increase the distribution of kits.
Assertive outreach	Those at high risk of drug-related harm should be proactively identified and offered support.
Drug checking facilities	Individuals can submit samples of substances for testing and receive information about the content and potency of the submitted drugs.

There is a national and international evidence base to support this response strategy however, the crisis has endured irrespective of the growing understanding of causal factors and the introduction of harm reduction interventions. There has been a continuous upward trend of DMDs in Scotland year-on-year since 2013 with the exception of a slight decrease (1%) between 2020 and 2021 figures and a further 21% decrease in 2022 (NRS, 2022a; NRS, 2023). However, the likelihood of dying from a DMD in the most deprived areas of Scotland increased from 2021 to 2022 which presented an increase in risk for those most vulnerable (Allik et al., 2020; NRS, 2023). Further to this, latest figures indicate the crisis is unrelenting and the number of DMDs increased by 12% in 2023 (NRS, 2024). This prompts consideration around whether there is a disparity in how the proposed harm reduction strategies are being accessed, received, and utilised by those they are intended to protect.

Additionally, the national response has limited consideration regarding the impact of the DMD crisis upon staff working in addiction services (Scottish Drugs Death Taskforce, 2022). Following the death of a service user, staff report acute grief reactions and high levels of self-blame and shame (O'Callaghan & Lambert, 2024a). This compounds the already existing

challenges of supporting a clinical population that is highly complex, significantly vulnerable, often transient, and ambivalent towards change (Farhoudian et al., 2022). The impact of this is reflected in elevated sickness rates and unfilled vacancies (Scottish Government, 2022b); which inadvertently negatively impacts upon client engagement, retention, and treatment outcomes (Audit Scotland, 2024; Landrum et al., 2012; Oser et al., 2013).

Beyond staff; in communities it is estimated that for each DMD there are at least 10 individuals bereaved (Dyregrov et al., 2020) creating a ricochet of grief, suffering, and trauma for an estimated 150,000 Scottish citizens from the period spanning 2002-2024 alone (Felitti et al., 1998; Kaplow et al., 2010; NRS, 2024; Titlestad et al., 2021). Additionally, due to the stigma surrounding addiction, surviving friends and family report high levels of unacknowledged trauma, shame, and guilt in the aftermath of a DMD. This can lead to a 'silencing' which makes it difficult to access support (Dyregrov et al., 2020; Lambert et al., 2021; Templeton et al., 2016). As such, grief can become disenfranchised, which occurs when a loss is socially invalidated, dismissed, or unacknowledged (Thompson & Doka, 2017).

From this, there is a small, yet growing, international body of research exploring the experience of being bereaved by a DMD within the context of addiction. Across Ireland (O'Callaghan & Lambert, 2024b), the United States (Macmadu et al., 2022; Schlosser & Hoffer, 2022), Norway (Selseng et al., 2023; Selseng et al., 2024), Canada (Kelly et al., 2021), and the Netherlands (Wojtkowjak et al., 2019) researchers have uncovered that for people who use drugs their social worlds are 'saturated' with death (Schlosser & Hoffer, 2022). This appears to lead to a desensitisation towards death and may evoke a sense of fatalism. To cope, some individuals become 'locked in avoidance' (Selseng et al., 2023), in which drug use intensifies to regulate, or avoid, the emotional experience of grief. For others, the death of a peer or family member from a DMD can facilitate reflections around their own drug use and elicit a desire to engage in less-risky drug using behaviours. These studies offer an insight into how drug deaths may impact upon someone in the context of their own drug use, the implications of such on the cultural grieving landscape for the community, and how this may be influential in drug use patterns and engagement with services.

Understanding whether these findings can be mapped onto a Scottish context is important in shaping our national response to the DMD crisis. However, there has been no known research exploring the impact of the DMD crisis on people who use drugs and the recovery community. This is incongruent with the recognition that the experiences, perspectives, and opinions of people who use drugs is of vital importance in shaping the national response (Scottish Government, 2022c). While there has been an increased effort to harness the voices of those with lived experience to guide recommendations, those who have elevated their voices are often

well resourced in terms of psychosocial supports and long into their recovery journey. Therefore, providing lived experience, as opposed to living experience, which may not be reflective of the current challenges, perspectives, and systems of care. Additionally, there are no known accounts of the voices from those in the most deprived areas, who are most vulnerable to experiencing a DMD. As such, we know little about the impact of the disproportionate rate of DMD in Scotland for people who use drugs and if the proposed interventions within the national strategy recognise and meet the needs of those intended to receive them.

Aim

This research will qualitatively explore the impact of the drug death crisis in Scotland from the perspective of individuals currently receiving treatment for illicit drug use in statutory services, therefore, being directly more vulnerable to DMD. Additionally, it will explore their perspectives on harm reduction strategies.

Method

This research is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007) (Appendix E).

Design

This qualitative research used Interpretative Phenomenological Analysis (IPA) to explore the experience of the drug death crisis in Scotland, and the meaning ascribed to it, for individuals currently accessing treatment for drug addiction. The aim of this study was to develop an understanding of the lived experience of having a drug addiction within the context of Scotland's drug death crisis. The intention was to prioritise the voices of participants in the analysis, with the aim of potentially informing and enhancing service provision. As such, it was important to select a qualitative method that could facilitate an understanding the participants' contexts and experiences, and how they made sense of them. As such, IPA (Smith et al., 2022) and Reflexive Thematic Analysis (RTA) (Braun & Clarke, 2022) were considered as suitable analytical approaches. IPA is grounded in three philosophical principles: phenomenology, hermeneutics, and idiographic inquiry which guides researchers to build an understanding of the unique and personal experiences of individuals within a homogenous group (Smith et al., 2022). Comparatively, RTA offers flexibility and can be applied across epistemological frameworks however, both methods can be employed upon the same dataset and may yield similar results (Smith et al., 2022). It was considered that RTA would have been more appropriate to capture a breadth of experience across participants but that IPA would provide a deeper understanding of individual experiences (Spiers & Riley, 2019). As the study sought to

understand how individuals in addiction treatment perceive and make sense of Scotland's drug death crisis it was considered that IPA would provide a comprehensive and nuanced understanding of the lived experienced. By gaining insight into their perspectives, services could be better tailored to meet their needs, identifying what support should be offered. Given this focus, IPA was deemed more suitable due to its depth of analysis, emphasis on participants' experiences, exploration of their sense making processes, and its idiographic approach which allows for the examination of their unique experiences, contexts and meanings.

Ethical Approval

Ethical approval was obtained from NHS South West England Research Ethics Committee (24/SW/0068) (Appendix F) and local NHS Research and Development (Appendix G).

Participation and Recruitment

Participants were recruited from three community Drug and Alcohol Services in the West of Scotland from August 2024 to November 2024. Participants were eligible if they were over 18 years old and receiving treatment for a drug-related difficulty within statutory Drug and Alcohol Services. This research specifically sought the perspectives of individuals currently in treatment for illicit drug use, as individuals with lived experience in long-term recovery may no longer reflect the current systems of care or challenges faced by those actively in treatment. Additionally, participants were recruited from rural locations to gain an understanding of the unique challenges faced by this population (e.g. limited access to healthcare and support services, diminished opportunities, and elevated rates of DMD) (NRS, 2024; Scottish Government, 2024; Scottish Health Action on Alcohol Problems, 2020). Exclusion criteria included non-fluency in English or participants appearing to be under the influence of substances at the time of consent or interview. This was to ensure clear communication, valid responses, and the safety of both participants and the researcher.

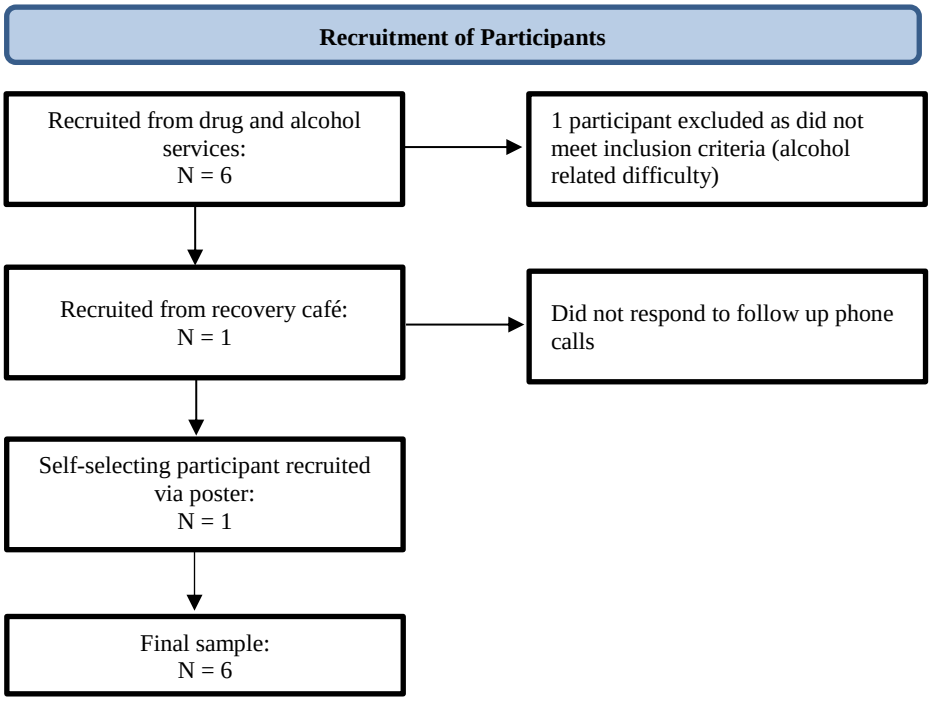
As recommended by Smith et al. (2022) we aimed to recruit between six and 10 participants to capture a range of experiences while maintaining depth of analysis. Recruitment was completed through a number of channels to increase access to the project. The multidisciplinary teams (including occupational health, psychiatry, nursing, psychology, social work, social care and addiction workers) were informed of the research and eligibility criteria via team distribution emails and discussion at team meetings (Appendix H). Using convenience and purposive sampling, staff were asked to identify any potential participants on their case load and inquire if they were interested in participating. For those who expressed interest, staff sought permission to share their contact details with the research team, who then followed up by telephone to provide more information and invite participation.

In addition, posters were supplied to waiting rooms and recovery hubs across the three health and social care partnerships inviting individuals to contact the research team if they were interested in participating (Appendix H). Researcher 1 (CD) also attended a local recovery café to promote the project and engage potential participants.

Initially, eight participants expressed interest in the project. One was excluded as they were accessing services only for an alcohol-related difficulty. One participant did not respond to follow up contact. Routes to participation are illustrated in Figure 2.

Figure 2

Recruitment Process



The final sample comprised of six participants (age range = 31–48 years; mean age = 40.8; 50% women; 100% White). As the aim of the study was to explore the lived experience of participants, rather than to analyse variations based on demographic characteristics, the collecting of comprehensive demographic information (e.g. marital status, education) was viewed as unnecessary for informing the analysis. The focus was on understanding the individual's meaning making process, and personal, subjective experiences. Demographic information for participants is provided in Table 4.

Table 4

Demographic Information of Participants

Participant	Age	Current substances	Current prescribed substances	Time in recovery	Historic substances used
Shona	38	Nil	Espranor	3 years	Codeine, crack cocaine, diazepam (street and prescription), gabapentin, heroin, morphine, pregablin, speed
Heather	39	Nil	Espranor	4 years	Codeine
Jack	31	Nil	Espranor	1 year	Cannabis, crack cocaine, crystal meth, heroin, mephedrone, street diazepam
Duncan	48	Crack cocaine, street diazepam	Espranor Zopliclone	Still in active addiction	Acid, amphetamine, benzodiazepam, cannabis, cocaine, heroin, magic mushrooms
Janie	42	Cannabis	Espranor	5 years	Crack cocaine, heroin
Gordon	47	Nil	Methadone	8 years	Crack cocaine, heroin, street diazepam

As interviews progressed information power was considered with reference to the study aim, sample specificity, use of established theory, quality of dialogue, and analysis strategy (Malterud et al., 2016). Following the initial six interviews, the data was considered in alignment with the study aim and the degree to which it provided rich insights into the lived experiences of the drug death crisis. The specificity of the sample, consisting of individuals currently in treatment for illicit substance use, aligned with the research aim and captured a range of perspectives and experiences. The established research base was considered and the emerging analysis appeared reflective of previous research. The quality of the dialogue was rich and detailed, with participants providing insightful and meaningful reflections. As analysis began, no additional and novel insights emerged. As such, further recruitment was deemed unnecessary as the data was adequately powered.

Procedure

An interview schedule was developed by the research team (Appendix H). Questions were open-ended to encourage free expression and covered two broad areas; the experience of the drug death crisis and perspectives on harm reduction strategies. The interview schedule was reviewed by a panel of peer support workers with lived experience of addiction to ensure the relevance and clarity of questions. They provided consultation, feedback, and approval.

Prior to the interview, participants had a phone information-sharing session with CD, during which details about the research and eligibility criteria were explained. Participants had the opportunity to ask questions, and those who wished received a copy of the project information sheet (Appendix H) via email prior to their interview. An interview date was scheduled at least two weeks after the initial phone contact to allow participants time to reflect on their decision to participate.

Data was collected using semi-structured interviews which were conducted within local, and convenient to participants, health and social care partnership clinic space (e.g. GP practices and Alcohol and Drug Services). All interviews were conducted by CD. Upon attending for their interview, participants were provided with the project information sheet and written informed consent was obtained (Appendix H). Demographic information pertaining to age, gender, ethnicity, and substance use was gathered. Interviews ranged from 51 to 130 minutes (mean = 80.17 minutes) and were recorded using a digital recorder.

Upon completion of the interview, participants were debriefed, advised upon emotional self-care, and informed that a clinician from Drug and Alcohol services would follow up with a phone call to ensure their wellbeing given the potentially distressing content of the interviews. Participants were given a £20 voucher to compensate them for their time.

Ethical Considerations

It was considered that the content of the interviews may have been emotionally salient and distressing for participants. To ensure interviews are conducted safely, participants were informed that the nature of the research was to explore grief in the context of substance use which could evoke difficult emotions and memories for them. Participants were advised they could pause the interview at any point and, if they wished, reschedule. All participants coped well and did not require to do so.

After each interview, a clinician within the team (i.e. key worker or Consultant Clinical Psychologist) followed up by phone call to check on their wellbeing; no additional support was required.

To prevent participants sharing information they would not do so when not under the disinhibiting influence of substances and support emotion regulation, participants were informed prior to the interview that it would be suspended if they arrived under the influence of substances, or if it was thought substances were taking effect during the interview. There was no evidence of substance use throughout the course of any interviews.

While these ethical considerations were pertinent in the design of the study, their redundancy provides evidence that people with drug and alcohol issues are safely able to participate in research about sensitive topics.

Data Analysis

Interviews were transcribed verbatim and pseudonymised. All researchers were familiar with the transcripts; however, the analysis was primarily conducted by CD, with supervision from senior researchers and clinicians (LR and LM) who were not involved in data collection. The analysis followed the IPA protocol as outlined by Smith et al. (2022). CD first familiarised herself with the transcripts by reading them several times and making exploratory notes (Appendix I). Each transcript was individually analysed line-by-line to produce experiential statements based on descriptive, linguistic, and conceptual features. Connections across experiential statements were made to develop personal experiential themes (PETS) for each transcript. Transparency and confidence in the findings was obtained by triangulation whereby LM and LR independently coded a sample of the transcripts. The emerging PETS were discussed and reflected upon in supervision with consideration of how personal experiences and factors may present in the narratives. PETS were then organised to develop group experiential themes (GETS) which represented the experiences and perspectives of all six participants (Appendix J).

Reflexivity

This study acknowledges that participants' experiences of the drug death crisis in Scotland are subjective and shaped by personal (e.g. experience of drug death) and systemic (e.g. political response, stigma) contexts.

CD is a white, female, Trainee Clinical Psychologist with clinical experience supporting those experiencing complicated bereavement, which may have heightened her sensitivity to themes of grief and loss. She had no professional or personal experience of addiction, limiting her insight into the lived experience and its social contexts. While this likely reduced over-identification, it could have limited her understanding of the nuances and complexities of addiction.

While originally from a rural town in the West of Scotland like the participants, CD was aware that her socioeconomic background, education, and professional role may have created a power imbalance, particularly given the association between deprivation and increased DMD rates. Additionally, her role as a healthcare professional may have influenced participants to share aspects of their experiences they deemed socially acceptable or professionally relevant. To mitigate this, she used non-clinical language and emphasised her position as an external researcher.

To adopt an interpretative approach, a double hermeneutic process was employed. First, CD empathised with participants' experiences of addiction and loss. While her training in clinical psychology informed this empathetic approach during interviews, significant effort was required to bracket diagnostic and formulation frameworks as that was not the function of the interview or analysis. This was supported by identifying and noting assumptions pre-interview, avoiding leading questions, the use of reflexive journaling, and engaging in supervision. The research team then critically reflected on the experiences with attention to how systemic, cultural, and personal factors shaped the narratives. LR is a white, female, Clinical Psychologist with clinical and research expertise in addiction, and LM is a white, female, Consultant Clinical Psychologist in addiction services. Supervision from experienced clinicians and CD's reflexive journal facilitated critical examination of positionality and maintained sensitivity to assumptions and biases throughout the analysis (Appendix K).

Prior to interview, CD's assumptions were that the drug death crisis would have created an environment of fear that would be motivating in seeking and adhering to treatment. She believed that a compassionate, health-focused approach was an effective way of addressing the crisis and assumed that participants would be in support of the proposed harm reduction strategies.

Results

Four GETS were identified in relation participants' lived experience of the DMD crisis in Scotland: Relentless Loss, Impact on Drug Use, Opposing Priorities, and Connection, Stability, Support. Table 5 presents the GETS and their corresponding subthemes.

Table 5

Group Experiential Themes and Subthemes

GETS	Subthemes
Relentless Loss	Every second day
	Stigmatised and unacknowledged
Impact on Drug Use	Fear as a deterrent, but for how long?
	No worth, no fear
	Guilt and responsibility
Opposing Priorities	Seen and treated, but not heard
	Harm what?
	We wouldn't use something like that
Connection, Stability,	Community investment
Support	Recovering through relationships

Relentless Loss

This theme presents participants' experience of the unrelenting nature of the DMD crisis in Scotland and how this impacted upon them.

Every second day

Participants had all been personally bereaved by a DMD; having lost parents, partners, friends, family members, and acquaintances. They attributed these deaths to heroin overdoses, crack cocaine, excessive poly-drug use, and an aging cohort of drug users whose 'bodies are packing in' (Janie). There was a consensus amongst all participants, except Heather, that the rise and access of street diazepam to the Scottish drug market had significantly contributed to the number of deaths:

> *People love [Valium] up here, it's crazy up here, man. You know down in England, I never met anybody that took street Valiums. It was just doctor Valium. But up here it's*

really bad for benzos they call them up here… blues. Street ones but. It's not the prescription ones that are killing people, it's the street ones. That's what my mum died of, and I guaranteed she could've tanned [taken] a lot of prescription vals [Valium] and not died that night. – Jack

About 2013. From then these street diazepams came in and everyone started dropping dead. It was like every second day someone else was dead, if you were going to score someone would say like 'such and such is away'. I didn't know them all personally but I'd met them. – Janie

Janie's description presents death as becoming as routine as obtaining drugs; another name mentioned in passing, another person 'away'. The bluntness of 'dropping dead' conveys an emotional desensitisation. This linguistic framing may indicate a protective mechanism, allowing Janie to recount mass death without being overwhelmed by its emotional weight.

When Shona was asked about her experience of losing someone to a drug death she replied, 'I've not lost anyone to that' however, as her interview progressed she began to recall various friends and acquaintances who had died. This gradual realisation suggests that the constancy of drug deaths made it impossible to acknowledge and, subsequently, remember each loss. This appeared to foster desensitisation and fatalism. As Gordon described, 'you get numb to it, I thought that was just the natural progression for me'. Gordon's use of 'numb' conveys an emotional anaesthesia. The phrase 'natural progression' appears to suggest a sense of resignation, suggesting that death became an inevitable, rather than a preventable, outcome.

Stigmatised and unacknowledged

This sense of despondency from within the addiction community, appears to have been compounded by stigma from the wider community. Heather, Gordon and Janie spoke of deaths being dismissed and written off as 'just another junkie' (Janie) which appeared to minimise the value of, and dehumanise, those who had died. When Heather was asked if she shares that her aunt and cousin died from DMDs she stated, 'No. I think that's from the fear of getting judged like "oh God, what's her family like"'. Heather's imagined dialogue offers insight into her internalised stigma. Duncan described a tangible absence in the community:

It's literally a whole generation of folk that have been wiped out. It's a lot of people missing, you can see it. You can see a big dent in the population. You'd see this face at the bus stop always floating about. You'd see this person, you'd see that person. And they're just gone now. They're not there and nobody's filled their shoes. – Duncan

Duncan's use of 'wiped out' and 'dent' evoke imagery of war or catastrophic disasters. His language moves beyond personal loss into collective mourning. Janie presented a list of those she had known who had died and described, 'I've kept that for years. I might be the only person that thinks about that person'. Together, participants' reflections present a profound sense of erasure within the addiction community.

Impact on Drug Use

This theme outlines drug using responses in the context of the crisis.

Fear as a deterrent, but for how long?

For some, the experience of DMD within their social networks instilled a sense of fear. Shona found that 'drugs became dirty' as she grappled with the reality of 'death or get sober'. Heather described that the death of her aunt and cousin to DMDs deterred her from ever using illegal substances. Janie detailed how the deaths led to her adopting safer strategies:

> *When I realised the amount of people dropping dead from those street diazepam I never used that again. I was more aware of what I was using, it shocked me to see that many people, it was one after the other, after the other. I didn't want to die like that. I did not want to die a diazepam death. – Janie*

Janie's determination to avoid a 'diazepam death' emphasises how fear and trauma encouraged her to use more safely. Importantly, for Janie and Shona, fear alone was insufficient in fostering long-term recovery. They both described being supported to access services by family members and having children which appeared to be a motivating influence:

> *I didn't want to let anyone down. And then I contacted services 'cause I didn't want to feel like that anymore. And I didn't want my kids coming back to a junkie. If they choose to come back – Shona.*

This is contrasted to Duncan's experience. After his best friend died from an overdose 15 years ago he 'started to take the stopping part more serious, I made more of an effort every time I tried to stop'. However, at time of interview Duncan was still grappling with active addiction and a few weeks prior had been in a coma following an overdose. This suggests that while shock and grief may be a temporary deterrent, on its own it is insufficient in supporting long-term recovery. As the emotional response dissipates, drug use reasserts itself.

No worth, no fear

For others, the DMD crisis had no impact upon their drug use. As Gordon described, 'you've got a fear that death is round the corner, but it doesn't bother you', reflecting that the

imminence of death coexists with a sense of indifference. This appears to stem from desensitisation to death, and diminished self-worth; 'I just felt worthless. And like no one loved me. And who gives a fuck if I die. I'm just a burden on them' (Jack). Or, the overpowering nature of addiction:

> *But that's the drug in you, the addiction in you, lies to you. I've been there, you'll sit there all day long arguing something is white when it's black, it speaks to you and argues with you. – Gordon.*

> *Deep down I used to say that could've been me. But I'll go get another tenner bag anyway. Cause that's the illness saying to you, "it doesn't matter, I need this and that's it". It's quite crazy how it can… it's just in your head, it's too strong in there, man. – Jack.*

Jack and Gordon's reflections highlight the powerful grip of addiction, and present addiction as a different entity, one that they are battling. They struggle with a deep internal conflict; recognising that they could meet the same fate as others, yet feeling powerless against the need to use. Or, perhaps, suppressed that fear by using drugs.

Guilt and responsibility

When drug deaths were associated with feelings of guilt, self-blame or acute grief; this led to a significant increase in drug use in an attempt to regulate the intensity of the emotion, or block out distressing thoughts, feelings and memories. Jack shared the impact of finding his mum dead from an overdose:

> *It was devastating. And feeling guilty about it 'cause you were with them the night before using drugs with them. And the next thing you wake up and you notice the time and your mums not up and usually she's up at the crack of dawn, and then you go into the living room and she's lying on the mattress with her eyes wide open staring at you. When I used to think about it I'd be like "I'm going to get a few whiskeys and a bit of smack 'cause my mum's in my head, man". I'd be thinking about it, "what if I never went there that night? Would she still be here?" I blamed myself so I tanned [took] drugs and drank alcohol. – Jack*

Jack's recounting of his mum's death in the third person creates a sense of distancing between himself and the devastating impact. The simplicity of 'I blamed myself so I tanned drugs' appears to dilute the intensity of the emotional pain underneath. His use of 'tanned' suggests urgent and, perhaps, reckless substance use in an attempt to cope with the profound emotional

burden of guilt and self-blame. His feelings of responsibility for his mum's death, and the traumatic nature in which she died, appear to have fuelled his drug use in an attempt cope.

Gordon described trying to grieve for his partner:

> *I grieved a bit. And… it was horrible. I was losing the person and got all guilt and I've had to work through that in my own head and with [psychologist] 'cause I'm more prone to going to Valium than other drugs and I don't want that route. The coping things she gives me, the breathing techniques they actually do work! I used to rubbish it! (..) That's a newer way of coping. I just used to blank it and put it to the back of my head but always when I got in a state I used to sit and think about that and guilt would set in. – Gordon*
>
> *Interviewer: Really heavy emotions.*
>
> *Aye, especially when you don't know how to deal with emotions (…) I knew how they made them [street diazepam] and what went in them, I'd still have taken them. – Gordon*

Gordon's description highlights how the intensity of the emotions and requirement to regulate them over rode any regard of the dangers associated with street diazepam. He also highlights the complex relationship between grief, guilt, and drug use; and the ongoing battle despite having been in recovery from illicit drug use for eight years.

Opposing Priorities

This theme outlines participants' experiences of recovery and what is important to them when accessing addiction services.

Seen and treated, but not heard

Participants reflected upon the stress of navigating services that were underfunded and inadequately supported. Gordon described his experience of a rotating staff team:

> *I saw nine different psychiatrists in the space of a year. And every time I would go to one I would tell them all about my problems and then the next week it'd be a new one and I'd need to do it all again, and again, and again. I don't know how many times I cracked up! And that got put down to me, "you've got an anger problem". – Gordon*

Gordon's account illustrates his attempt to make sense of how his interactions with services impact upon his emotion regulation. The revolving door of professionals led to frustration and feelings of being unheard and devalued. His distress was labelled as an 'anger problem' as

opposed to being understood as a consequence of systemic failure. Without consistency, stability, and a personal relationship, Gordon felt dismissed and distressed. Heather reflected, 'when I hear on the radio about all these drug deaths, I wondered how many of them came to a service like this and just gave up because it was so chaotic', suggesting that fragmented care may contribute to disengagement.

Janie described that those in active addiction 'should be heard and their pain and suffering acknowledged and not just put down to the fact they use drugs'. This suggests that distress may be reduced to drug use; with the underlying emotional or psychological pain remaining unacknowledged. There was a sense that this resulted in interventions directly related to drug use being prioritised:

> *In [Scottish town] they were rushed off their feet. Sometimes my drug worker would come meet me at the front of the building, give me my script and I could go. That's no good, man. You're going to use if you can't get in a room and talk to somebody and get all your feelings and emotions out. Cause if you don't get your feelings out you'll use more drugs to dull those feelings. – Jack*

Jack describes how quickly receiving a prescription without meaningful interaction left him feeling unsupported, increasing the likelihood of using drugs as a coping mechanism. He went on to describe the transformative impact of genuine and attentive support:

> *[drug worker] will listen to me. I can tell she really cares. It's really good to have her. I've not touched drugs since I met her! It's as if deep down she really cares. And you can tell she's always listening, "if you ever need anything give me a phone". I appreciate that. – Jack*

Having a worker who truly listened and cared made a significant difference in Jack's ability to stop using drugs. While medical interventions are vital; the prioritisation of such may result in the importance of meaningful connection and conversations being overlooked. For Jack, this was more powerful and restorative than receiving his methadone script. Gordon echoed this sentiment: 'it's mental health, not just a drug problem'.

Harm what?

Overwhelmingly, there was a lack of interest, awareness or support of harm reduction strategies. Heather who had been addicted to prescription codeine and had never consumed street drugs expressed support for these measures: 'I think the safe consumption rooms are amazing'. This perspective stood in stark contrast to the other participants who had been addicted to street drugs such as heroin, street diazepam, and crack cocaine. They thought safe

consumption rooms were ‘terrible’ (Gordon). There was notable confusion regarding the legality of carrying drugs versus being permitted to consume them within a safe consumption room which evoked a sense of wariness and the perception that they were punitive:

> *I’d use it if the police would back off us. There’d need to be an agreement with the coppers cause there’d be no point if they were just going to take the drugs off us. – Duncan*

Jack and Gordon felt that they ‘encouraged’ (Gordon) drug use:

> *I think that’s a bad idea because it gives someone an excuse to use drugs. Say their mum doesn’t want him using in the house, then he’s got somewhere to go and take them, I think that’s a bad idea. – Jack*

When offered the perspective that these spaces provide a safer alternative to street use, Jack remained unconvinced:

> *But what gets me is they could overdose in that room, it doesn’t make sense to me. Does it matter if someone dies on the pavement or in that room? – Jack*

Jack’s question suggests a profound sense of worthlessness. It suggests that death, and therefore life, is somewhat invaluable and inconsequential. The binary ‘pavement or in that room’ removes dignity from death and conveys a sense that Jack’s perspective is one in which saving lives is futile. It also appears that Jack is not aware that overdosing within a safe consumption room means there is a decreased likelihood of death, as staff are available to intervene.

We wouldn’t use something like that

There also emerged a sense that participants perceived harm reduction to be more appropriate for recreational drug users. Jack described the differences he had noticed between himself and the people that would test their drugs to make sure they were safe:

> *I’ve seen other countries do it on a bus and they can test their MDMA and that ‘cause they’re going raving with their pals. They should do that. [But] some people just don’t care about their lives, man. Some people think they’re worthless. You get certain people, they’re like hippies, they love drugs, right? But they can take as many drugs as they like and then stay off it for a few months. They would use something like that, so they know what they’re taking. – Jack*

When asked what distinguishes these groups, Jack responded:

They've got a job, they've not got time to use all day. They've got kids. A life. - Jack

Jack's insights suggest that the inclination to engage in harm reduction is linked to stability, care giving and receiving, self-worth, and a sense of purpose. It appears, from his perspective, when these supports are in place drug control is an effortless endeavour. There is a sense that the acquisition of these supports is the scaffold towards safer consumption. In the absence of these, the inclination for Jack to protect his life is diminished.

Janie expressed her frustration regarding drug checking services:

> *They're mixing it for a reason! And buying it cheaper because it's all they can afford, buying it cheaper 'cause they know it's mixed and bulked out with something. People are aware, they're not that daft! They're not gonna go and test that, they don't know what they're taking but they know they're paying less money so it's not proper stuff. – Janie*

Janie's account highlights a disconnection between the function of drug checking services, to ensure drugs have not been contaminated, versus the reality of addiction – consuming drugs with the knowledge they have likely been mixed with other substances. Her tone appears to convey frustration, 'they're not that daft!', and may be an attempt to challenge assumptions regarding the ignorance of people who use drugs.

Connection, Stability, Support

This theme highlights the profound impact a sense of purpose, stability, and meaningful relationships had on participants.

Community investment

All participants' shared the belief that recovery was supported by stability, a sense of purpose, and being connected to others. Duncan reflected; 'if I was working I didn't have time for all this [using]'. For Gordon, his recovery had been supported by relationships and acquiring a trade. That is where he believed change would occur:

> *If I had my way I'd have a community centre for all the kids with different sections. Art, music, building stuff, getting a trade, trying to get them into college. Cause that's the only way things will change. – Gordon*

Some participants emphasised the importance of funding services that address social and economic deprivation contributing to drug use, rather than into harm reduction strategies: 'Firing this money into safe injecting booths. No. Put this money into services. Into the

community' (Janie). Janie advocates for investment in broader social and community based services. She calls for a shift towards addressing underlying causes of drug use; such as economic deprivation, lack of opportunity, and social isolation. From Janie's perspective, harm reduction functions as a cosmetic solution to a deeply systemic issue.

Recovering through relationships

All participants, except Duncan, were currently in recovery from illicit drug use (with the exception of cannabis for one participant). When asked what had supported them to do so, they all outlined the personal relationships in their life. Participants spoke of partners, children, family members, and community members as supporting their recovery:

> *My husband and my son are the most important and they are the people that have kept me going – sorry (crying). I don't know where I would be without my husband. I've still got my dad but he has his own addiction problems so he's very chaotic. But my main focus is my husband and son. – Heather*

Heather's account appears to suggest that the consistency her husband and son provide is a stabilising influence with regard to her drug use and recovery. She contrasts this to her dad, who struggles to be a consistent support due to his own addiction difficulties.

What was more subtle in the narratives, yet emerged as a powerful and important theme, was the role that workers could play in supporting recovery. Jack tracked his timeline of recovery to that of being supported by his drug worker, and Gordon reflected that the work with his psychologist had supported him to develop coping strategies which diminished his reliance on drugs. Duncan reflected upon a period of recovery throughout his life:

> *I used to work with this lad, I think it was after he went on [extended] leave I started taking drugs again, (pause) it was kind of weird. He's the only one I've taken seriously and not lied to. He was really involved and would go out his way to make sure you were sorted. He was unbelievable. I could confide in him. He took me seriously. I took him seriously. The whole time I was with him I didn't take any drugs, for two years! He knew I could do it, so I just wanted to show him I guess. – Duncan*

Overwhelmingly, when all participants were in receipt of some form of caring, supportive, consistent relationship, whether that be professional or personal, they had better control over their drug use.

Discussion

This research has amplified the voices of six individuals 'inside' Scotland's drug death crisis. Four GETS were identified: Relentless Loss, Impact on Drug Use, Opposing Priorities, and Connection, Stability, Support. Their insights and perspectives offer an invaluable contribution to our understanding of the DMD crisis and provide avenues from which the national response can be enhanced to meet the needs of those most impacted.

A Grieving Community

Our findings present a grieving community. Participants' social networks were replete with drug deaths, yet these losses were routinely disregarded and dismissed by wider society. They contended with the 'double stigma' as identified by O'Callaghan and Lambert (2024b): grieving stigmatised deaths while being situated within a stigmatised group. Within our study, the societal disregard appeared to become internalised, further eroding self-worth. For some participants, the disenfranchisement of grief appeared to instil a sense of fatalism and emotional detachment. This may have emerged as a coping mechanism, allowing individuals to navigate an environment saturated with death, grief, and trauma without being entirely consumed by it.

As per previous research (Schlosser & Hoffer, 2022), we found that this sense of fatalism, rooted in grief, stigma and diminished self-worth, appeared to erode the inclination to engage with harm reduction strategies. Participants did not appear to consider death as something that could be actively avoided, nor did they perceive harm reduction to intervene upon the fundamental barriers to recovery such as self-worth, stability, and meaningful relationships. The persistence of DMD rates despite the introduction and expansion of harm reduction efforts in Scotland suggests an overlooked critical factor: the interplay between grief, self-worth, and continued drug use. The convergence of this finding with international evidence (Schlosser & Hoffer, 2022) suggests that without addressing these underlying psychological and social barriers, harm reduction alone cannot mitigate DMD crises.

Our findings align with previous research identifying that some individuals adopted safer practices in response to DMD (Macmadu et al., 2020; Schlosser & Hoffer, 2022). However, an important distinction emerged in the analysis: while the loss of peers and acquaintances instilled caution, the death of a significant other elicited an acute grief response which led to increased drug use. This aligns with, and strengthens, the growing evidence base identifying increased drug use as a grief response for people who use drugs (Macmadu et al., 2022; O'Callaghan & Lambert, 2024b; Schlosser & Hoffer, 2022; Selseng et al., 2023).

From this, the research base is converging to suggest that grief may be a maintaining mechanism of DMD crises. This has important implications given the sociality of addiction and

the estimate that for every drug death at least 10 individuals are bereaved (Dyregrov et al., 2020). As such, people with addiction in Scotland are highly likely to be grieving a drug death and coping with their grief using substances. This finding presents a crucial intervention point: urgent and responsive grief support for people who use drugs and experience a DMD of a significant other.

Unmet Emotional Needs

Further to this, when accessing and interacting with services participants found themselves situated as a drug user rather than as a person grappling with traumatic and painful experiences. Concurrently, staff working in addiction services face ongoing significant systemic stress as they contend with political expectations and public scrutiny (Mental Welfare Commission, 2023), their own grief responses at the loss of service users (O'Callaghan & Lambert, 2024a), and real term disinvestment from government (Audit Scotland, 2024). This results in a prioritisation of medical intervention; perhaps driven by the perception that this will reduce the risk and numbers of DMD. However, focusing on risk management results in emotional pain being unacknowledged and invalidated; contributing to further distress. A whole systems approach is required, from government to front line services, to acknowledge, validate, and address the grief experiences of the addiction and recovery community.

The prioritisation of drug treatment over emotional wellbeing, and the associated pitfalls, is an emerging trend in the literature (O'Callaghan & Lambert, 2024b; Schlosser & Hoffer, 2022; Selseng et al. 2023; Selseng et al., 2024). Participants in our study, and in previous research, consistently emphasise the importance of meaningful and supportive interactions with workers as being a key mechanism that supports their recovery. Ultimately, reducing their risk of DMD. Such interventions need not be complex or resource intensive; alongside harm reduction, individuals accessing addiction services require opportunities to talk about their emotional pain.

This recommendation is made with acknowledgement that individuals with drug and alcohol difficulties often struggle to find the language to articulate their emotional pain and grief, leaving staff unaware of the need for support (Selseng et al., 2024). Additionally, emotional detachment may manifest as incongruence which can be difficult for staff to make sense of and empathise with (Memarnia et al., 2015). During this study, some participants shared stories of distressing experiences without observable affect and there could be challenges in accessing the emotional impact of experiences. This highlights the importance of training in trauma-informed approaches to help staff recognise the varied impact of such experiences, and respond in ways that promote healing and recovery through connection and healthy professional relationships.

We also uncovered a gender split regarding the adoption of safer drug using practices in the context of DMD that has not yet been documented in the research. Within our study, women described adopting safer practices, such as avoiding substances they perceived as contributing to the deaths or seeking support from services, this response was not observed among male participants. This is noteworthy when considered alongside the data indicating that women's likelihood of dying from a DMD has increased at a significantly faster rate than men's (Tweed et al., 2022). Within the current analysis, there were indications that motherhood was a stabilising and motivating factor; contributing to both initial and long-term recovery. This has long been postulated in the literature (Roberts, 1999; Tweed et al., 2022) and our findings indicate that the national response, and its emphasis on harm reduction, may overlook the social and relational contexts of recovery.

Clinical Implications

This research has significant implications regarding service delivery and ongoing policy development. The grief experienced by individuals in addiction treatment, particularly bereavement caused by DMD, can be viewed as a complex, ongoing psychological process that may be influential in treatment and recovery outcomes. Grief from DMD appears to exacerbate emotional pain and increase the reliance on substances to cope. Clinicians in drug and alcohol services should be trained to recognise grief and provide appropriate emotional support. A holistic approach that integrates emotional support with drug treatment was valued by participants and, within the current study, promoted positive recovery outcomes.

The unmet emotional needs identified in this research, including the need for compassionate and continuous relationships with workers, should be considered a key component of service delivery. Services require support in facilitating relational continuity to support recovery outcomes. Indeed, one of the most critical findings from this research is the role of meaningful and attentive relationships. Participants consistently emphasised that recovery from drugs, and subsequently the DMD crisis, is dependent upon social and relational supports. They repeatedly called for community investment, increased vocational and educational opportunities, and consistent, long-term relationships with workers. Addressing these factors through policy reform and redistribution of funding streams is essential to disrupt the drivers of the DMD crisis.

Strengths, Limitations, and Future Directions

This is the first study conducted in a rural setting, offering critical insights into a community experiencing increased social isolation and economic deprivation (Eiser et al., 2022). Our findings are consistent with the research conducted in urban settings (Macmadu et al., 2020;

O'Callaghan & Lambert, 2024b; Schlosser & Hoffer, 2022; Selseng et al., 2023; Selseng et al., 2024) indicating that the challenges experienced by people who use drugs in the context of DMD crises, such as stigma, grief, and barriers to support, can be generalised across the addiction experience and geographical contexts. Additionally, although the sample was representative of the rural population in which the research was conducted, further research should examine how experiences of DMD within the context of addiction intersect with other structural vulnerabilities, such as being part of an ethnic minority group.

While this research provides valuable insights into the experiences of individuals in addiction treatment, the recruitment strategy is biased to those who were motivated to participate. The perspectives of those who have not yet accessed services, potentially the most vulnerable group, remain underrepresented. Future research should prioritise engaging these individuals to develop a more comprehensive understanding of barriers to service access and intervention needs.

Our finding that men and women adopted different responses following drug death strengthens the existing hypothesis that there are gender differences in substance-related epidemiology (Tuchman, 2010). It also contributes to a re-balancing of the male dominated research within the addiction literature (Crawford et al., 2023). Future research may wish to investigate how protective factors can be extrapolated and harnessed in intervention delivery.

The theme of community investment is less developed than others due to the study's focus on individual experiences of the DMD crisis and service responses. Exploring community interventions was beyond the intended scope of this research however, participants consistently highlighted the importance of resourced and connected communities in supporting sustained recovery. Future research should examine the role of community investment in addressing the underlying social determinants of DMD.

A final important finding is regarding participation. People with drug use difficulties have long been excluded from research due to concerns regarding capacity to consent and the perceived risk of destabilising recovery or drug use (Crawford et al., 2023; Finnegan & O'Donoghue, 2017). During the conception of this project, considerable thought was given to how participation could be supported (e.g. encouraging engagement, barriers to interview attendance, ensuring informed consent, check-in phone calls and signposting pathways, protocols for the use of substances during interview). The minimal need for additional support measures and ease of recruitment provides evidence that vulnerable groups can, and want to, participate in research. This challenges assumptions regarding the capacity of people who use drugs to engage in and cope with research. Post interview reflections emphasised how

participants valued the opportunity to share their stories, reinforcing existing literature on the empowering potential of research participation (Crawford et al., 2023).

Conclusion

While statistics conveying the scale of Scotland's drug death crisis are well documented in literature, media, and guiding policy, this study is the first to provide empirical evidence of the profound impact upon the addiction and recovery community. The stories shared offer an understanding, beyond numerical data, illuminating the lived and living experiences of those affected. Participants highlight the importance of interventions that go beyond drug treatment, to meet their emotional and relationship needs. When they were supported by caring and consistent relationships, either professional or personal, they had better control over their drug use; reducing their risk of DMD. It may be that the very access to these relationships is the reason for which they were able to participate in this research; having so far survived the crisis.

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Appendices

Appendix A

ENTREQ Checklist

No	Item	Guide and Description	Page Reported
1	Aim	State the research question the synthesis addresses.	13
2	Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology *(e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).*	20
3	Approach to searching	Indicate whether the search was pre-planned (*comprehensive search strategies to seek all available studies)* or iterative (*to seek all available concepts until they theoretical saturation is achieved).*	13
4	Inclusion criteria	Specify the inclusion/exclusion criteria *(e.g. in terms of population, language, year limits, type of publication, study type).*	13
5	Data sources	Describe the information sources used (e.g. *electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists)* and when the searches conducted; provide the rationale for using the data sources.	13
6	Electronic Search strategy	Describe the literature search *(e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits).*	13
7	Study screening methods	Describe the process of study screening and sifting *(e.g. title, abstract and full text review, number of independent reviewers who screened studies).*	14
8	Study characteristics	Present the characteristics of the included studies *(e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).*	16
9	Study selection results	Identify the number of studies screened and provide reasons for study exclusion *(e,g, for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications t the research question and/or contribution to theory development).*	15

10	Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings *(e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).*	20
11	Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings *(e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope* [25]*; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).*	16
12	Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.	20
13	Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.	22
14	Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? *(e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software).*	20
15	Software	State the computer software used, if any.	20
16	Number of reviewers	Identify who was involved in coding and analysis.	20
17	Coding	Describe the process for coding of data *(e.g. line by line coding to search for concepts).*	20
18	Study comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).	20
19	Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.	20
20	Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation.	24-29
21	Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).	30-33

Appendix B

Search Strategy

MEDLINE

1. Drug Users/ or Alcoholics/
2. exp Substance-Related Disorders/
3. Alcoholism/
4. (alcoholi* or amphetamine* or "drug use" or "drug abuse" or polydrug or "illicit substance" or cannabis or cocaine or heroin or opioid* or methamphetamine* or narcotic* or fentanyl or (benzo* adj2 abuse) or addict*).ab,ti.
5. 1 or 2 or 3 or 4
6. exp Bereavement/
7. exp Parental Death/ or exp Death, Sudden/ or exp Infant Death/
8. (grief or grieve or grieving or bereave* or mourn* or "ambiguous loss" or (loss adj2 parent*) or (loss adj2 child*) or (loss adj2 baby) or (loss adj2 peer) or (loss adj2 friend) or (remov* adj2 child*)).ab,ti.
9. 6 or 7 or 8
10. exp Qualitative Research/
11. (qualitative or ethnograph* or "grounded theory" or phenomenology* or "thematic analysis" or "content analysis" or narrative or interview* or "focus group*" or naturalistic* or IPA or lived experience*).ab,ti.
12. 10 or 11
13. 5 and 9 and 12

EMBASE

1. "Drug Users"/ OR Alcoholics/
2. exp "Substance-Related Disorders"/
3. Alcoholism/
4. (alcoholi* OR amphetamine* OR "drug use" OR "drug abuse" OR polydrug OR "illicit substance" OR cannabis OR cocaine OR heroin OR opioid* OR methamphetamine* OR narcotic* OR fentanyl OR (benzo* ADJ2 abuse) OR addict*).tw.
5. 1 OR 2 OR 3 OR 4
6. exp Bereavement/
7. exp "Parental Death"/ OR exp "Death, Sudden"/ OR exp "Infant Death"/
8. (grief OR grieve OR grieving OR bereave* OR mourn* OR "ambiguous loss" OR (loss ADJ2 parent*) OR (loss ADJ2 child*) OR (loss ADJ2 baby) OR (loss ADJ2 peer) OR (loss ADJ2 friend) OR (remov* ADJ2 child*)).tw.
9. 6 OR 7 OR 8
10. exp "Qualitative Research"/
11. (qualitative OR ethnograph* OR "grounded theory" OR phenomenology* OR "thematic analysis" OR "content analysis" OR narrative OR interview* OR "focus group*" OR naturalistic* OR IPA OR "lived experience*").tw.
12. 10 OR 11
13. 5 AND 9 AND 12

APA PsychInfo

1. “Drug Users”/ OR Alcoholics/
2. exp “Substance Use Disorders”/
3. Alcoholism/
4. (alcoholi*.ti,ab. OR amphetamine*.ti,ab. OR “drug use”.ti,ab. OR “drug abuse”.ti,ab. OR polydrug.ti,ab. OR “illicit substance”.ti,ab. OR cannabis.ti,ab. OR cocaine.ti,ab. OR heroin.ti,ab. OR opioid*.ti,ab. OR methamphetamine*.ti,ab. OR narcotic*.ti,ab. OR fentanyl.ti,ab. OR (benzo*.ti,ab. ADJ2 abuse.ti,ab.) OR addict*.ti,ab.)
5. 1 OR 2 OR 3 OR 4
6. exp Bereavement/
7. exp “Parental Death”/ OR exp “Death, Sudden”/ OR exp “Infant Death”/
8. (grief.ti,ab. OR grieve.ti,ab. OR grieving.ti,ab. OR bereave*.ti,ab. OR mourn*.ti,ab. OR “ambiguous loss”.ti,ab. OR (loss.ti,ab. ADJ2 parent*.ti,ab.) OR (loss.ti,ab. ADJ2 child*.ti,ab.) OR (loss.ti,ab. ADJ2 baby.ti,ab.) OR (loss.ti,ab. ADJ2 peer.ti,ab.) OR (loss.ti,ab. ADJ2 friend.ti,ab.) OR (remov*.ti,ab. ADJ2 child*.ti,ab.))
9. 6 OR 7 OR 8
10. exp “Qualitative Research”/
11. (qualitative.ti,ab. OR ethnograph*.ti,ab. OR “grounded theory”.ti,ab. OR phenomenology*.ti,ab. OR “thematic analysis”.ti,ab. OR “content analysis”.ti,ab. OR narrative.ti,ab. OR interview*.ti,ab. OR “focus group*”.ti,ab. OR naturalistic*.ti,ab. OR IPA.ti,ab. OR “lived experience*”.ti,ab.)
12. 10 OR 11
13. 5 AND 9 AND 12

CINAHL

1. (MH “Persons with Substance Use Disorders+”)
2. ((TI alcoholi* OR AB alcoholi*) OR (TI amphetamine* OR AB amphetamine*) OR (TI “drug use” OR AB “drug use”) OR (TI “drug abuse” OR AB “drug abuse”) OR (TI polydrug OR AB polydrug) OR (TI “illicit substance” OR AB “illicit substance”) OR (TI cannabis OR AB cannabis) OR (TI cocaine OR AB cocaine) OR (TI heroin OR AB heroin) OR (TI opioid* OR AB opioid*) OR (TI methamphetamine* OR AB methamphetamine*) OR (TI narcotic* OR AB narcotic*) OR (TI fentanyl OR AB fentanyl) OR ((TI benzo* OR AB benzo*) N2 (TI abuse OR AB abuse)) OR (TI addict* OR AB addict*))
3. s1 or s2
4. (MH Bereavement+)
5. (MH “Parental Death+”) OR (MH “Death, Sudden+”) OR (MH “Infant Death+”)
6. ((TI grief OR AB grief) OR (TI grieve OR AB grieve) OR (TI grieving OR AB grieving) OR (TI bereave* OR AB bereave*) OR (TI mourn* OR AB mourn*) OR (TI “ambiguous loss” OR AB “ambiguous loss”) OR ((TI loss OR AB loss) N2 (TI parent* OR AB parent*)) OR ((TI loss OR AB loss) N2 (TI child* OR AB child*)) OR ((TI loss OR AB loss) N2 (TI baby OR AB baby)) OR ((TI loss OR AB loss) N2 (TI peer OR AB peer)) OR ((TI loss OR AB loss) N2 (TI friend OR AB friend)) OR ((TI remov* OR AB remov*) N2 (TI child* OR AB child*)))
7. s4 or s5 or s6
8. (MH “Qualitative Studies+”)
9. ((TI qualitative OR AB qualitative) OR (TI ethnograph* OR AB ethnograph*) OR (TI “grounded theory” OR AB “grounded theory”) OR (TI phenomenology* OR AB phenomenology*) OR (TI “thematic analysis” OR AB “thematic analysis”) OR (TI “content analysis” OR AB “content analysis”) OR (TI narrative OR AB narrative) OR

(TI interview* OR AB interview*) OR (TI “focus group*” OR AB “focus group*”) OR (TI naturalistic* OR AB naturalistic*) OR (TI IPA OR AB IPA) OR (TI “lived experience*” OR AB “lived experience*”))

10. s8 or s9
11. S3 AND S7 AND S1

Appendix C
CASP Quality Assessment

First Author (year)	Aim	Method	Design	Recruit	Data Collect	Research Role	Ethics	Analysis	Findings	Value	Global Score	Quality rating
Creighton (2016)	1	1	1	1	1	0.5	1	1	1	1	9.5	High
Daniulaityte (2011)	1	1	1	1	1	0.5	1	1	1	1	9.5	High
Ehrmin (2002)	1	1	1	0.5	1	1	1	0	1	1	8.5	Moderate
Etherington (2007)	1	1	1	0.5	1	1	1	1	1	0.5	9	High
Janzen (2016)*	1	1	1	1	1	0.5	1	1	1	1	9.5	High
Grundetjern (2018)	1	1	1	1	1	0.5	1	1	1	1	9.5	High
Kelly (2021)	1	1	1	1	1	0.5	1	0	1	1	8.5	Moderate
Kenny (2015)*	1	1	1	1	1	0.5	1	1	1	1	9.5	High
Lamonica (2020)*	1	1	1	1	1	0.5	1	1	1	1	9.5	High

Macmadu (2022)	1	1	1	1	1	0.5	1	1	1	1	10	High
O'Callaghan (2024)*	1	1	1	1	1	1	1	1	1	1	10	High
Roberts (1999)	1	1	1	1	1	0.5	0.5	1	1	1	9	High
Russell (2025)	1	1	1	1	1	1	1	1	1	1	10	High
Schlosser (2022)*	1	1	1	1	1	0	0.5	1	1	1	8.5	Moderate
Selseng (2023)	1	1	1	1	1	0	0.5	0.5	1	1	8	Moderate
Selseng (2024)	1	1	1	1	1	0.5	1	1	1	1	9.5	High
Smith (2009)	1	1	1	1	1	0.5	1	1	1	1	9.5	High
Wojtkowiak (2019)	1	1	1	1	1	0	1	0.5	1	0.5	8	Moderate

*studies co-rated.

Scoring key: 9-10 (High), 7.5-9 (Moderate), below 7.5 (Low), exclude scores below 6.

Appendix D

Prevalence of Themes and Subthemes Across Studies

First Author	Creighton	Daniulaiyte	Ehrmin	Etherington	Grundetjern	Janzen	Kelly	Kenny	Lamondia	Macmadu	O'Callaghan	Roberts	Russell	Schlosser	Selseng 2023	Selseng 2024	Smith	Wojtkowiak
Locked in Loss and Addiction	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Intrinsically Interwoven	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Regulate, escape, avoid	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x
Fear based changes										x	x			x	x			
But how could I stop?	x			x		x	x	x			x	x			x	x		
Defeated and Defended	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Disenfranchised		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Addiction overshadows grief	x										x	x	x	x		x		
Avoidance disrupts help seeking	x				x						x	x	x	x		x		x
Routes to Recovery	x	x		x		x	x	x	x	x		x	x	x	x	x		
Concern for others				x					x	x		x		x	x			
Care, support and purpose	x	x		x		x	x	x	x	x		x	x			x		

Appendix E
COREQ Checklist

Item No	Guide Questions/Description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/ facilitator	Which author/s conducted the interview or focus group?	50
2. Credentials	What were the researcher's credentials? E.g., PhD, MD	Title page
3. Occupation	What was their occupation at the time of the study?	51
4. Gender	Was the researcher male or female?	51
5. Experience and training	What experience or training did the researcher have?	51
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	50
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research?	50
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	51-52
2 Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	47
Participant selection		
10. Sampling	How were participants selected? e.g., purposive, convenience, consecutive, snowball	47-48
11. Method of approach	How were participants approached? e.g., face-to-face, telephone, mail, email	47-48
12. Sample size	How many participants were in the study?	48
13. Non-participation Setting	How many people refused to participate or dropped out? Reasons?	48
14. Setting of data collection	Where was the data collected? e.g., home, clinic, workplace	50
15. Presence of nonparticipants	Was anyone else present besides the participants and researchers?	50
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	49
Data collection 48-49		
17. Interview guide	Were questions, prompts, and guides provided by the authors? Was it pilot tested?	49-50
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	50
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	50

Item No	Guide Questions/Description	Reported on Page #
20. Field notes	Were field notes made during and/or after the interview or focus group?	52
21. Duration	What was the duration of the interviews or focus group?	50
22. Data saturation	Was data saturation discussed?	49
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	No.
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	51
25. Description of the coding tree	Did the authors provide a description of the coding tree?	51
26. Derivation of themes	Were themes identified in advance or derived from the data?	51
27. Software	What software, if applicable, was used to manage the data?	N/A
28. Participant checking	Did participants provide feedback on the findings?	Participants will receive a copy of findings post-viva.
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g., participant number	53-60
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Yes.
31. Clarity of major themes	Were major themes clearly presented in the findings?	61-65
32. Clarity of minor themes	Is there a description of diverse cases or a discussion of minor themes?	61-65

Appendix F
Ethical Approval Process

Approval Letter 1: approved with conditions

NHS
Health Research Authority

South West - Central Bristol Research Ethics Committee
2 Redman Place
Stratford
LONDON
E20 1JQ

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

04 June 2024

Dr Lynda Russell
Lecturer in Clinical Psychology
University of Glasgow
Clarice Pears Building
90 Byres Road
G12 8TA

Dear Dr Russell

Study title:	**Exploring the perceptions of drug related deaths and methods of harm reduction amongst individuals with lived experience of drug use**
REC reference:	**24/SW/0068**
IRAS project ID:	**337213**

The Research Ethics Committee (REC) reviewed the above application at the meeting held on 31 May 2024. Thank you for attending to discuss the application.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below. .

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Number	Condition	Response from the applicant
1.	The Committee request incorporating an identity verifier for the participants, by asking them to provide a form of ID at the interview stage.	
2.	The Committee made a request for Lynda Russell to update her GCP training.	

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a public registry before the first participant is recruited and no later than six weeks after. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device

- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

A 'public registry' means any registry on the WHO list of primary registries or the ICMJE list of registries provided the registry facilitates public access to information about the UK trial.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

Where a deferral is agreed we expect the sponsor to publish a minimal record on a publicly accessible registry. When the deferral period ends, the sponsor should publish the full record on the same registry, to fulfil the condition of the REC favourable opinion.

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Where the study is registered on ClinicalTrials.gov, please inform deferrals@hra.nhs.uk and the Research Ethics Committee (REC) which issued the final ethical opinion so that our records can be updated.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter. Where a deferral is agreed, a minimum research summary will still be published in the research summaries database. At the end of the deferral period, we will publish the full research summary.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: Research summaries - Health Research Authority (hra.nhs.uk)

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland)being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Poster to invite]	2	18 April 2024
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor insurance]		14 July 2023
GP/consultant information sheets or letters [Information for staff team about project]	3	09 February 2024
Interview schedules or topic guides for participants [Interview schedule]	4	26 February 2024
IRAS Application Form [IRAS_Form_30042024]		30 April 2024
Non-validated questionnaire [Demographic questionnaire]	4	01 April 2024
Participant consent form [Consent form]	5	18 April 2024
Participant information sheet (PIS) [Participant information about study sheet]	4	18 April 2024
Participant information sheet (PIS) [Privacy notice]	2	05 April 2024
Research protocol or project proposal [Research protocol]	4	18 April 2024
Summary CV for Chief Investigator (CI) [CV for chief investigator]		26 April 2024
Summary CV for student [student cv]		26 April 2024
Summary CV for supervisor (student research) [supervisor cv]		26 April 2024
Summary, synopsis or diagram (flowchart) of protocol in non technical language [lay summary]	4	18 April 2024

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS project ID: 337213	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

Dr Julie Woodley
Chair

E-mail: centralbristol.rec@hra.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

"After ethical review – guidance for researchers" [SL-AR2 for other studies]
After ethical review guidance for sponsors and investigators – Non CTIMP Standard Conditions of Approval]

Copy to: Ms Shirley Mitchell
Lead Nation: England: approvals@hra.nhs.uk

Email correspondence

Cc: Shirley Mitchell <Shirley.Mitchell@glasgow.ac.uk>; gram.nrspcc@nhs.scot <gram.nrspcc@nhs.scot>
Subject: IRAS 337213. HRA & HCRW Approval Status Update - Favourable Opinion with Conditions

Dear Dr Russell,
I am pleased to provide the following update regarding the status of your application.
Please submit the requested information electronically through IRAS. Please provide your answers in the table(s) below and then submit this, with revised documentation where appropriate, underlining or otherwise highlighting the changes which have been made and giving revised version numbers and dates. A response should be submitted by no later than **04 July 2024**.
To enable the application to progress without delay we encourage you to provide these documents as soon as possible within the timeframes specified.

Ethical Review

The Research Ethics Committee has issued a **Favourable Opinion with Additional Conditions.**

Number	Condition	Response from the applicant
1.	The Committee request incorporating an identity verifier for the participants, by asking them to provide a form of ID at the interview stage.	
2.	The Committee made a request for Lynda Russell to update her GCP training.	

The letter confirming this opinion is attached. You should notify the REC once all conditions have been met and provide copies of any revised documentation with updated version numbers.
Please note, the standard conditions referenced in your REC favourable opinion letter as being attached ("After ethical review – guidance for researchers") can now be accessed through the HRA website.
NRSPCC - this study involves Scottish sites only but was reviewed at an English REC.
If you have any queries, please do not hesitate to contact me.
Kind regards,

Michael Pate
Approvals specialist
2 Redman Place | Stratford | Health Research Authority | E20 1JQ
T. 0207 104 8197
E. centralbristol.rec@hra.nhs.uk
W. www.hra.nhs.uk

Re: IRAS 337213. HRA & HCRW Approval Status Update - Favourable Opinion with Conditions

From Ciera Chalmers Davidson (PGR)
Date Thu 06/06/2024 15:34
To centralbristol.rec@hra.nhs.uk <centralbristol.rec@hra.nhs.uk>
Cc Lynda Russell <Lynda.Russell@glasgow.ac.uk>

1 attachment (403 KB)
GCP_Refresher.pdf;

Hi Michael,

Thank you for your email. We are pleased with the REC's opinion and appreciative of the helpful guidance in improving our project. I have provided responses to the conditions below and uploaded the relevant documents to IRAS.

Number	Condition	Response from the applicant
1.	The Committee request incorporating an identity verifier for the participants, by asking them to provide a form of ID at the interview stage.	Our protocol has been amended to incorporate this into the procedure.
2.	The Committee made a request for Lynda Russell to update her GCP training.	Dr Russelll has updated her training and certificate is attached.

Approval Letter 2: approved

Health Research Authority

South West - Central Bristol Research Ethics Committee
2 Redman Place
Straford
LONDON
E20 1JQ

Telephone: 0207 1048 088

Please note: This is an acknowledgement letter from the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

12 June 2024

Ms Ciera Davidson
University of Glasgow
Clarice Pears Building
90 Byres Road
G12 8TA

Dear Ms Davidson

Study title: **Exploring the perceptions of drug related deaths and methods of harm reduction amongst individuals with lived experience of drug use**
REC reference: **24/SW/0068**
IRAS project ID: **337213**

Thank you for your response of 12 June 2024. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 04 June 2024

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Other [GCP_Refresher]		04 June 2024
Participant consent form [Consent form]	6	05 June 2024
Participant information sheet (PIS) [Information sheet]	5	05 June 2024
Research protocol or project proposal [Protocol]	5	05 June 2024

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Poster to invite]	2	18 April 2024
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor insurance]		14 July 2023
GP/consultant information sheets or letters [Information for staff team about project]	3	09 February 2024
Interview schedules or topic guides for participants [Interview schedule]	4	26 February 2024
IRAS Application Form [IRAS_Form_30042024]		30 April 2024
Non-validated questionnaire [Demographic questionnaire]	4	01 April 2024
Other [GCP_Refresher]		04 June 2024
Participant consent form [Consent form]	6	05 June 2024
Participant information sheet (PIS) [Privacy notice]	2	05 April 2024
Participant information sheet (PIS) [Information sheet]	5	05 June 2024
Research protocol or project proposal [Protocol]	5	05 June 2024
Summary CV for Chief Investigator (CI) [CV for chief investigator]		26 April 2024
Summary CV for student [student cv]		26 April 2024
Summary CV for supervisor (student research) [supervisor cv]		26 April 2024
Summary, synopsis or diagram (flowchart) of protocol in non technical language [lay summary]	4	18 April 2024

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

IRAS Project ID: 337213 **Please quote this number on all correspondence**

Yours sincerely

Sarah Prothero
Approvals Specialist

E-mail: centralbristol.rec@hra.nhs.uk

Copy to: Ms Ciera Davidson

Lead Nation - Scotland: gram.nrspcc@nhs.scot

Appendix G

NHS Research and Development Approval

NHS Ayrshire & Arran

Research & Development
56a Lister Street
University Hospital Crosshouse
Kilmarnock
KA2 0BB

Dr Lynda Russell
University of Glasgow
Clarice Pears Building
90 Byres Road
G12 8TA

Date 17 July 2024
Your Ref
Our Ref CM/LM/CI R&D No 2024AA018

Enquiries to Libby Mullings
Senior Research Advisor
Email elizabeth.mullings@aapct.scot.nhs.uk

Dear Dr Russell

Exploring the perceptions of drug related deaths and methods of harm reduction amongst individuals with livedexperience of drug use

I confirm that NHS Ayrshire and Arran have reviewed the undernoted documents and grant R&D Management approval for the above study.

Documents received:

Document	Version	Date
Localised Organisation Information Document	1.0	15/04/2021
IRAS Form	6.3.6	30/04/2024
Protocol	5.0	05/06/2024
Poster	2.0	18/04/2024
Information Sheet	5.0	05/06/2024
Privacy Notice	2.0	05/04/2024
Consent form	6.0	05/06/2024
Demographic sheet	4.0	01/04/2024
Interview schedule	4.0	26/02/2024
Schedule of Events	2.0	18/04/2024

The terms of approval state that the investigator authorised to undertake this study within NHS Ayrshire & Arran is: -

- Ciera Davidson, Trainee Clinical Psychologist, NHS Ayrshire & Arran

With additional investigators:-

- Dr Laura Mitchell, Consultant Clinical Psychologist, NHS Ayrshire and Arran

The sponsors for this study are University of Glasgow.

This approval letter is valid until 30 October 2025.

Regular reports of the study require to be submitted. Your first report should be submitted to the Research & Development generic mailbox randdprojectteam@aapct.scot.nhs.uk in 12 months time and subsequently at yearly intervals until the work is completed.

Please note that as a requirement of this type of study your name, designation, work address, work telephone number, work e-mail address, work related qualifications and whole time equivalent will be held on the Scottish National Research Database so that NHS R&D staff in Scotland can access this information for purposes related to project management and report monitoring.

In addition approval is granted subject to the following conditions: -

- All research activity must comply with the standards detailed in the UK Policy Framework for Health and Social Care Research http://beta.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research and appropriate statutory legislation. It is your responsibility to ensure that you are familiar with these, however please do not hesitate to seek further advice if you are unsure.

- Recruitment figures must be submitted to R&D on a monthly basis. If recruitment figures are not received timeously you will be contacted by a member of the R&D team to provide this data.

- You are required to comply with Good Clinical Practice (ICH-GCP guidelines may be found at www.ich.org/LOB/media/MEDIA482.pdf), Ethics Guidelines, Health & Safety Act 1999, General Data Protection Regulation (GDPR) and Data Protection Act 2018.

- If any amendments are to be made to the study protocol and or the Research Team the Researcher must seek Ethical and Management Approval for the changes before they can be implemented.

- The Researcher and NHS Ayrshire and Arran must permit and assist with any monitoring, auditing or inspection of the project by the relevant authorities.

- The NHS Ayrshire and Arran Complaints Department should be informed if any complaints arise regarding the project and the R&D Department must be copied into this correspondence.

- The outcome and lessons learnt from complaints must be communicated to funders, sponsors and other partners associated with the project.

- As custodian of the information collated during this research project you are responsible at all times for ensuring the security of all personal information collated in line with NHS Scotland policies on information assurance and security, until the secure destruction of these data. The retention time periods for such data should comply with the requirements of the Scottish Government Records Management: NHS Code Of Practice. Under no circumstances should personal data be stored on any unencrypted removable media e.g. laptop, USB or mobile device (for further information and guidance please contact the Information Governance Team based at University Hospital Crosshouse 01563 825831 or 826813).

If I can be of any further assistance please do not hesitate to contact me. On behalf of the department, I wish you every success with the project.

Yours sincerely

Dr Crawford McGuffie
Medical Director

c.c. Shirley Mitchell, University of Glasgow (sponsor contact)
Hugh Bunyan, Finance, Ailsa Hospital
Information Governance, NHS Ayrshire & Arran
Ciera Davidson, NHS Ayrshire & Arran
Dr Laura Mitchell, NHS Ayrshire & Arran

Appendix H
Key Project Documents

Final University Approved MRP Proposal - https://osf.io/mepzs

Final Revised Protocol approved by REC - https://osf.io/cedr6

Information for staff - https://osf.io/9y2pe

Poster - https://osf.io/r3s98

Interview schedule - https://osf.io/6xwg4

Participant information sheet - https://osf.io/k3g4q

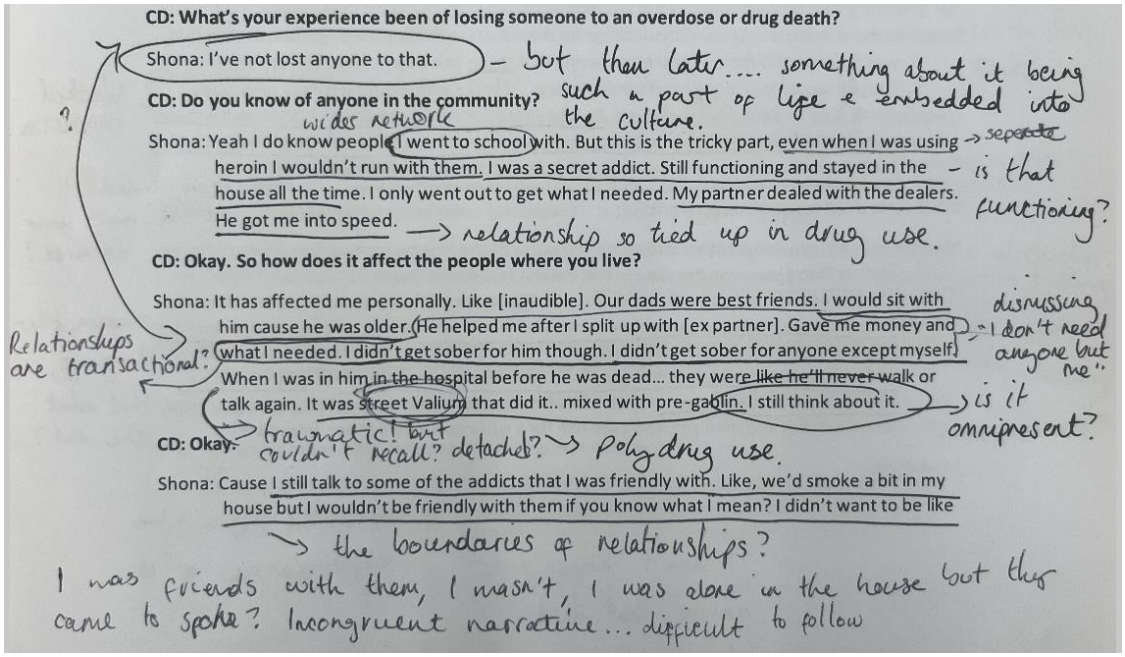
Participant consent form - https://osf.io/7qr8x

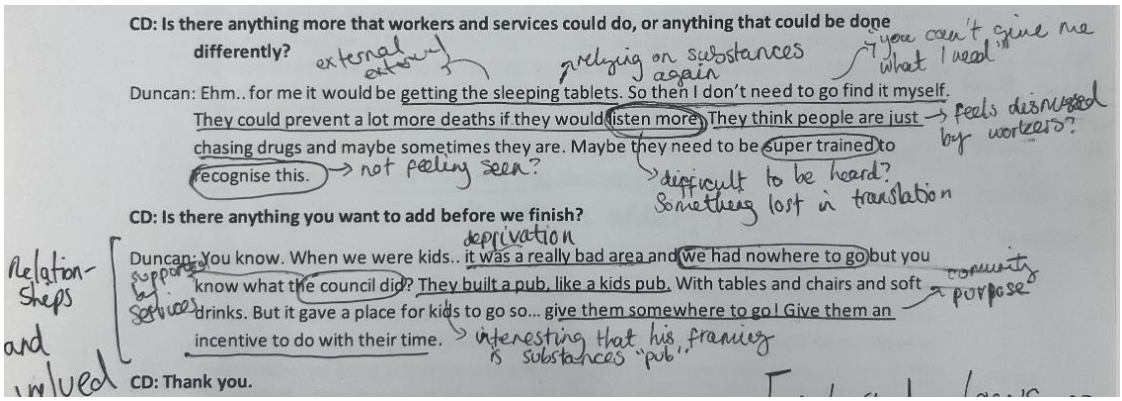
Demographic form - https://osf.io/ja57w

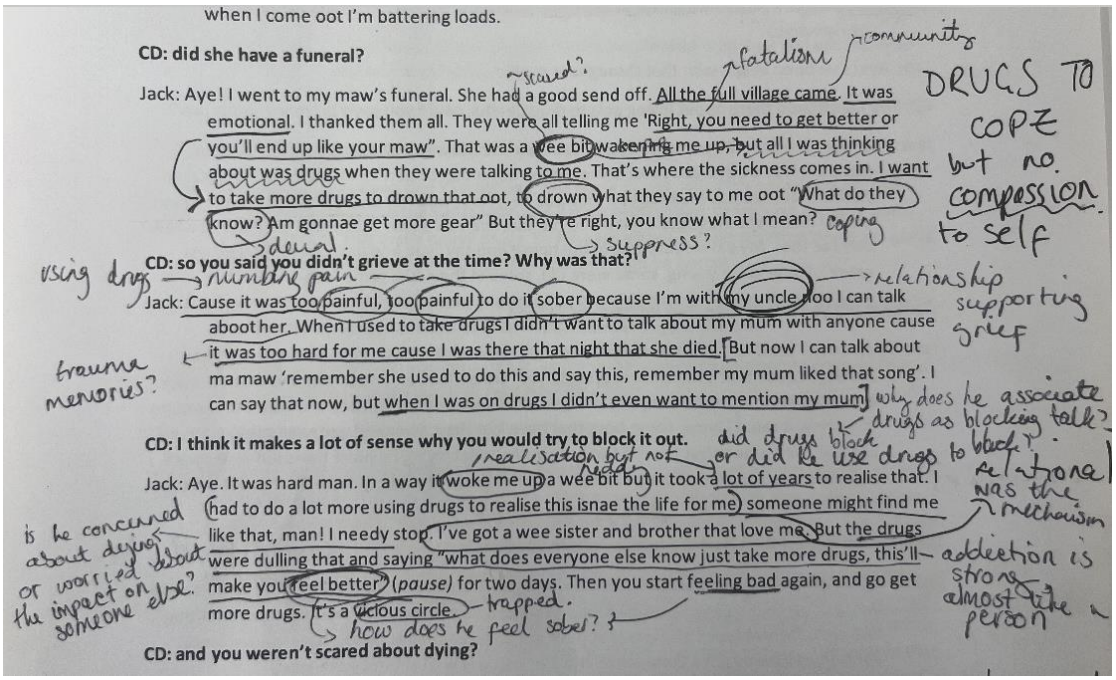
Data analysis plan - https://osf.io/pgnsb

Appendix I

Sample of Annotated Transcripts







Appendix J

Summary of the Group Experiential Themes as applicable per participant

Participant	Relentless Loss	Impact on Drug Use	Opposing Priorities	Connection, Stability, Support
Shona	Shona had lost friends and acquaintances to DMD although, she found it difficult to recall them all. DMD was not an unusual or noteworthy event.	Shona became concerned about why people were dying, she didn't understand the increase in deaths and she became more cautious of the drugs she took.	Shona was confused by safe consumption rooms.	Shona was supported by her partner and community. This motivated her to stay sober, as did her desire to have contact with her children again.
Heather	Heather had lost her aunt and cousin to DMD. She was aware of constant reports in the media.	Heather was deterred from using street drugs.	Heather felt services were fragmented and disorganised. She found it difficult to engage with them as they made her feel anxious.	Heather was supported towards recovery by her husband and motivated by her son.
Jack	Jack had lost many friends and his mum to a DMD.	Jack increased his drug use to cope with grief. He didn't feel able to cope without substances.	Jack did not feel harm reduction strategies met his needs.	Jack was well supported by his uncle who provided stability and connection. Jack's drug worker was key in supporting his recovery.
Duncan	Duncan had lost friends and acquaintances. He described a whole generation being wiped out.	Duncan expressed a sense of anxiety and fear regarding the number of deaths, yet this did not significantly impact upon his use.	Duncan did not feel listened to. Duncan was not motivated to use harm reduction strategies.	Duncan was motivated towards recovery when he had a good relationship with his drug worker.

Janie	Janie knew many people that had died from a DMD. She fought to remember and acknowledge them, aware of how they were disregarded by society.	Janie became cautious regarding her intake of substances.	Janie was 'disgusted' by harm reduction strategies. Janie felt people who use drugs have difficulty in being heard.	Janie was supported by her mum and sister into recovery. Her son provided a sense of purpose and stability. Janie called for community investment.
Gordon	Gordon had lost two partners and multiple friends to DMDs. He came to view death as inevitable.	Gordon increased his drug use to cope with feelings of guilt, self-blame, and grief.	Gordon felt dismissed and alienated by a revolving door of professionals. Gordon opposed harm reduction strategies.	Gordon was motivated to maintain his recovery so as to provide a good parenting experience to his daughter.

Appendix K
Excerpts from Reflexive Journal

Reflections after first interview – 9th September 2024

I was quite struck by her saying that she hadn't lost anyone to a drug death and then as we spoke began recalling many people, it makes me wonder how normalised it might be in the community and culture, it was almost like they hadn't registered.

I think I could do more to be more focussed throughout the interview and keeping her on track, it felt a bit tangential, maybe need to direct a bit more. I think my questions should be more probing, follow up etc around the emotional experience of the grief, the impact and the response.

It was interesting her framing throughout 'I'm not like them' about other drug users, she's framed herself as different, like she was trying to distance herself, I wonder why she would want to be seen as different and if she always is like that or if it is a reflection of the power between us i.e. attending for a 'professional' interview.

Reflections after interview – 16th October 2024

I was quite shocked by him using with his mum, when he spoke about if she didn't die with me it could've been with a cousin like just how normalised it was within his family, just being so core to families, that's the life and that's what happens. It shocked me, to be so exposed to drugs your whole life in that way, I can't imagine it, definite reflection of my naivety and privilege. I wonder if he felt my surprise, and what that would've been like for him, would he have felt the difference between us, in our backgrounds, and then could that have influenced what he decided to share? Perhaps experiences that were 'less shocking', or more socially acceptable.

Reflections after coding – 20th December 2024

While coding this interview I was aware of Heather's difference in perspective regarding harm reduction, she was more supportive than the other participants. I wonder if this is related to the substance she used, and the associated lifestyle. It seems like she has a much more compassionate voice e.g. 'people with addiction issues deserve help', as where there was a sense of personal responsibility from some of the others, we need to help vs they need to help themselves.

My own perspectives on harm reduction would align with Heather's, and perhaps I need to be more mindful of how I am removed from the lifestyle of drug use, and how this could influence my interpretations or interactions, I noticed that I offered Gordon some data about safe consumption rooms, but I didn't provide Heather with the alternative opinion or explore with her what the barriers to engagement of them could be. Perhaps need to be mindful of not aligning myself with perspectives that I am more familiar with, and discuss in supervision.

Appendix L

Data Availability Statement

Due to the personal and sensitive nature of the data, full transcripts are not freely available and are stored in accordance with university and health board guidelines. They may be made available upon reasonable request, subject to institutional approvals and ethical considerations.