UNIVERSITY OF CALGARY

“There's no one-size-fits-all solution for opioid use:” A Situational Analysis Exploring Opioid Use and the Opioid Crisis

by

Avery J. Sapoznikow

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF SCIENCE

GRADUATE PROGRAM IN EDUCATIONAL PSYCHOLOGY

CALGARY, ALBERTA

JUNE, 2022

Abstract

Canada is currently in the midst of an ongoing war on drugs and poisoning crisis, otherwise known as the Opioid Crisis. Overdoses and deaths are occurring across the country in all provinces and territories. The situation of opioid use and the Opioid Crisis is wrought with conflicts, tensions, and complexity. To best understand the complexity of opioid use and the Opioid Crisis, the perspectives of self-identified former opioid users were collected through a survey (n=83) and follow up interviews (n=6). Situational Analysis (SA) was used to analyze the data to elucidate and explore the complexity of opioid use and the Opioid Crisis from the perspectives of self-identified former opioid users. Multiple iterations of visual maps were created to display the complexity of the situation and outline various perspectives and contests of former opioid users. Through the analytic mapping of participant data, I identified human and non-human elements related to opioid use and the Opioid Crisis. This includes sites of tension such as the morality and utility of opioid use, the causality of the Opioid Crisis, and approaches to recovery from opioid use. I review these findings within the context of the current literature and consider the implications of the results in terms of impacts on opioid users, policy, and counselling practice.

Keywords: opioids, opioid use, substance use, heroin, prescription opioids, recovery, treatment, situational analysis

Acknowledgements

- To the participants – thank you for offering your time, energy, and honesty.
- To my supervisor, Dr. Tanya Mudry, I am so thankful for all your support and effort over the course of editing and developing this thesis. I cannot even imagine completing this project with such high quality without your ongoing guidance, support, and help.
- To my examiners Dr. Elisa Lacerda-Vandenborn and Dr. Gabriela Alonso Yáñez – Thank you for your time and effort reviewing my thesis.
- To my partner, Sara, for your never-ending encouragement, compassion, and love everyday, especially during the stressful days working on this project.
- To my parents and brother, Brenda, Garry, and Aaron, for your constant support and love throughout this entire process.
- To my friends, Carson, Ethan, Dixon, Solly, Matthew, and Steven, for you words of encouragement and well needed laughs, distractions, and game time away from work.

Table of Contents

List of Tables

List of Figures and Illustrations

List of Symbols and Abbreviations

Acronym	Definition
SA	Situational Analysis
CAPUD	Canadian Association of People who Use Drugs
BC	British Columbia
BIPOC	Black, Indigenous, People of Colour
SES	Socioeconomic Status
SC	Social Constructionism
GT	Grounded Theory

Chapter 1: Introduction

> Many [opioid] users are regular people who are facing either physical or mental health issues. They don't steal. They don't assault. They don't give drugs to kids. They have jobs. They have families. They don't want to be ‘non-functional’ they just don't want to feel like shit and be treated like garbage. (Survey participant #61)

The ongoing war on drugs and poisoning crisis, otherwise known as the Opioid Crisis (i.e., a public health crisis associated with increases in overdose deaths thought to be originally fueled by the overprescribing of opioid analgesics; Jalali et al., 2020; Volkow & Blanco, 2021) is occurring across Canada in all corners of every province and territory (Belzak & Halverson, 2018). The economic costs of the Opioid Crisis are estimated at $3.5 billion per year (Canadian Centre on Substance Use Costs and Harms Scientific Working Group, 2018). In addition, the loss of human life associated with this crisis (22,828 opioid-related deaths reported between January 2016 and March 2021; Public Health Agency of Canada, 2021) warrants a timely inquiry into this topic and implementation of resources to save lives and funding for further resources and supports.

The Opioid Crisis is riddled with complexity in terms of questions and perspectives on pertinent topics surrounding opioid use. Examples of this complexity are clear when considering the multitude of perspectives held regarding what entails opioid use, causes or reasons for opioid use, factors maintaining opioid use, potential utility and functionality of opioids, approaches to and definitions of recovery, and varied understandings of the Opioid Crisis. The complexity of opioid use and the Opioid Crisis is in part due to varying perspectives and positions (i.e., stances taken on specific issues) held by stakeholders in this topic of inquiry (e.g., strong positions in support of abstinence-only approaches to recovery or alternative recovery approaches). These varying perspectives are important to explore due to implications of the actions individuals may take based on the perspectives they hold. For example, there could be significant impacts on the quality and delivery of care to people currently using opioids or

working towards recovery from opioid use if a stakeholder in the medical community (e.g., doctors or nurses) holds discriminatory perspectives regarding opioid users. Furthermore, some of these perspectives could lead to decisions in government policy in relation to opioid use and treatment (e.g., closing supervised consumption sites or reducing funding to treatment centers) that may harm opioid users.

Adding to the complexity of opioid use and the Opioid Crisis are debates and controversies surrounding this situation of inquiry. Stakeholders may debate topics ranging from harm reduction (i.e., approaches that reduce the risk of harms without requiring abstinence; Chan et al., 2022) to systemic oppression (Allie-Turco et al., 2021) to equity for substance users (Collins et al., 2019). Individuals locate themselves within a given issue and take up a position which describes their stance on the issues being discussed. Individuals also take up positions based on their lived experience. For example, a position held by an outreach worker might be: "supervised consumption sites reduce risk of overdose and saves lives," based on their experiences of working with individuals using these harm reduction services.

Some dominant perspectives regarding opioid use and the Opioid Crisis toe the line of blaming the substance user (classifying and defining the person's character based on their substance use; Coleman & Fitz-Gibbon, 2020) for getting themselves into the situation they are in (i.e., addiction), while other perspectives suggest people struggle with addiction when they are victims of traumatic events and abuse (e.g., Dinh & Oliver, 2021; Kim et al., 2021). Differing perspectives such as these are important to examine because some perspectives can result in discrimination and stigmatization of opioid users, which is associated with poor treatment outcomes (McCradden et al., 2019). Treatment outcomes, including whether or not someone makes use of a supervised consumption site, are often influenced by decisions made by others who view opioid use and the Opioid Crisis through a specific lens (Gerster, 2019). This can occur in different contexts – for example, policy makers debating whether

to grant supervised consumption sites licenses to operate in residential neighbourhoods. Additionally, the public is also influenced by and influence impact on opioid users. Consider a local resident walking down the street ignoring or negatively interacting with an opioid user, adding to further stigmatization.

Some argue that to understand opioid use, one must understand that it is nuanced (i.e., inherently complex, bearing multiple potential positions on related topics) and involves deeply personal lived experience (Rieder, 2018). People who are rigid or binary in their thinking regarding opioid use and the Opioid Crisis may not be considering the multitude of factors that make this topic complex, such as the background of opioid users, how people ended up using opioids, and their attempts at recovery. This rigid thinking may be related to lack of experience and relationships with the opioid users and their contexts and perspectives, resulting in limited understandings and perspectives.

Limited understandings and perspectives on opioid use and the Opioid Crisis are commonly expressed in the media, using sensationalized or dehumanizing language in headlines surrounding opioid use or users, thereby avoiding any nuance in reporting. For example, the authors of a *New York Post* article, “Apparent junkies turn stretch of NYC’s Midtown into a shooting gallery” (Coleman & Fitz-Gibbon, 2020) applied labels such as “junkie” to opioid users, demonstrating a lack of empathy and understanding of opioid user’s lived experience and the complexity of their lives. Lacking such an understanding may result in the use of discriminatory language which further stigmatizes opioid users (McGinty et al., 2019). If these authors engaged with the topic more critically and explored different perspectives on opioid use, perhaps they would have titled the article differently.

The experiences of opioid users are impacted not only by the perspectives held by others, but also by the policies in government surrounding substance use. Current policy on substance use in Canada does not focus on the context of substance use, personal circumstance that results in substance use, or the nuance of the entire situation, but rather on the criminalization of the possession and use of opioids as a substance of abuse (Controlled Drugs and Substances Act, 1996). Criticism against current

policies on substance use in Canada are growing (Belzak & Halverson, 2016; Canadian Public Health Association, 2016) as grassroots community organizations such as the Canadian Association for People who Use Drugs (CAPUD) express their distaste for the status quo and call for the decriminalization of all substances in Canada. Movements like CAPUD center on the perspective that individuals with lived experience of using opioids and other substances hold the greatest amount of knowledge on opioid use and the complexity of the issue. While each person will have their own lived experience, it is that experience in and of itself that is so valuable when trying to understand behaviour (i.e., opioid use). So why is it that current policies on substance use and perspectives on opioids users tend to sway more towards hostility against opioid users (Ezell et al., 2021)? What are the perspectives of opioid users on the Opioid Crisis? What complexities are often overlooked when inquiring about opioid use?

The Current Study

I conducted this study with the aim of benefitting opioid users through better understanding the intricacies and complexities of opioid use and the Opioid Crisis. Currently, healthcare and treatment options are often based on policy decisions stemming from research that does not attend to the complexity of the topic being researched (e.g., drawing from evidence-based treatment established exclusively on clinical trials rather than a combination of clinical trials and real-world studies (Kim et al., 2018). Unfortunately, many (often quantitative) studies largely ignore the nuances in participant responses and thus lose complexity and depth of results (Al-Busaidi, 2008; Williams et al., 2019). For example, Entress (2021) explored the relationship between race and opioid use disorder. While the results of this study were robust and clearly demonstrate a correlation between race and prognosis of opioid use disorder, individual participant experiences of racism in this context were not explored or articulated. This resulted in purely numerical, non-personal data that lacked depth based in descriptions of lived experiences of racism. Research focused on the exploration and understanding of individual's experiences of healthcare services are less common, with researchers using methodologies that do not

attend to complexity. In contrast to the gaps in more dominant, quantitative approaches, qualitative research is well positioned fill in these gaps in the literature.

Unfortunately, qualitative methodologies are still lacking in addiction and substance use research, with qualitative research accounting for only 7% (100/1338 studies reviewed) of papers published in addictions journal focusing on social sciences (Rhodes et al., 2010). In contrast to the quantitative methodologies that are commonplace in addiction research, qualitative research more adequately captures the perspectives of people with lived experience regarding the topics being researched. For example, Thomas et al. (2020) reviewed studies using qualitative methodologies to explore the lived experiences of rural communities regarding the impacts of rurality (i.e., being located in a rural setting) on opioid-related harms. This study demonstrated that while this pool of research is limited (i.e., only 32 studies total), it is beginning to grow and provide tangible evidence for the utility of qualitative research highlighting the actual perspectives of people with lived experience. Often qualitative studies are quite specific, for example, studies focusing on a specific population such as comorbid HIV infection in addition to opioid use (Tofighi et al., 2019) or specific methods of harm reduction such as the use of naloxone in opioid overdoses (Kline et al., 2020). The current study zooms out from a narrow focus within the topic of opioid use and the Opioid Crisis and explores the topic more broadly to contrast the specificity of other studies. Given the lack of research focused on the complexity of opioid use and the Opioid Crisis from the perspective of those most impacted, my research is well positioned to fill an important gap in the literature. The current study

My hope with the current study was to examine the complexities and nuances involved in opioid use and the Opioid Crisis, articulated by the individuals who know opioid use best, people who have lived it and used opioids. I explored the question*: How is the complex situation of opioid use and the Opioid Crisis represented by former opioid users?*

To investigate this question, I used Situational Analysis (SA), a theory-methods package (i.e., theories and methods are mutually dependant on each other; Clarke et al., 2015) created by Adele Clarke (Clarke, 2005). SA utilizes visual maps to articulate and explore the intricacies and complexities of a topic of inquiry (e.g., opioid use and the Opioid Crisis). In the context of my research question, I created three kinds of visual maps (i.e., situational, social worlds/arenas, and positional maps) to explore opioid use and the Opioid Crisis from the perspective of self-identified former opioid users. These maps explored relevant objects, individuals, groups, organizations, governmental bodies, etc. that are involved with opioid use and the Opioid Crisis. Using SA, I created various iterations of three forms of visual maps which served different purposes in displaying human, non-human, and discursive components of opioid use and the Opioid Crisis. Using SA, I identified and articulated the complexity of opioid use and former users' perspectives on the Opioid Crisis. Furthermore, I identified social groupings (i.e., social worlds) of relevant actors in the situation and the resulting tensions (i.e., conflicts in positions; Strong et al., 2018) on specific issues of concern: morality of opioid use, the function and utility of opioid use, the causality of the Opioid Crisis, and approaches to recovery from opioid use. According to Clarke (2005), "The situation per se becomes the ultimate unit of analysis, and understanding its elements and their relations is the primary goal" (p. xxii). Thus, the tensions that emerge and the intricacy underlying them within the situation are central to developing a more concrete understanding of opioid use and the Opioid Crisis.

Personal Relevance and Positionality

As a student of Counselling Psychology with a keen interest in psychopharmacology, I have immersed myself in research and volunteer work in the areas of addictions, substance use, harm reduction, and policy on substance use. Through this research and experience, I have expanded my understanding of the work done by individuals involved and interested in the ongoing war on drugs and poisoning crisis, otherwise known as the Opioid Crisis. By engaging with the writings of Adele Clarke, I

have come to realize the importance of situating myself within the research I am conducting. Clarke (2005) stated:

> There has historically been a problematic pretense that the researcher can be and/or should be invisible . . . I assert that we cannot help but come to almost any research project already 'knowing' in some ways, already inflected, already affected, already 'infected' (p. 12).

By engaging with this quotation and considering the various aspects of my positionality, my understanding of the influence of my positionality shifted. My positionality is not only influenced by the objects, information, and interactions I undertake.

My positionality directly influences how and what I choose to engage with. For example, my interest in gaming, the Internet, and substances as a teenager led me to discover erowid.org, a website where people can submit first-hand accounts of substance use as "experience reports." Similar interests led me to discover substance use communities on reddit.org. On both websites, I used to read what people had to say about their substance use experiences and got excited about what it would be like to experience what I was reading. These kind of write ups excited me and sparked even more interest in this field of study when opportunities to pursue research became available. I was curious about how these people saw the world in different ways and what their substance use meant to them. For example, I remember reading an experience report about a man who drank the hallucinogenic tea ayahuasca, saw visions, and had a spiritual experience that changed the way he lived his life from that moment forward. I was so curious about what exactly he saw and how that reshaped the way he thought about his life. I had so many questions for him but could never actually ask them. Given these experiences, my curiosity has influenced my areas of study and research (choice of topic, qualitative methodology), and therefore impacts how I have and will engage with the topic of substance use. Based on this reasoning, throughout the research process, I examined my positioning based on my experiences and how they influence my knowledge and ways of engaging with the research topic and process.

My desire to conduct research on opioid use stems from my interest in substances and substance use from a young age, as well as personal experiences involving substance use and overdose throughout my life. When I was in high school, I looked up every kind of substance imaginable and researched the effects, side effects, long-term impacts of use, etc. As a child and adolescent, my exposure to substance use included depictions in media, family members and people in public smoking tobacco, people smoking cannabis at concerts and parties, and hearing about a cousin who was in recovery from cocaine and opioid use. I only heard about my cousin's substance use in negative contexts and I remember wondering what exactly what going on with my cousin that had so many adults worried and upset. Once I enrolled in my undergraduate degree programme, I struggled to choose a major, bouncing from biology to chemistry and ultimately settling on psychology. During this time, I met and spent time with some people who partied a lot in the first year of my undergraduate degree. Sadly, a couple years after we no longer associated with each other, one of the people from that group overdosed on fentanyl from a contaminated batch of MDMA (i.e., ecstasy). I remember being shocked that it happened and everyone trying to keep it very quiet before the newspapers inevitably reported that a UBC Okanagan student died from a lethal overdose. I wanted to understand how this could happen, why this happened, and what could be done to prevent this from continuing to happen.

What interested me most within psychology was psychopharmacology, or how substances impact individuals. I enrolled in courses on substances and behaviour, completed a directed study, published a paper on the hallucinogenic admixture ayahuasca (the same substance I read experience reports about years before), and completed my honours thesis on the topic of cannabis and attention. While I engaged fully with and enjoyed completing these projects, I felt as though I was only scratching the surface of what it really meant to take, experience, and understand psychoactive substances. I knew that my prior work had not been personal and did not explore complexity or intricacy within each topic.

Therefore, in this research, I engaged with research in a different manner – I immersed myself within the data to allow myself to be "directly in the situation [I was] studying" (Clarke, 2005, p. 12).

In addition to academic experience, I volunteered in a variety of capacities that introduced and made me more comfortable working in the fields of substance use, recovery, and harm reduction. I worked with opioid users directly on harm reduction initiatives such as organizing and running substance checking workshops, learning how to use naloxone, running naloxone training workshops with nurses, and presenting on differences between depressant (e.g., opioids) and stimulant (e.g., cocaine) overdose symptoms. This experience was made possible through my ongoing work with the Canadian Students for Sensible Drug Policy, where I hold an executive board position and meet monthly to collaborate with colleagues from all areas of Canada on national harm reduction initiatives to be executed by the many chapters associated with universities across Canada. My role within the Canadian Students for Sensible Drug Policy has undoubtedly shaped my positionality and opinions on harm reduction and substance use, as some of the main objectives of the organization are to promote equity for substance users and progressive substance use policy change at a governmental level. This includes advocating for supervised consumption sites, the dispersal of harm reduction supplies to those who need them (e.g., needle exchange programs), and for substance users in other areas of life where advocacy is needed.

I began this project with general knowledge of opioid use, various methods of recovery, harm reduction, policies on substance use, and support systems for opioid users. As I do not have personal lived experience with opioid use, I wanted to learn more about opioid use directly from those who have used. My positionality influenced both how I spoke to participants and understood their perspectives, as well as what I was able to gain in terms of the knowledge they had to share that I was unaware of or had no prior knowledge. For example, I knew a lot of the lingo and slang used in the opioid community due to my exposure to their written accounts on reddit and erowid.org. This may invited ease of

communication and more openness from participants when speaking to them, as I might have seen less of an outsider. However, even though I knew the slang and could speak about the topic, I did not live it. I simply wanted to engage with the topic of opioid use with opioid users, not from a fearful or judgemental way, but in a way where I could strive to further humanize opioid users. Given this gap in my knowledge and experience, the participants' experiences, and my candid conversations with them, were invaluable in terms improving my understanding of the complex situation of opioid use and the Opioid Crisis.

Overview of Thesis Chapters

In this chapter I introduced my study along with the research question: *How is the complex situation of opioid use and the Opioid Crisis represented by former opioid users?* In Chapter 2, I review the relevant literature focused on the history of opioid use and the Opioid Crisis, portrayals of opioid users, social structural barriers to care, and treatment and recovery options. In Chapter 3, I describe SA and outline steps taken for the current study. In Chapter 4, I report the findings for the study and present my research products, three visual and analytical maps. In Chapter 5, I discuss my findings in the context of current literature and describe implications to counselling psychology and future directions for similar research.

Chapter 2: Literature Review

In this chapter, I present the context for my research by reviewing the literature on opioid use and the Opioid Crisis, including the historical context of opioid use and the Opioid Crisis, marginalization and stigmatization of opioid users, systemic oppression in BIPOC communities, social and structural barriers to care, treatment and recovery, and stakeholders in opioid use and the Opioid Crisis. I briefly explore discourse, opioid use, and the Opioid Crisis, existing discursive conflicts and complexity, and introduce the current study. The topics reviewed within this chapter were chosen based on my own positionality, experiences, and knowledge through decisions regarding what I deemed important in terms of context for the current study. For example, in this chapter, I focus on social justice and socially oriented aspects of opioid use and the Opioid Crisis (e.g., impacts of marginalization and stigmatization, the Opioid Crisis, etc.) versus more common addiction focuses such as DSM-5 criteria for substance use disorder or neurobiology of addiction and substance use.

Historical Context of Opioid Use and the Opioid Crisis

"Opioid use" is an umbrella term for consumption of both naturally occurring opiates (e.g., morphine, codeine, etc.) and semi-synthetic opioids (e.g., heroin, fentanyl, oxycodone, etc.). One of the earliest depictions of opioid use for medical purposes occurred in China in the 7th century and opium addiction became a problem in China when the practice of smoking opium began in the 17th century (Brownstein, 1993). In current medical practice, opioids are used to treat pain at various levels of severity, based on doctor recommendations and prescriptions (Trescot et al., 2006). In recent decades, there has been a notable increase in the use of both legal and illicit opioids across North America, coinciding with the production and marketing of semi-synthetic opioids such as oxycodone (Cicero & Ellis, 2017). These new semi-synthetic opioids were originally marketed as having low abuse potential with longer lasting effects than the opioids that were on the market at that time. Pharmaceutical companies touted these opioids as a "safer" alternative opioid for consumer use in the context of pain

management (Cicero & Ellis, 2017). While these companies marketed these substances more widely in the United States, the marketing of opioids was not absent in Canada.

Between 2000-2010, Canada saw prescription opioid use double, likely due at least in part to increased marketing to physicians who could prescribe opioids and a push for more prescriptions (International Narcotics Control Board, 2009). More recently, the rate of opioid use in Canada placed us second globally for rate of opioid use, right behind the United States (Belzak & Halverson, 2018; Fischer et al., 2016). Wilson et al. (2021) recently published a study exploring trajectories of prescription opioid use, reporting that for high-risk individuals (based on individual factors), even short or low-dose prescriptions for opioids were associated with a significant increase in the risk of persistent opioid use. The risk is even more concerning when considering a recent report from the Canadian Center on Susbtance Use and Addiction (2020) describing that 11.8% of the Canadian population uses opioids, and an average of 17 hospitalizations occur daily due to opioid poisoning and subsequent overdose. This report also highlighted a stark increase in opioid-related deaths between January 2016 and December 2019, confirming that we are in the midst of a worsening overdose (i.e., poisoning) and Opioid Crisis.

The Opioid Crisis is a complex situation involving various perspectives regarding potential causes of the notable increases in overdose deaths from prescription and contaminated illicit opioids. Some research has suggested that the sharp increase in opioid overdoses over the past decade stems from the overprescribing of prescription opioids in the treatment of pain, leading to prescription misuse and subsequent experiences of addiction to opioids (Jalali et al., 2020; Volkow & Blanco, 2021). In this section I examine the context of the Opioid Crisis in relation to contamination of the illicit opioid supply and opioid-related mortality and risk of overdose and availability of opioids in Canada.

Contamination of Illicit Opioids and Opioid-related Mortality

It is not a simple task to pinpoint the cause or any specific parties responsible for the current state of opioid use in Canada. Some factors contributing to the current state and worsening of this crisis

include a largely contaminated illicit supply of substances (i.e., illicit opioids and other substances contaminated with fentanyl and fentanyl-analogues; Health Canada, 2018) and misuse of prescription opioids (Health Canada, 2019). Higher rates of contamination and misuse of prescription opioids are associated with increases in rates of overdose (Health Canada, 2019). Of the 11.8% of Canadians who use opioids (Canadian Center on Substance Use and Addiction, 2020), 2.9% use prescription opioids outside of prescribed directions for use (i.e., approximately 100,000 Canadians; Canadian Center on Substance Use and Addiction, 2020). In total, there have been 22,828 opioid-related deaths between January 2016 and March 2021, with 1,772 apparent opioid-related deaths between January and March 2021 (approximately 20 deaths per day), representing an increase of 65% compared to the reported deaths between January and March 2020 (Public Health Agency of Canada, 2021).

Within Canada, British Columbia (BC), Alberta, and Ontario have experienced the highest rates of opioid-related mortality, with 90% of all opioid toxicity deaths in Canada occurring in those three provinces (Public Health Agency of Canada, 2021). The increases in mortality rates associated with opioid use are especially troubling because it demonstrates the lack of tangible responses to the ongoing Opioid Crisis. These numbers have also increased since the COVID-19 pandemic began (April 2020 to March 2021), with 6,946 opioid-related deaths, representing an increase of 88% from the same time period prior to the pandemic (April 2019 to March 2020 saw 3,691 deaths; Public Health Agency of Canada, 2021). The COVID-19 pandemic has greatly exacerbated an already damaging Opioid Crisis in Canada, which has led to loss of life and substantial healthcare and economic cost.

Prior to the COVID-19 pandemic, the economic cost of the Opioid Crisis accounted for upwards of $3.5 billion per year (Canadian Centre on Substance Use Costs and Harms Scientific Working Group, 2018), with a large portion of cost coming directly from healthcare services used to treat opioid users for overdoses and other medical problem related to opioid use. This cost accounts for 3.4% of the total substance-related healthcare costs in Canada, or $438.6 million (Canadian Substance Use Costs and

Harms Scientific Working Group, 2020). Given the substantial cost of the Opioid Crisis, it is imperative to prioritize aid for people involved in the crisis. Current efforts to mitigate risks associated with opioid use (e.g., opening supervised consumption sites) have been relatively successful at preventing death, but not overdose, and as a result, the inherent risk of overdose from using opioids still exists.

Risk of Overdose and Availability of Substances in Canada

The leading cause of unintentional death in Canada is overdose from substance use, mainly opioid overdoses (BC Coroners Service, 2020). The crisis of sudden death following use of opioids is not exclusive to those intentionally using opioids. The contamination of substances such as cocaine, methamphetamine, and benzodiazepines purchased from illicit sources is becoming increasingly common, leading to an increased likelihood of opioid overdose, even when users are not intentionally using opioids (Hayashi et al., 2018). While fentanyl contamination of other substances is less common, it is prevalent enough to influence rates of opioid overdoses (Hayashi et al., 2018). Previous research has deemed the combined use of opioids and other central nervous system depressants such as benzodiazepines (e.g., Valium, Ativan, Xanax, etc.) and alcohol (Coffin et al., 2003) as significantly more dangerous than opioids alone. While it is not as common for people to intentionally take multiple depressants at once, the risk comes from the unwanted contamination of other substances, such as cocaine (a central nervous system stimulant), which are often used in combination with opioids (e.g., speedballs – a mix of cocaine and heroin). Notably, since 2015, this situation is occurring more frequently, as demonstrated by a sharp increase in reports of overdose following exposure to unknown substances in illicitly purchased substances in the United States and Canada (Fairgrieve et al., 2020).

The contamination of the global illicit market of substances with potent opioids such as fentanyl and other unknown substances increases the risk of overdose or adverse reactions to using opioids. In general, it is common for individuals who sell opioids to frequently cut their product (i.e., mix other substances into a larger supply to falsely inflate the amount of product an individual is selling) to

increase profit margins. Since the onset of the COVID-19 pandemic, the practice of cutting opioids has dramatically increased due to large disruptions in international trafficking routes, creating supply chain issues resulting in reduced and delayed shipping of opioids through regular trade routes (United Nations Office on Drugs and Crime, 2020). This has caused a spike in both the price and rates of cutting and contamination in the international illicit supply of substances (United Nations Office on Drugs and Crime, 2020). The widespread contamination of the global illicit opioid market leads to many harmful consequences, including an increase in the risk of overdose for people who choose to use opioids. Furthermore, increases in the likelihood of experiencing overdose may also be associated with a higher probability of experiencing a traumatic event (e.g., witnessing or experiencing overdose, arrest, and incarceration, etc.), which could negatively impact an individual's ability to cope, leading to further opioid use and even greater risk.

Opioid use bears many inherent risks to users including overdose, death, and experiences of traumatic events. These risks are influenced and potentially exacerbated by other factors related to opioid use that contribute to negative experiences – marginalization and stigmatization of people who use opioids.

Marginalization and Stigmatization of Opioid Users

Marginalization (i.e., being disempowered and disadvantaged) and stigmatization (i.e., disparaging individuals or groups; Room, 2005) occurs when judgement or evaluation is placed on personal characteristics of people (e.g., opioid use; Osei Baah et al., 2019). In the context of substance use, people are less likely to openly discuss substance use in comparison to other topics due, in part, to the stigmatization associated with using illicit substances. Opioids are heavily stigmatized substances, which bear a unique relationship with moral judgements of character and societal stigmatization that is widespread or commonly supported in society. Individuals with a prescription for opioids face much less societal stigmatization in comparison to illicit opioid users (Perry et al., 2020). For example, people who

use illicit opioids report discrimination, alienation (Ahern et al., 2007), and lower psychological well-being (Kulesza, 2013) as a result of their use of illicit opioids. Societal stigma (e.g., from police officers, healthcare workers, the media, and the general public) and harmful public messaging (often perpetuated by the news media) about opioid use impacts opioid users and discourages them from seeking treatment (Kennedy-Hendricks et al., 2017; McGinty et al., 2019). Unfortunately, this problem is compounded by negatively framed depictions of marginalized populations, often perpetuated in media depictions.

Media Depictions of Opioid Use

Frequently, white and non-dominant groups are depicted differently in the media when it comes to substance use. Media depictions of Black, Indigenous, and People of Colour (BIPOC) are frequently biased and depict non-dominant groups as criminals and "addicts," while White people are often depicted as "victims" of substances (Netherland & Hansen, 2017). There are distinctions in the language used in media depictions, with White people often referred to as "suburban" and non-dominant populations as "urban," a form of codified racism (Netherland & Hansen, 2017). Furthermore, race is seldom mentioned when covering stories of White people and substance use. Being unlabelled is a hallmark of Whiteness, as "the unmarked category against which difference is constructed, whiteness never has to speak its name, never has to acknowledge its role as an organizing principle in social and cultural relations" (Lipsitz, 2016, p. 98). With large gaps in access to healthcare, due in part to internalized racism, stereotyped media depictions, and perceptions of increased complexity in treatment, many opioid users unfortunately fall through the cracks of the medical system, especially if the opioid user is a member of a BIPOC population (Netherland & Hansen, 2017).

Systemic Oppression in BIPOC Communities

In addition to marginalization and stigmatization due to perceptions and opinions of opioid use, many opioid users are often part of other marginalized groups (e.g., individuals of lower socioeconomic status (SES), people of colour, and Indigenous peoples). Previous research has shown that racial

(Netherland & Hansen, 2017) and socioeconomic inequity and stigmatization (Cairncross et al., 2018) play a role in the worsening of the Opioid Crisis. Aside from stigmatization directly related to opioid use, these groups frequently experience stigmatization at disproportionate levels, compared to the general population. This stigmatization often emerges through discriminatory interactions with non-marginalized populations (Stuber et al., 2008).

When already stigmatized people use opioids, the complexity and intensity of the stigmatization and marginalization due to the oppression they already experience is greatly increased. This often leads to negative outcomes at interpersonal (e.g., loss of relationships), structural (e.g., lack of access to healthcare services), and societal (e.g., public shaming) levels (McCradden et al., 2019). Additionally, membership in a marginalized group itself has been identified as a risk factor in opioid-related deaths through inequities in access to healthcare, food, and shelter. Groups that face this particularly high mortality-rate are those of lower SES (Cairncross et al., 2018; Carrière et al., 2018; Probst & Rehm, 2018; Singh et al., 2018), non-dominant races (Netherland & Hansen, 2017), and Indigenous status (Carrière et al., 2018).

The disproportionate impact of opioid-related mortality on BIPOC communities is well documented, with recent death rates for Black communities in metropolitan areas of the United States increasing 103% from 2015 to 2017 (Lippold et al., 2019) and reports of extremely high levels of opioid-related mortality among Indigenous populations in Canada (Canadian Center on Substance Use and Addiction, 2020). In the United States, BIPOC communities (especially Black communities) have been prevented from accessing legal prescription opioids through biased medical assessments and misperceptions of pain tolerance of BIPOC individuals by medical professionals (Pletcher et al., 2008). These biases partly stem from racist beliefs of laypeople and medical students and residents, such as the idea that Black people have thicker skin than White people and therefore have different tolerance to pain (Hoffman et al., 2016). This is a form of implicit bias and racism that has become commonplace in

medical settings (Kabir & Zaidi, 2022). Furthermore, disparity in prescription opioid dispersal to Black communities has been observed and can attributed to some medical professionals' beliefs of increased likelihood of substance-seeking behaviour in Black communities (i.e., racial stereotypes that Black people are more likely to seek substances in order to abuse or sell opioids; Singhal et al., 2016).

Systemic oppression based on race is one path leading people who lack access to proper healthcare (e.g., methods of pain management) to turn to other means to resolve their medical issues (e.g., buying opioids illegally because they cannot obtain a prescription). When access to legal opioids is prevented, people might be forced to turn to the illicit substance market to find solutions to their pain. The research on the experiences of the Black community in the United States parallels some of the research on the experiences of Canada's Indigenous communities. In Indigenous communities, the disproportionate rate of opioid-related mortality is partly due to the high levels of non-medical opioid use among some Indigenous populations. For example, within the Cat Lake First Nation in North Western Ontario, up to 70% of the community members are addicted to opioids (Nishnawbe Aski Nation, 2012). The higher rate of opioid use within Indigenous communities is an example of the many negative effects of intergenerational trauma and ongoing systemic and societal racism towards Indigenous peoples (Bombay et al., 2009; Bombay et al., 2014; Marsh et al., 2015). There are complex relationships between Indigenous peoples, systemic oppression, opioid use, and negative outcomes for individuals who face oppression regularly. Inequity in access to healthcare or treatment options is widespread in these communities and is only further exacerbated by social and structural barriers, resulting in inequity in housing and SES of these population.

Social and Structural Barriers to Care

When seeking health or social services, opioid users often face social and structural barriers that prevent them from receiving the same quality care and treatment that more privileged people may receive. In this context, I define social barriers as barriers which stem from social attitudes and labelling

of individuals (Carrillo et al., 2011), an example of which is stigmatization experienced by opioid users from the public. Structural barriers are defined as "obstacles that collectively affect a group disproportionately and perpetuate or maintain stark disparities in outcomes. Structural barriers can be policies, practices, and norms that favour an advantaged group while systematically disadvantaging a marginalized group" (Simms et al., 2015, p. v). An example of a common structural barrier is excessive wait times for subsidized housing (Carrillo et al., 2011). Social and structural barriers to care are evident in housing and SES, experiences of traumatic events, and access to healthcare.

Housing and SES

Lack of secure housing is a social-structural barrier that impacts opioid users (Zivanovic et al., 2015). People who use illicit substances commonly experience homelessness and unstable housing (Aidala et al., 2005; Tompsett et al., 2013) and substance use tends to increase the risk of first-time homelessness (Thompson et al., 2013). Similarly, homelessness is associated with using substances in excess, higher rates of injection-based substance use (i.e., more risky substance use), and higher rates of relapse among those who have sought and received treatment for substance use (Linton et al., 2013). These findings suggest that effective housing solutions could reduce negative impacts of substance use.

Considering the overlap between unstable housing and opioid use, many opioid users have experienced living in lower-income areas with few supports or interim housing with "dry" policies (i.e., no substance use on the property; Ickowicz et al., 2017). Given no private space to use, some people resort to using opioids in public on the streets, which poses additional risks for overdose based on reduced access to emergency services due to a lack of phone or static address (Milaney et al., 2021). In addition, opioid users face harsh, o0ften hateful, criticism from the public when they use opioids on the streets or people observe them as high while in public (Ickowicz et al., 2017; Kennedy-Hendricks et al., 2017). Undoubtedly, facing criticism and discrimination based on substance use, race, SES, and other often unmanageable circumstances makes an impact on people and likely results in negative outcomes

such as further substance use, experiences of traumatic events, feelings of shame, and resentment towards the public and oneself.

Metropolitan areas such as Vancouver, BC, have the highest rates of opioid-related mortality, with 96 reported opioid-related deaths in 2018 and 243 deaths in 2019, many of which were individuals facing housing insecurity (BC Coroners Service, 2020). In BC, the number of overdose deaths were at an all-time high in 2020 (2,351 deaths), with 87% of all illicit substance toxicity deaths (2,045 deaths) involving fentanyl and analogues, and 30.5% (717 deaths) involving other opioids (BC Coroners Service, 2021). Furthermore, a trend involving the timing of death emerged – more illicit substance toxicity deaths occurred during days following income assistance payment than all other days in 2020/2021 (BC Coroners Service, 2021). This statistic speaks to the observed trend of individuals of lower SES disproportionately experiencing opioid-related harms and death. The higher rates of homelessness and lower SES comprising much of the downtown east side of the City of Vancouver accounts for this disproportionately high rate of opioid related mortality. These observed trends of opioid-related mortality and homelessness and lower SES may be consistent in other inner-city communities across Canada.

Experiences of Traumatic Events

"Rather than choice, chance or genetic predetermination, it is childhood adversity that creates the susceptibility for addiction" (Maté, 2012, p. 56).

Trauma, in the context of opioid use and the Opioid Crisis, is associated with the marginalization, racism, oppression, and violence experienced by opioid users who are members of Black (Substance Abuse and Mental Health Services Administration, 2020) and Indigenous communities (Loppie et al., 2014). Members of BIPOC communities have reported many forms of trauma including direct trauma (i.e., traumatic events experienced by the specific individual; Menzies, 2019), intergenerational trauma (i.e., traumatic events experienced by one generation and the

consequences passed on to the next; Menzies, 2019), and historical trauma (i.e., trauma shared by a group of people in a society; Menzies, 2019), all of which are associated with an increased likelihood of substance use (Carter, 2007; Fitzgerald et al., 2021). Race-based trauma results in emotional or physical pain based in the hostility and discrimination towards BIPOC individuals which, in many cases, is associated with an increased likelihood to use substances such as opioid and alcohol (Carter, 2007). Traumatic events experienced by BIPOC communities are both subtle and overt, occurring at institutional levels (i.e., systemic oppression and racism) and/or interpersonal levels (e.g., microaggressions; Carter, 2007). Undoubtedly, due to the widespread experience of traumatic events in BIPOC communities, trauma is a key factor to consider when exploring the complexity of opioid use and the Opioid Crisis as it directly contributes to the complexity of the experiences of opioid users.

Opioid users, especially those who are members of BIPOC communities, who lack housing, are of lower SES, or have experienced stigmatization and marginalization, disproportionately experience traumatic events. Much of the inequity experienced by these individuals is due to social and structural barriers in place that prevent these populations from accessing proper healthcare or being treat by professionals while avoiding systemic oppression.

Structural intersectionality (i.e., the individual experiences of people at the intersection of various identities and multiple categories of difference; Crenshaw, 1991), in the context of opioid use, speaks to the widespread experiences of traumatic events, in addition to other social and structural barriers experienced by BIPOC communities. In the context of BIPOC populations, current research demonstrates that the structural intersectionality of people who have experienced institutional racism and oppression is a strong predictive factor of health (Homan et al., 2021). This is important to consider in the context of opioid use and the Opioid Crisis because many opioid users who are members of BIPOC communities may experience the impacts of traumatic events and other intersectional factors (e.g., SES, gender, housing situation, etc.) based on their past experiences and risk-related environments

(e.g., substance use settings, housing instability, public discourses around public health and substance use; Collins et al., 2019). These experiences influence the likelihood of substance use for not only low SES populations, but in other groups of people often excluded from dominant narratives, such as young, high-income Black populations (Collins et al., 2019; Persmark et al., 2019). This speaks to the widespread and intricate nature of the Opioid Crisis, such that it does not occur exclusively in low SES, housing insecure, traumatized people, but it occurs across many intersecting experiences and identities. The widespread and indiscriminate nature of the Opioid Crisis also describes the complexity of understanding opioid use and the Opioid Crisis and its direct impacts.

Access to Healthcare

Opioid users attempting to access healthcare face common barriers such as stigmatization from healthcare providers, peers, and the public; complexity of treatment and recovery management; time limitations in busy practices; lack of supplies such as naloxone, clean needles; and regulations on prescribing opioid-agonist medications in some Canadian jurisdictions (Donroe & Tetrault, 2018). Each of these barriers reduce the likelihood an individual will seek or receive treatment in both emergency and primary-care settings.

Currently, in Canada, there is limited access to options (i.e., long waitlists) for people seeking treatment for opioid use. Less than one in five people who need treatment for opioid use actually receive it (Wu et al., 2016). People often access healthcare through emergency medical situations such as overdose, which forces them to receive care in a general medical setting following a traumatic experience or because of mandated treatment following arrest. These are not optimal pathways to recovery, as the agency of the individual is taken away. As a result, opioid users' loss of agency may be associated with potential harms and violations of human rights (Werb et al., 2016). Donroe and Tetrault (2018) suggested a more preferable pathway pointing towards primary-care providers (i.e., doctors' offices) taking the lead on treatment for opioid use as they have received training to manage complex

healthcare concerns. Primary-care providers, rather than emergency service providers, are well positioned and better equipped to manage ongoing complex medical cases (Donroe & Tetrault, 2018), such as the treatment of substance use, however, with the onus placed on primary-care providers for treatment, barriers to access these services exist for opioid users.

In Canada, most provinces have sub-par geographic coverage (i.e., some areas of the province do not have easy access to healthcare services) and availability of treatments for substance use, with options for opioid users seeking treatment even more limited (Bruneau et al., 2018; Eibl et al., 2017). Furthermore, Dassieu et al. (2019) stated that "restrictive prescription measures implemented in response to the [prescription opioid] PO crisis may have consequences similar to prohibitionist policies: they heighten overdose risks for [people who use drugs] PWUD by increasing exposure to street drugs laced with fentanyl" (p. 150). Unfortunately, even in situations when individuals have access to care, it is not uncommon for them to face stereotyping by healthcare workers leading to bias in treatment decisions and poor treatment outcomes (Burgess et al., 2006). Many of these biases and stereotypes still exist due to the lasting impacts of current and historical criminalization of substance use and people who use substances. Lack of access and lack of appropriate care forces people to live with their addiction without supports, often resulting in further opioid use, unstable housing, and experiences of homelessness.

Treatment and Recovery

Within Canada, there are several options for treatment for opioid use, with many people seeking and being recommended withdrawal management (i.e., detox), abstinence, and residential treatment as the first-line approach to recovery (Taha, 2018). Contrary to these popular and well-known routes of treatment, recent studies report that pharmacotherapy (i.e., opioid maintenance therapy using prescriptions for suboxone, bupropion, methadone, etc.) is unequivocally the evidence-based first-line treatment for opioid use (Bruneau et al., 2018; Donroe & Tetrault, 2018; Rieb et al., 2020; Srivastava et

al., 2017; Taha, 2018). Often, at the beginning stages of recovery, users may attempt withdrawal management (independently or through medical facilities) and subsequent abstinence exclusively, which has been associated with relapse and death (Bruneau et al., 2018; Donroe & Tetrault, 2018). In the case of subsequent long-term residential in-patient treatment following medical withdrawal management, these risk are reduced, but are still less effective treatment when compared to pharmacological interventions (Donroe & Tetrault, 2018; Taha, 2018).

Commonly, both in-patient residential treatment facilities and opioid maintenance therapy programs are wrought with excessive wait times, a barrier to accessing treatment (Wells et al., 2019). Furthermore, when wait times are excessive, the odds of the individual returning for treatment appointments is substantially lower when compared to individuals who received same-day or next-day appointments (Roy et al., 2020). In the case of in-patient residential facilities, reduced utility of resources following excessive wait times has also been observed (Moroz et al., 2020).

In addition to excessive wait times for treatment, many of the treatment methods are not appropriate for historically traumatized populations (i.e., BIPOC communities). Evidence exists supporting the use more manualized approaches as well 12-step programs (generally involving abstinence; Bøg et al., 2017) and harm reduction approaches to recovery (Chan et al., 2022; Logan & Marlatt, 2010). However, a recovery-oriented approach recommends offering all possible options to clients while inviting them to decide which option best suits their goals and needs. For example, a frequently used and supported evidence-based approach for substance use treatment is Cognitive-Behavioural Therapy (CBT; Sudhir, 2018). Evidence-based approaches like CBT are often not recovery-oriented (i.e., work with individuals and families to reach chosen recovery goals, build on personal strengths and skills; Alberta Health Services, 2019) nor do they attend to the intersectionality of the opioid user. For example, many evidence-based treatment options (e.g., CBT) may serve to further traumatize and colonize Indigenous peoples (Comas-Díaz et al., 2019; Lavallee & Poole, 2010). In the

case of Indigenous substance users seeking treatment, the use of cultural interventions (e.g., sweat lodges) has been shown to be beneficial for improving all areas of wellness (Comas-Díaz et al., 2019; Rowan et al., 2014).

In the context of conventional treatment for opioid use (e.g., CBT in in-patient facilities following withdrawal management), it is essential to reemphasize the importance of culturally sensitive interventions (e.g., adjusting protocols to suit the unique needs and culture of the client) and the use of alternative interventions based in the culture of the populations in recovery (e.g., healing lodges for Indigenous populations; Comas-Díaz et al., 2019; Rowan et al., 2014). Furthermore, the use of the recovery-oriented approach to treatment may be more helpful when working with all clients.

A recovery-oriented approach emphasizes the importance of putting the client first and letting them direct the course of treatment. The therapist adapts the therapeutic approach and treatment goals to the individual and their family's preferences (Alberta Health Services, 2019). There are six dimensions that comprise a recovery-oriented approach to treatment (Mental Health Commission of Canada, 2015). The first dimension emphasizes creating a culture and language of hope, suggesting that recovery is possible for all who seek it. The idea behind this guideline is that hope stimulates recovery. If a person learns how to communicate with hope and optimism in this context, they can begin to feel valued, important, welcomed, and safe and begin the process of recovery.

In terms of the second dimension, recovery is viewed as personal and specific to the individual. This recommendation suggests that everyone is unique in their experiences and has the right to decide their own path in recovery and mental health treatment. Acknowledging this uniqueness bolsters the individual's autonomy and focuses on the person's strengths, thus leading to more positive relationships (Mental Health Commission of Canada, 2015). The third dimension specifies that recovery occurs in the context of one's life. Emphasis is placed on understanding the context, or complexity, of the individual's

life. This includes all relationships and cultural aspects of a person's life that can play an important role in supporting recovery (Mental Health Commission of Canada, 2015).

The fourth dimension suggests that from a recovery-oriented approach, we must respond to the diverse needs of everyone in Canada. Specifically, this refers to respecting the diversity of different populations and being culturally responsive, safe, and competent. All principles that inform the recovery-oriented approach must be applied to all populations, no matter their personal demographic characteristics (e.g., race, gender, sexuality, nationality, Indigenous status, etc.; Mental Health Commission of Canada, 2015). The fifth dimension specifically focuses on addressing the needs of First Nations, Inuit, and Métis communities. There are commonalities between recovery principles and shared Indigenous teachings and understandings of wellness. From the recovery-oriented perspective, this is a strong opportunity to learn and strengthen mental health policies and practices that are grounded in Indigenous knowledge and culture (Mental Health Commission of Canada, 2015). This must occur while also attuning to the distinct cultures between many Indigenous communities.

Finally, the sixth dimension focuses on viewing recovery as a means of transforming services and systems by provide skills and support to allow all organizations to express their commitment to recovery. Regardless of the specific services offered, the location, or specific populations served, this dimension suggests pushing for a commitment to the expression of recovery in everything and organization does. This includes ensuring support for the skills and resources required to provide a recovery-oriented practice (Mental Health Commission of Canada, 2015).

From the recovery-oriented approach, the combination of mental health concerns and substance use treatment is considered "complex" or "dual" recovery (Ness et al., 2014). It is more common than not for people seeking treatment for substance use to also have concurrent mental health concerns. Therefore, in line with this approach, it is preferred to support the recovery of the person as whole, rather than specifically focusing on substance use or a single mental health concern. Ness et al. (2014)

identified three themes associated with recovery: 1) having a meaningful everyday life; 2) focusing on strengths and the future; and 3) re-establishing social life and supportive relationships. Notably, none of these themes are directly associated with abstinence, pharmacological, or other evidence-based or alternative treatment options. However, these themes speak to the hopeful, strengths-focused, socially connected, meaning-oriented, unique recovery journey of each person.

Ness et al. (2014) also argued that the lack of tailored help and complex systems/uncoordinated or non-collaborative medical services are detrimental to the recovery process. Together, the recommendations and guidelines by Ness et al. (2014) and the Mental Health Commission of Canada (2015) recommend against the idea of "one-size-fits-all" approaches to recovery, with more individualized, collaborative, and person-centered and guided treatment as a more fitting way of working with individuals seeking treatment for substance use.

Opioid users frequently face social and structural barriers to treatment and recovery such as housing insecurity and low SES, the impacts of trauma, access to (appropriate) health and mental healthcare, and the intersections between aforementioned factors associated with opioid use. While plenty of research exists regarding structural barriers to healthcare, research focused on opioid user perspectives and the perspectives of other stakeholders in the complex situation of opioid use and the Opioid Crisis are extremely limited.

Stakeholders in Opioid Use and the Opioid Crisis

Opioid use and the Opioid Crisis comprise a complex situation that includes many stakeholders involved in different aspects of opioid use and/or the recovery process. This includes but is not limited to the media, health practitioners (doctors, psychologists, nurses, etc.), policy makers, family and friends, etc. Each of these stakeholders has their own experiences, social interactions, and educational and professional backgrounds associated with opioid use (i.e., they may have direct or indirect experience learning about or engaging with opioid use). In addition to the unique experiences of

individuals in each group of stakeholders, each may have different perspectives on what entails opioid use, who is an opioid user, what can/should be done about opioid use, and associated actions and practices. These perspectives and practices are located in the various discourses available to them, based on their individual contexts, histories, and relational experiences with opioid use the Opioid Crisis.

Discourse, Opioid Use, and the Opioid Crisis

Opioid use and the Opioid Crisis can be considered a complex situation, with various stakeholders and a range of perspectives and discourses. Discourses can be defined as sets of meaning, metaphors, representations, or common understandings that produce a particular version or viewpoint of events and dictate what is good or bad, socially acceptable or not, etc. (Burr, 2015). There are many discourses relevant in the contexts of addiction, substance use, and recovery. Each stakeholder (e.g., pharmaceutical companies, doctors, police officers, the public, opioid users themselves, etc.) engages with discourses surrounding opioid use in their varied contexts. Bailey (2005) described popular discourses of substance use and how these discourses are used, explaining that often the dominant discourse regarding addiction and substance use hinges on the notion that people struggling with substance use are helpless and have no power over their behaviour. From this discourse, the medical professionals are meant to "save" the user from their "helpless" situation. Furthermore, people who are "addicted," those who sell illicit substances, and the substances themselves are morally judged as "evil" (Bailey, 2005). Other researchers have suggested that substance use and addiction is framed within the dominant discourses of medicine, morality, law, economics, politics, and popular culture (Bright et al., 2008), speaking to the far-reaching influence of dominant discourses. Because discourses inform what we understand and how we behave, "the notion of addiction itself is accomplished in and materialized through the use of discourse" (Mudry, 2021, p. 2).

For example, healthcare workers may have engaged with a "harm reduction" discourse in their education and work experience. Based on their interactions with others and the world around them,

involving opioid use and harm reduction, they take up specific discursive positions (i.e., perspectives on issues located in a specific discourse) on the topic. Someone training to become a nurse will have likely worked with nurses, doctors, and patients, each of whom have their own ideas and opinions on opioid use. Everyone the nurse interacts with is drawing from existing discourses surrounding opioid use to come to their own perspective on the situation. Their perspectives might be reinforced by others who share similar beliefs (i.e., draw from the same discourses) or belong to the same social sphere (e.g., groups of nurses, police officers, doctors, etc.), or be opposed by individuals who draw from alternative discourses (e.g., police officers who are trained to criminalize some forms of substance use). The interactions with discourses upheld or opposed by others and the experiences of the individual result in different potential positions to be taken on an issue such as opioid use. One position on opioid use might be "harm reduction saves lives," while another position might be "harm reduction enables substance users and puts them at more risk." Using this example, even though two individuals might be talking about harm reduction, they are positioning themselves in opposition. Opioid users also hold different positions regarding opioid use and the Opioid Crisis, based on their relational, contextual experiences.

Existing Discursive Conflicts and Complexity

Opioid use and the Opioid Crisis as a topic of inquiry bears numerous conflicts between discursive positions. These discursive positions are products of social interactions situated in the historical and cultural contexts of each person (Burr, 2003). Consider potential positions taken up by police officers versus outreach workers or nurses. While each professional group works with opioid users, they might hold conflicting positions related to opioid use. For police officers, the context of their work and social interactions involves the enforcement of laws and criminalization of substance use and possession, which may involve confrontational interactions with people using opioids. These interactions are shaped by and continue to shape the police officers' perspectives. Negative recurrent interactions may lead to negatively oriented positions regarding opioid use (e.g., "all users are junkies")

and subsequent interactions with opioid users will likely perpetuate this position (i.e., treating opioid users as "junkies" inviting negative responses from the opioid user). Furthermore, the legal status of opioids and a focus on criminalization and punishment could also shape the positions held by police officers which continues shape and be shaped by their interactions with opioid users.

The context of work and social interactions is quite different for outreach workers. They might support opioid users in daily living, provide harm reduction supplies (e.g., clean needles, naloxone, etc.) and connect them to supportive resources (e.g., treatment options, housing). These workers also receive specific training regarding opioids through their education and employment, resulting in different relationships with the topic of opioid use and opioid users themselves. An example of a position held by outreach workers might be "opioid users are no different than you and I." The contrast in experiences between police officers and outreach workers (both professional work and education) could result in a discursive conflict. Outreach workers are often trained to approach opioid-related concerns through a health and social lens versus a criminal-justice lens. Understanding differences in positionality and context sheds light on how stakeholders in the situation of "opioid use" may take up different discourses and hold their own positions on opioid use that can be different or at odds with discursive positions held by others in related fields.

What remains unclear, however, is how opioid users themselves relate to and understand opioid use and the Opioid Crisis. Just like other stakeholders in the situation of opioid use and the Opioid Crisis, opioid users relate to and engage with this situation through discourses and express their own unique positions on opioid use and the Opioid Crisis. Based on their lived and relational experiences with opioid use, these positions may be in line with or different from the positions taken up by others. For example, opioid users could be sympathetic and supportive of others in a similar situation and engage with discourses such as "morality of opioid use," leading to a position such as "opioid users are good people stuck in bad circumstances."

Opioid users and former opioid users have first-hand accounts and relational experiences with opioids. They hold their own perspectives on opioid use, which have been impacted by their lived experiences as opioid users. Their perspectives are particularly complex, as each opioid user has their own experiences using opioids, as well as experiences with others, both positive and/or negative. For example, some opioid users may receive support from frontline healthcare workers, thus shaping a positive perspective on the healthcare system, and some may feel they did not receive support from the healthcare system because of unhelpful or harmful experiences. To best understand opioid use, we must engage with individuals who have had the most direct relational and social experiences with opioids. To truly understand the intricacies and complexity of opioid use and the Opioid Crisis I aimed to explore how opioid users understand and represent opioid use and the Opioid Crisis.

The Current Study

The purpose of this study was to explore and articulate the complexity of opioid use from the perspectives of opioid users by posing the question: *How is the complex situation of opioid use and the Opioid Crisis represented by former opioid users?* Rather than exploring opioid use using quantitative methods (which inherently oversimplify and reduce the topic of inquiry into aggregate data), I sought to explore this complicated topic by allowing the messiness, complexity, and existing conflicts in positions related to the situation to speak for themselves. It is within the messiness of this situation of inquiry that I may articulate the complexity of opioid use and the Opioid Crisis. Through identifying relevant human, non-human, and discursive elements, and exploring any emerging conflicts or tensions (Strong et al., 2018) between these elements, my hope was to promote different ways of understanding opioid use and the Opioid Crisis. Additionally, I hoped to articulate the complexity and nuances of opioid use in order to reduce stigmatization of this already vulnerable and marginalized population. To this end, the perspectives of self-identified former opioid users were privileged in this study.

My academic preparation before undertaking this project was purely quantitative, so a shift towards engaging with the messiness and complexity of a topic was new for me. It was not easy to shift perspectives and theoretical lenses for this project, however, I am pleased that I was given an opportunity to grow and learn more about critical qualitative research by working with people with lived experience with opioid use. I am also pleased that I was able to focus my literature review on topics related to social justice versus common dominant topics such as the neurobiological mechanism of addiction, and conduct a study using a postmodern ontology. This study was and continues to be a learning experience for me that continually shapes my own ways of being and engaging with this topic of research, even though this approach involves stepping into the messiness and complexity of a topic.

Chapter Summary

In this chapter I provided a literature review relevant to the current study. First, I described the historical context of opioid use and the Opioid Crisis (including rates of use and mortality in Canada, contamination of the illicit opioids, risk of overdose and availability of substances in Canada). Second, I described different portrayals of opioid users (including media depictions, and systemic oppression in BIPOC communities). Third, I explored the literature on social and structural barriers to care (including housing insecurity and low SES, impacts of trauma, and access to healthcare). Fourth, I explored treatment options and recovery (including exploration of abstinence, harm reduction and recovery-oriented approaches to recovery), stakeholders in opioid use and the Opioid Crisis, discourse and opioid use, and existing discursive conflicts and complexity surrounding the situation of opioid use and the Opioid Crisis. I concluded the chapter by presenting the current study and research question. In Chapter 3, I explore my methodological approach to answering my research question.

Chapter 3: Methodology

The purpose of this research was to explore the complex situation of opioid use and the Opioid Crisis from the perspectives of self-identified former opioid users. I sought to explore and articulate how these individuals represent their experiences and understandings of opioid use and the Opioid Crisis. The experiences of opioid users are relational and contextual, and influenced by interactions with other people (e.g., other opioid users, friends, family, police officers, healthcare workers, etc.) whom each have their own perspectives and positions of opioid use and the Opioid Crisis. Differing perspectives on opioid use can be conflicting, resulting in tensions and contests between discourses and discursive positions.

To explore this complex situation, I chose Situational Analysis (SA), a qualitative theory-methods package to research which examines and highlights the intricacy of the situation and explores relevant stakeholders and positions taken on the topic of inquiry. First, I outline my Social Constructionist orientation (including the significance of discourse, and tensions and complexity). Second, I describe the theory-methods package of the current study, SA. Third, I review my research process (including data collection and data analysis). Fourth, I review the rigour and trustworthiness of the current study using Shenton (2004) and Clarke's (2005) recommendations in addition to an identity map (Jacobson & Mustafa, 2019) to review the influence of my positionality on the current study. Finally, I conclude the chapter by outlining ethical considerations for this study.

Social Constructionist Orientation

In this research, I adopted a social constructionist (SC; Burr, 2015) perspective, which has the following assumptions (Burr, 2015):

1. Research should take a critical stance towards taken-for-granted knowledge by challenging the notion that knowledge is based on objective, unbiased observations.

2. All meaning is historically and culturally situated – specific to and products of culture and periods of history, dependant on existing social and economic arrangements of that time.
3. Knowledge is created and sustained through language and social processes. Understandings are co-constructed between people through interactions (conversations, goings on of individuals' daily lives), and every human practice influences and forms the shared versions of knowledge (i.e., discourse) that are co-created.
4. Knowledge and social action go together. Each construction of reality invites different action from humans.

Everyone involved in the Opioid Crisis has their own perspective on opioid use and the Opioid Crisis, based on their own experiences and positionality. However, in the context of this topic, I was most interested in opioid users' perspectives. From a social justice perspective, the viewpoints of those with lived experience related to the situation are essential. Understanding the complexity of opioid use entails embracing the relational dynamics of opioid use and individual lived experiences of those who use. Each opioid user will have their own ideas regarding what opioid use and the Opioid Crisis entails, based in the relational engagement with the world around them. From a SC perspective, knowledge is created and sustained through language and social practices (i.e., conversations and daily life with others resulting in the co-construction of knowledge; Burr, 2015). Opioid users co-construct their perspectives of opioid use and the Opioid Crisis through their daily interactions with others and their experiences, including their interviews with me as the researcher.

A social constructionist orientation adopts the understanding that people come to describe, explain, or makes sense of the world they live in through discourse (i.e., systems of human meaning-making; Gergen, 1985). Opioid users' relationship to opioid use and the Opioid Crisis is discursive. When they engage in opioid use or recovery, they understand their use and/or discuss the Opioid Crisis through discourse. They draw from available discourses (e.g., opioid use as criminal, a disease, moral

failure, or choice), the social-cultural-historical context of opioid use, and their own interactions with opioids. While there are shared discourses surrounding opioid use, each opioid user offers a unique perspective, which allows for a more nuanced and complex understanding of opioid use and the Opioid Crisis.

The Significance of Discourse

Social constructionists view discourse as a key characteristic of human meaning-making (Burr, 2015). Burr (2015) described discourse as:

> A set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events. It refers to a particular picture that is painted of an event, person or class of persons, a particular way of representing it in a certain light. (p. 74)

Burr (2015) explained that multitudes of alternate versions of reality are available through language and communication. There are a variety of different discourses surrounding any one object, person, etc., each with unique differences in terms of how the world is represented. Discourse serves as the basis for laws and governing policies (e.g., laws criminalizing the use and possession of opioids), as well as functioning in daily life. Discourse also contributes to the unique understandings of various phenomena and how individuals conceptualize complex situations of inquiry. For example, discourses contribute to the unique conceptualizations of the complex situation of opioid use and the Opioid Crisis. To engage socially, people must conduct themselves according to shared behavioural norms (i.e., patterned interactions) that can include specific knowledge claims, specific types of people, and specific conditions for engagement. For example, in the context of public opioid use, certain rules (e.g., standard socialized rules for behaviour in public) are expected to be adhered to when in public. In the context of the downtown east side of Vancouver, BC, these standard societal norms exist, but they exist concurrently with alternative subcultural norms (i.e., norms of smaller groups within society) of the

population of people who live there (e.g., it may be more common to inject opioids in public in this context). This can result in conflicts or tensions when norms based on different groups do not overlap seamlessly.

Anyone wishing to be in public and not experience conflict is expected to follow patterned interactions according to behavioural norms, such as not using in public. People in public will generally adhere to social rules set in place and any violations of these norms may result in consequences. For example, if social rules are violated, it could result in disagreements with others or the involvement of police officers in the case of substance use. The material conditions in this example are the public sidewalks, buildings, parks, paraphernalia, prescription opioids, heroin, fentanyl, etc. All these components make up the context for the creation, maintenance, and influence of discourses. Discourses, therefore, are not simply descriptions of meaning, but rather consist of descriptions of meaning, related practices, social rules, and non-human elements that influence knowledge and behaviour through interactions. In the context of this study, each participant has their own interactions with opioid use, non-human elements related to opioid use, societal rules, and other people involved with opioid use, and as such their constructions about opioid use will be unique to their own experiences and experiences shared with and by others.

Given that there are a wide variety of perspectives regarding substance use, particular discourses exist and govern the behaviours of opioid users and other stakeholders such as police officers, paramedics, addictions counsellors. These varied discourses may overlap or conflict, and individuals may find themselves torn between potential ways of acting, based on their subscribed discourses. For example, consider an outreach worker on their first shift in an inner-city community approaching a man who is using opioids in an unsafe manner (e.g., reusing needles repeatedly). One discourse might tell the worker to provide this opioid user with a safe supply of paraphernalia and substances to ensure safety in their substance use, which would involve taking up a discourse of harm reduction. An alternative

discourse of criminalization could also be at play, resulting in the worker calling the police because the opioid user may be a harm to themselves and using illegal substances. These two discourses may contradict one another, and the worker may feel pulled in multiple directions before deciding which discourse they take up and what action occurs as a result. This conflict of discourses can be referred to as tension(s).

Tensions and Complexity

A tension refers to competing accountabilities encountered in interactions between one approach or perspective with other approaches or perspectives (Strong et al., 2018). Tensions, at face value, are often viewed in a negative light, giving rise to opposition, messiness, complexity, and confusion on a variety of topics. From a positivist methodology (Park et al., 2020), complexity is often simplified or reduced for purpose of clarity as these positivist approaches rely on hypothetico-deductive methods to confirm or refute hypotheses quantitatively. This aversion to complexity also exists outside of positivist methodologies and arises in qualitative practice by researchers classifying data into "themes" that describe an experience. From a SC perspective, tensions are unavoidable, and often create new forms of knowledge (Burr, 2015; Clarke, 2005).

I see the current situation of opioid use and the Opioid Crisis as hotly contested and muddled in tensions and complexity. Individuals' actions (located in discourses) related to opioid use have real world consequences (e.g., most suitable healthcare options). Considering the real-world consequences, this topic warrants further exploration using a method aimed to explore tensions and articulate complexity.

Situational Analysis

To capture the complexity of opioid use, while honouring the theoretical assumptions of SC, I opted to use SA (Clarke, 2005). SA was created by Adele Clarke as a response to Grounded Theory (GT; a research methodology concerned with explaining social processes through the construction of

theory “grounded” in systematically collected data) and its relationship with postmodernism. Clarke studied GT under Anselm Strauss who, alongside Barney Glaser, developed GT (Glaser & Strauss, 1967). Through her work studying under Strauss, Clarke noted the strengths of this approach from a postmodern perspective but felt as though it could be pulled further into the postmodern paradigm. She argued that while GT contained elements of postmodernism (e.g., descriptions of participant characteristics), it still retained mostly positivist underpinnings (i.e., lack of subjective interpretations).

Clarke offered critique and changes to “push grounded theory more fully around the postmodern turn” (Clarke, 2005, p. 11). Clarke argued that GT inadequately evaluated power dynamics, insufficiently addressed material conditions (i.e., non-human elements), and bolstered modernist dichotomies (e.g., correct or incorrect). Studies using GT often presented results as “rational” and ignored the inherent messiness of human interactions. Clarke (2016) criticized GT and other modernist approaches for their reliance on “master discourses” (p. 138), which fail to adequately capture the intricacies and complexities of changing social situations (e.g., opioid use). Clarke wanted an approach that honoured the complexity of situations and explicitly mapped and represented complexity and messiness (Clarke, 2005). She argued that GT and other positivist methodologies often erased the voice of the individual, opting for aggregate and summary data. This kind of data removes potential contradictions and conflicting positions within a data pool, leaving only summary data that ignores individual contributions that differ from norms or common responses.

To push GT more into postmodernism, Clarke (2005) adapted GT with six strategies, ultimately leading to the creation of SA. First, Clarke (2005) argued that we must acknowledge reflections and experiences of the researchers as major components of the research process, while accepting the existence of multiple realities or “truths” that are equally valid. The researcher is *situated* and *embodied*, meaning they are located culturally, historically, and socially, and therefore are uniquely positioned within the situation of inquiry.

Second, Clarke (2005) described making the topic of inquiry both the research phenomena (situation) and site for analytical grounding. This is taking a step away from traditional modernist distinctions between phenomena and context towards acknowledging that conditions and elements related to the topic of inquiry are not separate. For example, the situation of opioid use and the Opioid Crisis is the topic of inquiry, but it is also the site from which I, as the researcher, am grounded in.

Third, Clarke (2005) described how assumptions and representational strategies evolve from simple homogenous distinctions to messy, heterogenous representations of complexity. Rather than following reductionist methods commonplace in modernist methodologies, SA invites the messiness, complexity, heterogeneities, and tensions to be preserved and honoured (e.g., through the use of visual maps).

Fourth, Clarke (2005) described transitioning from the development of formal theory from a modernist perspective to viewing and accepting sensitizing concepts (i.e., tentative descriptions) and theorizing as useful products of research. This process describes a shift from the production of specific theory based on the results of research towards the acceptance of complexity and non-exhaustive definitions of conclusions as a product of research.

Fifth, Clarke (2005) proposed a reiterative analytic mapping process for data analysis throughout the research process. These maps are both tools for further analysis and the research product themselves through multiple examinations and iterations meant to extract the most salient elements of the situation of inquiry.

Finally, Clarke (2005) placed emphasis on the role of discourses (e.g., narrative, visual, and historical) in understanding the situation of inquiry. Anyone engaging in the situation of opioid use and the Opioid Crisis will undoubtedly draw from existing discourses when forming their own perspectives on different issues. Therefore, it is important to consider the existing discourses when developing the visual maps throughout the SA procedure.

Clarke (2005) hoped her suggestions for adaptations of GT into SA would allow for greater reflexivity, modesty, uncertainty, and power dynamic analyses, while allowing the messiness, contradictions, and complexity of the situation of inquiry to exist. The iterative process refers to SA mapping techniques which aim to explore situations and describe major and minor components of the situation and how they relate to each other. By allowing space to describe individual components of the situation in terms of their relationships with other elements, it is easier to see how components of a situation relate to each other and influence the overall situation of inquiry.

In the context of the current study, an inquiry into the complex situation of opioid use and the Opioid Crisis, SA is ideally suited to fully capture the convoluted and intricate nature of the situation. The situation of opioid use and the Opioid Crisis is wrought with diverse perspectives on a multitude of relevant issues such as the impacts of the enforcement of substance-related laws, harm reduction, abstinence, alternative recovery pathways, morality in opioid use, etc.). In order to develop an understanding of opioid users' perspectives on opioid use and the Opioid Crisis, SA is an ideal approach to explore and articulate complexity, while honouring the perspectives the participants.

Research Process

In this section, I outline my research process including data collection (literature review, survey data, and semi-structured interviews, etc.) and data analysis (including memoing, and mapping procedures).

Data Collection

The data for this study were comprised of survey data, and transcripts from semi-structured interviews with individuals who identified as former opioid users. Throughout this process, I reviewed and consulted with my supervisor and lab members through meetings and emails.

Literature Review. The data collection process started with a literature review on topics related to opioid use. I searched Google Scholar and the University of Calgary Library databases for peer-

reviewed journal articles and books using the following terms: “opioids,” “overdose,” “Opioid Crisis,” “influence of race on opioid use,” “opioid-related mortality,” “marginalization and opioid use,” stigmatization and opioid use,” “media influence of stigmatization,” “historical context of the Opioid Crisis,” “drug policy and opioid use,” “trajectories of opioid use,” social determinants of health and opioid use,” “BIPOC opioid use,” “Indigenous opioid use,” “treatment and opioid use,” “abstinence and opioid use,” “harm reduction and opioid use,” “utility of harm reduction in opioid use,” “supervised consumption sites,” “safe supply and opioid use,” “treatment availability in Canada and opioid use,” “homelessness and opioid use,” and “medication-assisted treatment and opioids.” Once relevant articles were identified, it was common to find other related articles cited within.

This literature review served as the foundation for my research process. I reviewed literature on opioid use and opioid use trajectories, which informed the project and aided in my initial identification of relevant human and non-human elements pertinent to the situation of inquiry and future iterations of SA maps. By engaging with and immersing myself in the literature, I was also able to further clarify my own role and positionality as a researcher. Through this process, I realized that my own positionality and my real-world experience was quite limited in terms of exposure to opioids and opioid use, and this would undoubtedly influence how I engaged with and interpreted the data. Furthermore, my own positionality influenced what I searched for and what research articles I considered for inclusion in my literature review (see literature introduction for examples of how).

Survey Data. Following approval from the University of Calgary’s Conjoint Faculties Research Ethics Board in December, 2020, I invited participants to participate in a survey via poster (see Appendix A). I dispersed the poster (which included an embedded link to the survey) through the University of Calgary research recruitment website and postings on reddit.com, a website hosting a large collection of active communities referred to as “subreddits.” I had personal experience using reddit.com, so I was familiar with the website’s layout and with certain communities pertaining to opioid use and

substance use. Furthermore, I enjoy reading people's stories and experiences on reddit, including the links they share and all of the unique perspectives written about related to substance use and their personal lived experiences. I selected subreddits directly related to opioids and substance use such as "r/opioids," "r/heroinrecovery," "r/methadone," and "r/drugnerds." The survey (Appendix B) collected demographic information (e.g., age, sex, gender, race, education, etc.) and responses to open-ended questions regarding opioid use (e.g., Please describe your first experience with opioids).

I used the following inclusion criteria for individuals completing the survey: 1) self-identification as a former opioid user; 2) 18 years of age or older; and 3) ability to speak English fluently. Exclusion criteria included those under the age of 18 and those who have not used opioids. The initial sample size for the survey was 103 however, following the removal of incomplete responses, the total sample was 83. Survey participants read and provided informed consent (see Appendix C) prior to beginning the survey. At the end of the survey, participants were provided space to write their email and indicate if they would like to be contacted for a semi-structured interview. A total of 36 participants provided their consent and contact information for further participation. I contacted all 36 potential interviewees twice and received responses from ten individuals, resulting in six participants who were interviewed (See Appendix D for email script). All potential participants who desired to participate in the semi-structured interview were interviewed. Four of the ten participants that initially responded to my email did not respond further once I began scheduling interviews, so they were not interviewed.

Semi-Structured Interviews. The final source of data for this study was semi-structured interviews. Interviews were conducted over the course of three weeks. Before the interview, the participants read and signed a consent form pertaining to the interview portion of the study (See Appendix E). In the beginning of each interview, I introduced myself, reviewed the consent form once more, answered any questions, and recorded their verbal consent to participate. I conducted interviews via my secure University of Calgary Zoom account, making use of the auto-transcription and recording

features. The interviews were approximately one hour in length. I used an interview guide that included questions such as, “Could you tell me about a few things that made you want to use opioids and what kept you using?” (See Appendix F). The six participants had various levels of education and were from various levels of SES. All participants in this component of the study were White and only one participant identified as a woman, with the rest identifying as men. I reviewed the automatically generated transcripts were closely reviewed for accuracy and edited into verbatim transcripts for analysis.

Data Analysis

To answer my research question, I followed SA guidelines by utilizing traditional aspects of GT, such as memoing, in addition to the procedures of SA of mapping (situational, social worlds/arenas, and positional maps).

Memoing. Throughout the research process I used memoing for the purpose of recording ongoing reflections and reactions during the research process. This included my opinions, thoughts on new findings, and any questions that emerged from conducting the research. For example, a memo from May 7th, 2021 reads, “Both of the interviewees so far used the term ‘addict’ when speaking of opioid users and themselves previously. Why are they using a stigmatized term to describe themselves?” In addition, memoing helped me identify missing data or positions that were relevant but not explored or mentioned within the data. For example, a memo from May 24th, 2021 reads, “Interviewees so far have described abstinence and harm reduction as the two main methods of supporting recovery, what might other stakeholders from different backgrounds think about this?” This memo led to the development of a position expressed in a positional map, regarding approaches to recovery, that was not articulated by participants explicitly, but is still a possible position to be taken up on the topic.

Mapping the Situation. Once data were collected, I began the analytic process of SA. The procedure of SA involves creating three maps (i.e., situational, social worlds/arenas, and positional

maps) that depict different characteristics of the situation of inquiry. Based on survey and interview data, I created and revised each map several times resulting in messy iterations and "final" cleaner maps. I began by creating the messy situational map, followed by an ordered map, the social worlds/arenas map, and the positional maps. Following the guidelines of SA, I read over the data (survey and interview data) multiple times, while memoing about my decision-making processes, my thoughts related to the research, my reactions, curiosities, and observations. The intention behind the memoing process was to immerse myself in the topic of inquiry, as I am also a relevant actor within the situation of inquiry. It also allowed me to gain a more in-depth understanding of the topic of inquiry before beginning the mapping process. I created all maps using pencil and paper on large pieces of printer paper as I felt more connected and immersed in the mapping process when completed by hand. This also assisted me to become more familiar with the data and followed Clarke's (2005) suggestion of conducting the data analysis in a manner that motivates the researcher to become immersed and explore data as deeply as possible.

Based on SA guidelines, I created three distinct forms of SA maps designed to promote different forms of analysis and thinking about the data: (a) situational maps; (b) social worlds/arenas maps; and (c) positional maps. These maps allowed me to explore micro, macro, and meso-level interactions between elements related to the situation of inquiry.

Situational Maps. To create the first messy map, I began by identifying salient human and non-human elements (i.e., objects, structures, technology, and organizations such as heroin, supervised consumption sites, police officers, the media, etc.) that largely make up the situation of inquiry (Clarke, 2005). This form of mapping aims to elucidate intricacies and broadly explore all elements of the topic of inquiry, regardless of the final impact any element may have. Since SA mapping is an iterative process, the various iterations of situational maps that I created were abstract and may be difficult to follow, therefore, they are called "messy maps." They are messy since they are illustrations of

everything deemed influential in analysis. Human, non-human, symbolic, and material elements, discourses, stakeholders, and sites of debate were all illustrated through situational maps in an unordered format (Clarke, 2005). I displayed these elements with connecting lines and arrows (a form of relational analysis) to provide an overview of the situation of inquiry (Clarke et al., 2015). This form of relational analysis is key as it reveals the existing complexity, intertwinements, and interconnectedness of different factors related to the situation of inquiry (e.g., opioid use and the Opioid Crisis).

Once I completed several iterations of the messy maps and I determined that the "final" map sufficiently captured the complexity of the situation and all relevant elements, I sorted the elements into an ordered situational map, in the form of a table. Clarke (2005, p. 90) suggested 13 categories for elements of the situation (See Table 1).

Table 1

Clarke's (2005) Ordered Categories

Individual Human Elements/Actors e.g., key individuals and significant (unorganized) people in the situation	**Nonhuman Elements/Actants** e.g., technologies; material infrastructures; specialized information and/or knowledges; material "things"
Collective Human Elements/Actors e.g., particular groups; specific organizations	**Implicated/Silent Actors** as found in the situation
Discursive Constructions of Individual and/or Collective Human Actors as found in the situation	**Discursive Constructions of Nonhuman Actants** as found in the situation
Political/Economic Elements e.g., the state; particular industry/ies; local/regional/global orders; political parties; ngos; politicized issues	**Sociocultural/Symbolic Elements** e.g., religion; race; sexuality; gender; ethnicity; nationality; logos; icons; other visual and/or aural symbols
Temporal Elements e.g., historical, seasonal, crisis, and/or trajectory aspects	**Spatial Elements** e.g., spaces in the situation, geographical aspects, local, regional, national, global spatial issues
Major Issues/Debates (usually contested) as found in the situation; see positional map	**Related Discourses** e.g., normative expectations of actors, actants, and/or other specified elements; moral/ethical elements; mass media and other popular cultural discourses; situation-specific discourses

Clarke (2005) noted that it is not necessary for researchers to make use of every category that exists in this example, as she encouraged researchers to consider what is most optimal for their dataset to examine the situation of inquiry. Furthermore, creating this table was not a required procedure in SA, but I chose to do so to further engage with, scrutinize, and critically think about opioid use.

Social Worlds/Arenas Maps. Following the messy and ordered situational maps, I began to create the social worlds/arenas map. This form of mapping aimed to explore the major stakeholders and social groups involved in the situation of inquiry (i.e., opioid use and the Opioid Crisis). Rather than exploring micro-level elements and their relational interactions, researchers use this form of mapping to depict groups of micro-level elements that engage with the situation of inquiry (e.g., nurses or lawyers). This mapping aims to describe how these groups engage with the situation through belonging to specific *social worlds* and *arenas* that act on the situation of inquiry. Clarke (2015) described social worlds as "social spheres" (e.g., police offices, lawyers, therapists) that engage with the situation of inquiry from a shared context (i.e., arenas). Overlapping social worlds and arenas is commonplace and social worlds can exist in multiple arenas simultaneously (e.g., outreach workers existing in recovery and social and political arenas). Furthermore, individuals can also exist in many worlds (i.e., an individual can be both a therapist and an outreach worker), which may indicate potential sites of tension and warrant added exploration.

Positional Maps. While developing situational and social worlds/arenas maps, I identified potential topics of tension within the situation of opioid use and the Opioid Crisis, leading to many positional maps. Positional maps are the final iterative map in SA. I used positional maps to explore positions identified (and not identified) in the data through visual representations of major positions taken within the situation of inquiry. Clarke (2015) emphasized that these maps illustrate existing positions in discourses, not any individuals or groups. These maps often illustrate the tensions and existing areas of contention uncovered (or missing) from the data by placing them across two axes (i.e.,

x and y) displaying where each position would exist in relation to topic of tension being mapped. I depicted positions as they were within the data.

Rigour and Trustworthiness

Throughout this research process, I strived to ensure my process was rigourous and trustworthy. Previously established guidelines for the rigour and trustworthiness of qualitative studies have been outlined by Shenton (2004) and includes dependability, credibility, and confirmability. In addition, Clarke (2005) emphasized the role of reflexivity, memoing, and peer consultation in terms of the rigour of SA.

Dependability

The dependability of qualitative studies is often addressed through in-depth descriptions of methods used (e.g., operational detail of data gathering and reflexive procedures during data collection in SA) to allow for the study to be repeated and fully understood (Shenton, 2004). Furthermore, in studies using SA, following the SA procedure carefully according to Clarke's (2005) descriptions. I addressed dependability by adhering to Clarke's (2005) guidelines and providing in-depth methodological descriptions in chapters three and four, in addition to memoing (Clarke, 2005) during data collection and analysis.

Credibility

Credibility, the qualitative version of "internal validity" for quantitative studies, is defined by Shenton (2004) as the answer to the question "how congruent are the findings with reality?" (p. 64). In this study, credibility was ensured through the use of previously validated research methods (Clarke, 2005). Furthermore, the use of semi-structured interviews and surveys with open-ended questions ensured an open space for participant responses (which were quoted exactly as written or spoken by the participants), allowing for honesty in participant responses and triangulation of data (i.e., use of difference methods for data collection; Clarke, 2005; Shenton, 2004). To add further credibility to this

study, the results and conclusions of this study were examined by my research supervisor and lab members (at master's and doctoral levels) to ensure proper procedural and evaluative processes.

Confirmability

Confirmability of qualitative studies involves ensuring that the results are reflective of the participants' true experiences as opposed to the areas of interest for the researcher. To address confirmability, I invited my supervisor and research lab to scrutinize my results and ensure they were interpretable by other people aside from myself (Shenton, 2004). I met with my research lab multiple times throughout the analysis process, sharing various iterations of the visual maps, and invited them to provide feedback and criticisms. This process confirmed that my decision-making process and subsequent results were located in participant data (using exact quotes), rather than solely driven by my own positionality and past research. Even though confirmability is not an explicit goal of SA, the methodology lends itself well to open exploration of a contested situation while ensuring the quality results based on participant responses. The process of mapping is iterative in nature, meaning I constantly returned to the participant responses, using them to directly inform the creation of newer iterations of my situational maps. This process avoids any issues of confirmability through the lens of SA.

Reflexivity

Clarke (2005) emphasized the importance of reflexivity throughout her descriptions of the procedures for conducting SA. Reflexivity is an important characteristic of SA, acknowledging that through the very act of research, the researcher is "directly in the situation we are studying" (Clarke, 2005, p. 12). To accomplish reflexivity in my analytic procedures, I engaged in reflexive journaling and memo writing to consistently challenge my thinking and critically examine the data and how I interpreted the data. I also acknowledged and considered my own assumptions and positionality regarding opioid use the Opioid Crisis while developing the research products and findings. This process

ensured that I was honouring the perspectives of the participants of this study over my own beliefs or assumptions. Furthermore, I created an identity map to further consider the influence of my positionality. In her newest SA book, Clarke (2017) emphasized several positivist recalcitrancies of GT regarding positionality. This included a lack of reflexivity about the research process and products, and the assumption that the researcher should be a tabula rasa (i.e., blank slate) in terms of prior experiences and scholarly knowledge or theory. In terms of my own reflexivity, the topic of this study, the questions I asked, how I engaged with and interview participants, how I analyzed the data, what I placed emphasis on in analysis, and how I wrote, were all influenced by my positionality. For example, my questions in both the survey and interview about the police, the healthcare system, and personal relationships were likely influenced by my work with the [Sensible drug policy group] and interest in social justice. My background as an MSc Counselling Psychology student has also influenced the questions I asked (e.g., orienting to lived experience and recovery) and the relational pathways I and see in the data due to my orientation towards social justice and advocacy.

Memoing

As I collected and analyzed the data, I engaged in thoughtful journaling (i.e., memoing; Clarke, 2005) regarding my relationship with the research I was conducting. These memos themselves are a form of data in analysis as I am also situated within the context of the study and therefore, an actor in the situation of inquiry. I acknowledged my own situatedness and positionality in relation to opioid use and my perspectives shifted throughout the data collection process based on the ideas I pondered and questions I asked myself (see Figure 3 in Chapter 4). The notes I wrote focused on my thoughts and assumptions regarding the interviews and other data I was analyzing. I asked myself questions such as, “how does this perspective make sense given their experiences?” or “what stakeholders are missing or what perspectives are missing from the data?” This informed the data by allowing me to consider multiple perspectives on any given topic (e.g., utility of harm reduction).

Peer and Expert Consultation

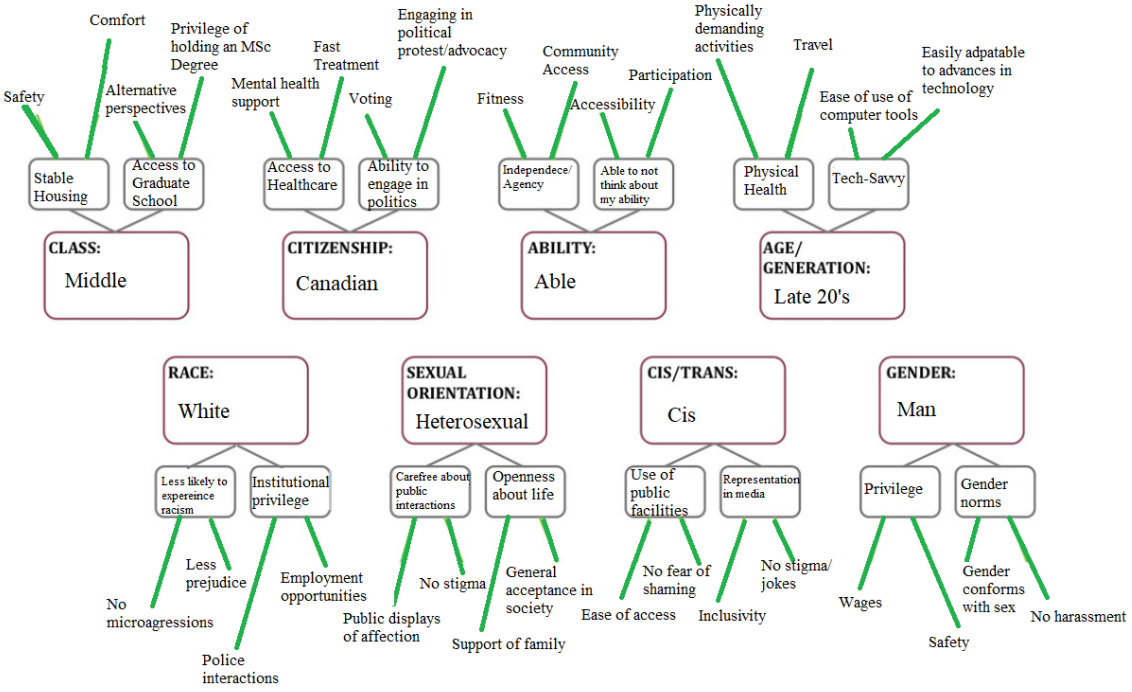
As a part of the research process, I consulted with my research supervisor, a doctoral student in my research lab who has experience with SA, other doctoral and master's students in my lab, and two experts in critical qualitative research (my examining committee; Drs. Lacerda-Vandenborn and Alonso Yáñez). Their thoughts added rigour and trustworthiness to my method as I used their critiques and comments while I was creating the "final" research products. I consulted with the larger group of lab members again when creating the positional maps to determine if the maps were sufficient and fully inclusive of salient elements of the situation and existing contests therein. Additionally, my examining committee's expertise in critical qualitative research increased my awareness of the influence of my positionality in this project.

Identity Map

Following consultation with experts in qualitative research (Drs. Lacerda-Vandenborn and Alonso Yáñez), I was recommended to complete an identity map (Jacobson & Mustafa, 2019) to further explore and articulate my understanding of the influence of various aspects of my own positionality on the research I conducted. I considered how my own personal characteristics including, but not limited to, my ability, age, race, sexual orientation, and gender influenced my research process and writing.

Figure 1

Identity Map



While creating this identity map (Figure 1), I struggled to fill in every gap because before this exercise, I believe I had never gone this far in-depth regarding my positionality and its influence on my work (research and counselling practice). Previously, when considering aspects of my own identity such as class (middle), ability (able), age (late 20's), race (White), sexual orientation (heterosexual), and gender identity (cis male), I knew they all had an influence over my writing. This was because of previous reflexive exercises throughout my degree programme which made me consider how these factors influenced my work (e.g., being respectful of others and acknowledging my biases and assumptions). However, I did not fully consider how these aspects of my identity influenced most areas of my life, and of this project including how I interacted with participants, how I interpreted the data, and what I chose to focus on in terms of discussion, conclusions, and implications. Through completing this exercise, I gained more perspective on how these personal characteristics of my identity have shifted my engagement with my research topic.

In terms of my class, I grew up in a middle-class family and did not have experiences with housing and food insecurity. My own class experience resulted in feelings of safety and comfort, which are two aspects that may be different for some participants in this study who did face housing and food insecurity in their lives. My own experience with class influenced my interpretations of participant experiences who did not share the same background as me, as I lack their experience. As previously mentioned in the literature review, housing is one of many important characteristics involved in risk of overdose. As a result, my discussion of this topic is mainly based on literature and not lived experience.

Additionally, I have no idea how participants perceived me as a researcher during interviews or after reading consent forms before the survey, and how this might have impacted responses. For example, if I had lived experience various social inequities, there might have been a more common ground and connection between myself and some participants. This would change our interactions. I wanted to create a safe space for discussion in this study, but I don't know if this was felt or if participants would have spoken to me differently if the context was different. Since the interviews were all audio, responses could have also differed if participants were able to see me and what I was wearing – I always wore casual clothes versus collared shirts to not give off the image of expertise or higher class or status and this could have directly influenced our conversations.

My age/generation influenced some aspects of this study, such as recruitment, mainly through my technological preference and ability. I identify as a tech-savvy individual, meaning I feel comfortable and proficient using computers and technology and accessing different resources and communities online. My ability in this area allowed me to utilize reddit.com for most of my recruitment and to retrieve research articles commonly inaccessible due to paywalls by journals. I was excited to use reddit.com because of my previous experiences with the website and knowledge that I would likely get a good sample and access a population easily. At the completion of my research project, I realize that this

likely impacted the demographic representation of my sample. Specifically, my sample was comprised of other technologically inclined individuals who choose to discuss substance use in an online forum.

My race, sexual orientation, and gender identity were also factors that influenced how I engaged with this research project. I identify with primarily dominant populations in terms of my race, sexual orientation, and gender identity, therefore, I lack personal insight into the experiences of members of non-dominant groups. As previously mentioned in terms of my class, my knowledge regarding the influence of these intersectionalities is limited to my exposure to the academic literature on the topic and discussions with friends who identify as members of non-dominant groups. This has provided me with second-hand context for my own understanding of how these aspects of one's identity and social location can influence opioid use. I do not know what it is like to be a member of a non-dominant population and the additional systemic barriers and oppression that members of these communities face daily, which undoubtedly influences how they may cope (e.g., through opioid use or other methods). The literature review for this study emphasized the disproportionate impact of harmful opioid use on BIPOC populations, but the sample of this study was mainly White, with the vast majority of the interviews being White men, likely due to recruitment choices.

Ethical Considerations

Before data collection, I received ethical approval for my study from the University of Calgary Conjoint Faculties Research Ethics Board. This included the approval of my recruitment poster which included the phrase "They're just junkies!" This phrase was later deemed harmful, and the poster was removed following an email from a participant that was expressing concern about the language on my poster. The poster was made and used with what I thought were good intentions, simply creating a provocative poster to pull in potential participants (through provocation or curiosity), but I inadvertently harmed at least one participant through its use (see discussion for further reflection on the poster.)

Thankfully, this individual had the courage to speak up and advocate for herself and others and I changed the recruitment method as a result.

I considered the participants of the survey and interview process a vulnerable population, with their history of opioid use (i.e., illicit substance use). To reduce the likelihood of any negative implications from participation in my study, I opted only include participants who self-identified as recovered from opioid use (versus individuals actively using opioids). I made this decision to prioritize the health and well-being of participants. Since I considered the participants members of a vulnerable population, I took additional steps to ensure their safety throughout the research process. In terms of the survey portion of the study, participants read a consent form (See Appendix C) and provided their informed consent before answering any questions. Following the end of the survey, or if someone chose to end the survey early (by clicking "end survey"), a page appeared for all participants that included a list of resources related to treatment for substance use and relapse prevention, along with additional mental health supports. For the interview portion of the study, participants read and provided informed consent a second time using a different consent form specific to the interview process (See Appendix E). Before beginning the interview, I reviewed the consent form again, asked participants if they had any questions, and informed them that they could stop the interview at any time.

All interviews were audio recorded and auto-transcribed using Zoom, a secure University of Calgary video platform. I provided participants with the opportunity to retract their participation for two weeks following their interview. All but one participant chose to have their video off from the beginning of the interviews, with the one person who initially had theirs on choosing to turn it off once we began. The option to have the camera off may speak to the degree of comfort and vulnerability of the participants when discussing a sensitive topic such as prior opioid use. Upon reflection, choice of audio only may have influenced the depth sharing of personal experiences regarding opioid use, whereas video might have reduced comfort and consequently depth of sharing.

Due to the sensitive nature of the topics discussed in the interviews, I took steps to protect the confidentiality of all participants. Following the two-week period, I removed all identifying information from transcripts before analyzing the data. Each participant was given a number and a corresponding pseudonym. If participants uttered any personal information in their interview, I manually removed this identifying information and replaced it with "<REDACTED>". All data (e.g., transcripts, survey data, consent forms, etc.) were stored, based on an assigned participant number, on a secure external hard drive with encryption. All physical information (e.g., maps, memos, etc.) was stored in a binder in a locked filing cabinet.

Chapter Summary

In this chapter, I provided an overview of my chosen theory-method package, SA. First, I reviewed the theoretical underpinnings of the project, SC, and introduced the notions of tension and complexity within the situation. Then I introduced SA as a theory-methods package ideal for use in the context of this research project. Next, I reviewed my research process including data collection and analysis. I concluded this chapter with a discussion of rigour, trustworthiness, and ethical considerations. In the next chapter, I share the data and research products I created using SA.

Chapter 4: Results

To explore my research question, *How is the complex situation of opioid use and the Opioid Crisis represented by former opioid users?*, I collected and analyzed survey data and transcripts from interviews. I used Clarke's (2005) Situational Analysis (SA) to represent the complexities and contested nature of the situation of inquiry (opioid use and the Opioid Crisis) from the perspectives of the participants. Following Clarke's (2005) analytic process for conducting SA analyses, I created multiple maps to explore the situation broadly and examine the data in meaningful ways.

Participant demographic data were collected in the survey completed by all participants (See Appendix G). The demographic data included: age, race, gender, religion, education, income level, and marital status. All quotations from interviews can be traced back to the specific interview participant and their demographic information found in Table 2. All other quotations are from survey participants who were not interviewed. All quotations are un-edited.

Table 2

Demographic Characteristics of Interview Participants

Pseudonym	Age	Gender	Race	Education	Income Level	Religion	Marital Status
Cara	33	Female	White	High School	Middle Income	Christian	Engaged
Walter	35	Male	White	Bachelor's Degree	High Income	Atheist	Single
James	26	Male	White	High School	Middle Income	Christian	Married
Liam	26	Male	White	High School	Middle Class	Atheist	In a Relationship
Bill	29	Male	White	High School	Low Income	Agnostic	Single
Derek	36	Male	White	Master's Degree	Low Income	Agnostic	Single

Situational Analysis Mapping Process

Using the analytic mapping procedures outline by Clarke (2005), I created, modified, and revised three kinds of maps to explore different aspects of the survey and interview data: (a) situational maps, (b) social world/arenas maps, and (c) positional maps. My analytic process consisted of examining participant data while keeping in mind the literature, my positionality (paying attention to who I am in the research process), my prior assumptions, and memos (used to reflect on my own assumptions and thoughts throughout the research process). Since I wanted to privilege the voices of participants, I used their data to guide my inquiry. I consulted with my lab members and supervisor while iteratively revising all maps several times by editing, adding, removing, and relocating pertinent elements in each map until the "final" maps were deemed to be adequately representative of the data. The intention behind these maps is to provide a representation of opioid use and the Opioid Crisis based on the data collected. These maps are not intended to be considered absolute, objective representations of the situation (Clarke, 2003). Rather, they were created to better understand opioid use from the perspectives of former opioid users and invite discussion about opioid use as a deeply complex and contested topic. Next, I describe my process of map making, as well as the meaning and use of these maps in this research project.

Situational Maps

I created two forms of situational maps: messy maps and ordered maps. For each map, I outline the purpose, analytic process, and findings.

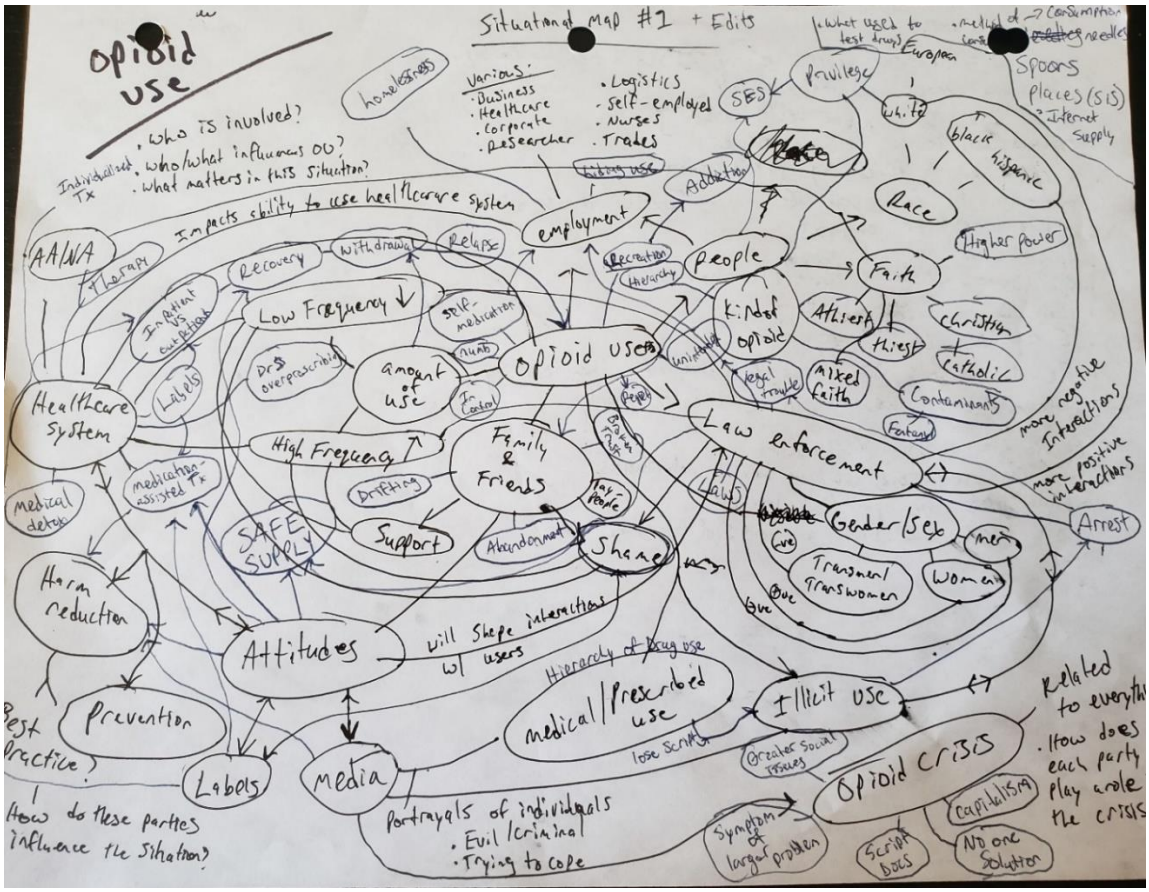
Messy Situational Maps

Messy situational maps are free-form representations of all human, non-human, material, and discursive elements described by the participants as important in the situation of inquiry – opioid use and the Opioid Crisis. Messy situational maps explore relationships and complexity between elements. The nature of these messy situational maps is just that, visually messy and complex. They are meant to be unsystematic, exploratory in nature, and function as an analytic exercise intended to immerse the

researcher in the data (Clarke, 2003). Once I finished collecting survey data, I began creating the first messy map (Figure 2). I analyzed the survey data by reading the spreadsheet line-by-line and noting all relevant elements related to opioid use and the Opioid Crisis. Next, I plotted each element I noted while simultaneously linking them with directional arrows indicating the directionality of the relationship (e.g., an arrow pointing from "friends and family" to "support" and "abandonment" indicates that friends and family are associated with either support or abandonment or both in the context of opioid use). Once I determined that the messy map had sufficiently captured the perspectives reflected in the survey data, I reviewed the interview transcripts line-by-line while listening to the audio recordings of the interviews and began the same process with a new iteration of the messy map. For each interview, I noted all relevant elements and added them to the map, along with directional arrows. This resulted in several more iterations of the messy situational map. During this process, if I felt I could organize the messy map more clearly or there were too many new elements to add in a small space, I would restart the map and begin a new iteration.

Figure 2

First Iteration of the Messy Situational Map



A major purpose of the messy maps was to conduct a relational analysis (as observed by the arrows in Figure 2). The purpose of the relational analysis was to explore the many potential relations between all existing elements involved in opioid use and the Opioid Crisis (i.e., how they interact, alter, stabilize, or influence each other; Clarke, 2005). I chose to construct messy maps and complete relational analyses concurrently as it felt more natural to explore the relationships between the identified elements within the map itself as I was creating the map and considering all elements. Additionally, by conducting these two processes at the same time, I was able to identify contests and tensions within the data before explicitly exploring various positions in the positional maps. For example, in Figure 2, I depict a relational pathway between the elements “healthcare system,” “harm reduction,” “prevention,” and “attitudes.” This relational pathway highlights a relationship between the role of the healthcare system and the implementation of harm reduction and prevention strategies to treat addiction.

Throughout this process, I wrote memos focused on potential relationships between elements (see Figure 3 for an example).

Figure 3

Research Memo from June 12th, 2021

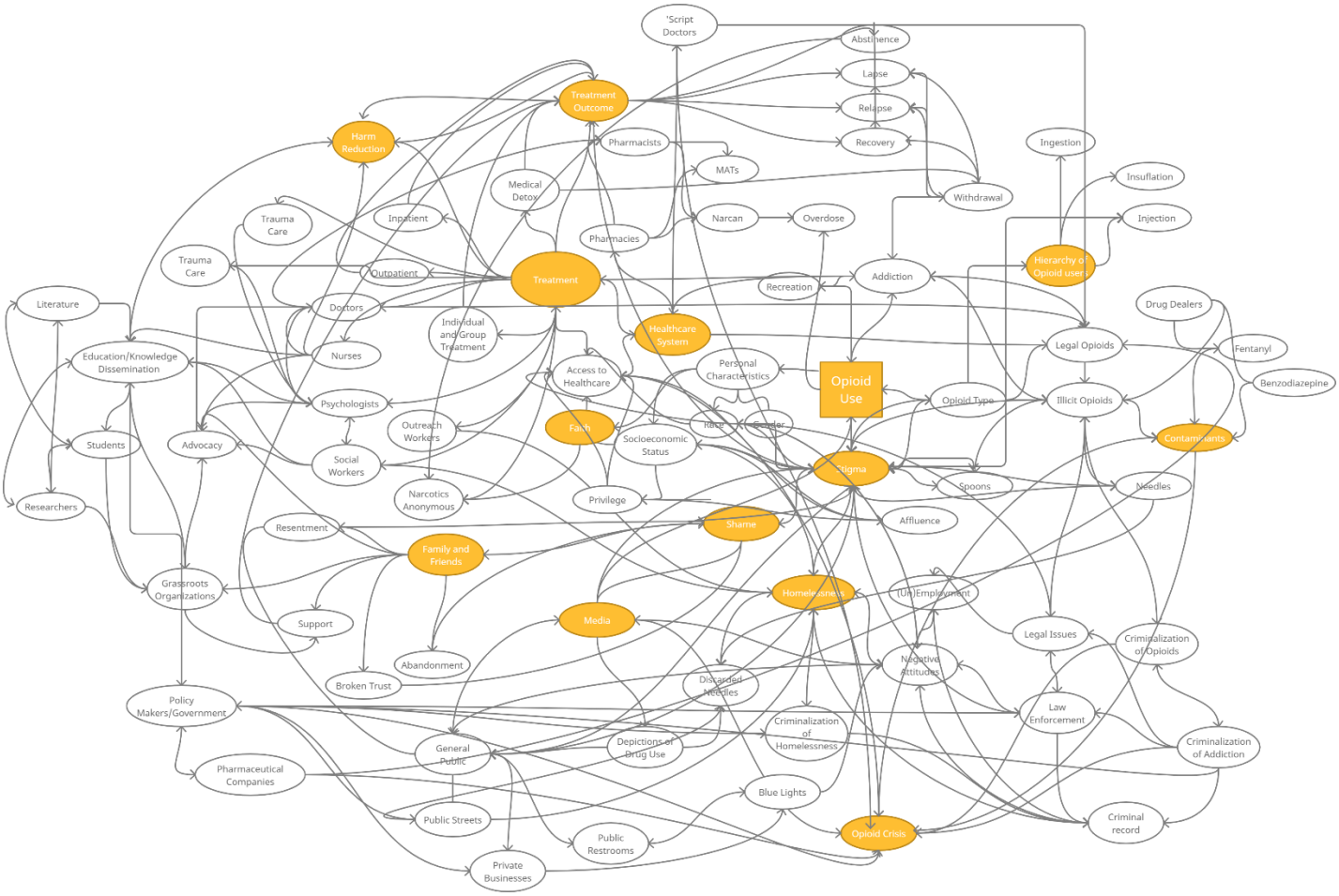
June 12, 2021:
Messy map notes:

- Opioid use as the central connecting point for all elements
- Who is involved? Who/what influences OU? How do these elements influence each other? What actually matters in this sitation?
- Opioid use directly branches to recovery, treatment (therapists, different treatment methods, the healthcare system itself), supports (e.g., church, family and friends), aspects of criminalization, contributions of form of use (i.e., frequency, type of drug, method of administration)
- Connections between branches to recovery and existing supports?
- How do attitudes play a role in shaping interactions between users and others?
    - Stigmatization of a vulnerable population → increases difficulty of recovery
- It seems as though most specific elements are connected to a wide variety of other elements that may not be thought of as being directly related.
    - E.g. – Capitalism and opioid use → initially pharma companies pushing doctors to overprescribe → more people use opioids → increases in addiction rates.
- Stigma wasn't specifically mentioned at first but it is extremely relevant and influences the situation directly though stigmatization of opioid users
- Does a hierarchy of opioid users exist?
    - Hierarchy based on drug used
    - Based on method of use
    - Based on SES??
    - What the implications of this hierarchy? → different access to Tx? Different treatment from the public/police/healthcare workers?

Due to the sheer messiness of adding new elements to existing maps repeatedly, I created several iterations of the messy map before settling with a "final" version (Figure 4). It is worth noting that while this map is termed "final" it is not meant to insinuate that this is an exhaustive map of every possible element that could be related to opioid use and the Opioid Crisis.

Figure 4

"Final" Messy Map



Note. The yellow shapes on this map reflect the most salient elements expressed by participants in both survey and interview data.

For the final version of the messy map (Figure 4), I considered all elements mapped and retained through the various iterations of the map. I used the colour yellow to indicate the elements that were most salient and the primary focus of relational analysis. Due to the complexity and multitude of interconnected relationships between many of the elements within this map, it is not feasible to do a relational analysis for each potential relationship. However, I outline several pathways that were especially pertinent due to the higher number of participants discussing these topics. First, I depicted a relational pathway between the elements: Opioid use → Media → Stigma → Shame. This pathway explored the relationship between media depictions of opioid use and the subsequent shame and

marginalization felt by opioid users. It is common for media depictions of opioid use and opioid users to be negatively framed, resulting in shame, as described by opioid users (participants). Survey participant #50 wrote:

> Media and pop culture has a way of mocking drug users, or portraying them in a non sympathetic light. These people need love and support, not to be told that they're part of an ongoing crisis, it makes you feel so hopeless and marginalized.

Second, I noted the relational pathway: Opioid Use → Opioid Type → Stigma → Treatment Outcomes. This pathway describes stigmatization participants described based on the type of opioid (i.e., illicit powder heroin, prescription pills) they used, leading to negative treatment outcomes (e.g., not attending treatment or giving up on treatment). According to some participants, individuals who use powder opioids or inject opioids are viewed as "different" than individuals who use prescription opioids. Being viewed as "different" or as an outcast could potentially lead to further opioid use in a harmful context. This is an example of a commonly described outcome (i.e., poorer treatment outcomes because of the direct impacts of stigmatization) described by participants who experienced stigmatization from others based on the type of opioid they use. Survey participant #1 wrote, "some attempt to separate the responsible users from abusers needs to take place. Prescription users are different than illicit abusers." Similarly, some participants also noted how family members and friends were a source of stigmatization. Survey participant #31 wrote, "I lost many friends, and my father's side of my family. It got to the point where they'd just call me a junkie and avoid me."

Experiences of stigmatization from police officers and medical professionals reportedly occurred as well. Survey participant #62 wrote that her experiences with police officers were "All bad. Treated like scum every single time. Regardless if they were there because of me, or if I was just there etc." She went on to explain:

> I went to the hospital and was admitted, i was treated like human scum. I was searched by medical staff. I was told i would go to hospice and visitors and myself would be searched going in and out. I was treated like shit, by the higher level nurses and social workers at the hospital. I was on the literal edge of death for over a week and day in and out i was treated like i was a pile of human garbage. (Survey participant #62)

Stigmatization from the general public was also reported, most commonly by opioid users who experienced homelessness. Survey participant #51 wrote, "The public doesn't have a very good understanding of people on opiates and looks [at] everyone who's ever used or been addicted as a junky. Turn their head up at you." These survey responses highlight how opioid users themselves, family members, friends, police officers, healthcare workers, and the general public all contribute to the perpetuation of stigmatization, which indirectly influences opioid use (i.e., causes further use) and outcomes of treatment.

Third, I identified the relational pathway: Opioid Use → Addiction → Treatment → Treatment Outcomes → Abstinence, Lapse, Relapse, and Recovery. This pathway explores commonly reported trajectories for recovery. Some participants expressed that abstinence was the solution to opioid use. For example, survey participant #2 wrote, "my family paid significant money for me to go to long-term inpatient treatment which resulted in me remaining abstinent for the last 5 years. My abstinence saved my life." Others described abstinence as helpful for some people, but not the only route towards recovery. For example, survey participant #41 wrote, "harm reduction education needs to be a thing instead of just abstinence. It works for some but definitely not everyone." Some participants reported that recovery involved periods of abstinence, lapses, and relapses, and often involves harm reduction. In her interview, Cara said:

> I do counselling with harm reduction practices, which is something I previously had like four years clean because of, and when I had a relapse I kind of realized, even though I thought I was like I got four years I'm good, I still had a short relapse, but it was still a relapse.

Finally, I identified the relational pathway: Socioeconomic Status → Access to Healthcare → Treatment → Treatment Outcomes. This pathway describes the impact of the opioid user's SES on access to healthcare, treatment, and subsequent treatment outcomes. SES is one of the elements that comprises social determinants of health (i.e., non-medical factors that influence health outcomes, such as race, social supports, and housing status; Haghdoost, 2012; McGovern et al., 2014). Social determinants of health play a role in treatment outcomes because an individual's circumstances may afford or limit access to resources (e.g., affluent people may have more readily accessible healthcare or treatment options versus people of lower SES). In the case of the participants from this study, low SES was reported to influence their access to treatment, which impacted their recovery trajectory and treatment outcomes. Survey participant #57 wrote:

> I believe there is a cultural crisis. There is a perspective crisis. Lives, unfortunately, are not valued equally. The homeless prostitute addicted to heroin is not seen as having the same value [as] a credible scientist and wont get that same treatment or get into rehab.

While these messy maps are visually complicated, they serve to highlight the complexity and messiness of the situation described by participants. After creating the messy maps, I moved to constructing an ordered situational map.

Ordered Situational Map

Once I completed several iterations of the messy maps and I determined that the "final" map sufficiently captured the complexity of the situation and all relevant elements, I sorted the elements into an ordered situational map, in the form of a table (Table 3). Creating this table is not a required procedure in SA, but I chose to do so to further engage with, scrutinize, and critically think about opioid

use. I followed Clarke's encouragement to consider what is most relevant for the data, therefore, the elements and categories I included in my ordered map are not identical to the categories outlined by Clarke (2005). For example, I chose to collapse Political/Economic and Sociocultural/Symbolic Events into one category because when I considered the context of opioid use, I saw the sociocultural elements as political in nature. Sociocultural elements refer to social and cultural aspects of a topic of inquiry such as race, religion, sexuality. In the context of policy on substance use related to opioid use (which is political), policy decisions disproportionately impact opioid users based on certain sociocultural factors (e.g., the disproportionate rate of opioid use and subsequent incarceration of Indigenous people).

Table 3

Ordered Situational Map

Individual Human Elements/Actors Opioid users, families and friends of opioid users, allied health professionals, nurses, doctors, dealers, doctors likely to prescribe opioids, employers, researchers	**Non-human Elements/Actants** Self-help opioid/recovery literature, academic literature, clinician literature, media/news, opioids, heroin, morphine, methadone, suboxone, bupropion, needles, spoons, powder, substance contamination, fentanyl, legislation/policy, enforcement of laws, blue (anti-injection) lights, paraphernalia
Collective Human Elements/Actors Health authorities, therapists, medical personnel (e.g., hospital staff), law enforcement, support groups (e.g., AA/NA), grassroots advocacy groups, substance user advocacy groups, researchers, students, government officials, outreach workers, social workers, religious leaders, the general public, policy makers, lawyers, juries	**Implicated/Silent Actors/Actants** "lay" people, politicians, pharmaceutical companies
Discursive Constructions of Individual and Collective Human Actors (e.g., individual and group stakeholders) Opioid users as experts, opioid users as relational, opioid users as oppressed, opioid users as victims of traumatic events, therapists as advocates, doctors as harmful, doctors as allies, medical personnel as advocates, medical personnel as harmful, medical personnel as helpful, families and friends as allies, outreach workers as allies, researchers as allies	**Discursive Constructions of Non-human Actants** Harm reduction as dangerous, opioids as dangerous, opioids as helpful, needles as dangerous, methadone/suboxone/bupropion as supportive, methadone/suboxone/bupropion as enabling, fentanyl as prolific, blue lights as prevention, opioid literature as biased, opioid literature as legitimate

<table>
<tr><td>Sociocultural/Political/Economic Elements
Socioeconomic status, homelessness, gender, race, education, religion, psychology, substance policy organizations, human rights, mental health policy, personal/professional histories, capitalism, media, Opioid Crisis, movies, music, social media, harm reduction movements, capitalism, mental health policy, policy of substances/ substance use, access to care, peer support, cost of treatment</td><td>Spatial Elements
Public streets, private residences, hospitals, schools, private businesses, detox facilities, sweat lodges, regional addictions recovery centers, pharmacies</td></tr>
<tr><td>Temporal Elements
Current government, Opioid Crisis, active use, lapse, criminalization/scheduling of opioids, relapse, weather conditions</td><td rowspan="2">Related Discourses
Social justice, harm reduction, abstinence-only, anti-substance use, anti-opioid use, substance use as political, anti-oppression, systemic oppression, morals, “proper” or “real” recovery, medical/disease model of recovery, equity for substance users</td></tr>
<tr><td>Major Issues/Debates
Morality of opioid use, function and utility of opioids, location of blame for opioid use, causality of the Opioid Crisis, approaches to recovery, abstinence and harm reduction approaches, safest method of opioid use, responsibility (to self vs others)</td></tr>
</table>

I tried to maintain the complexity of the situation through the “final” iterations of both the messy and ordered maps, but I acknowledge that these maps do not include every possible element related to the situation of inquiry. This map was useful to help me consider elements I overlooked (i.e., systemic oppression) or were not in this dataset, in addition to identifying discursive elements related to opioid use (e.g., identifying discourses such as “abstinence-only”). When creating the messy maps, I privileged participant data, while being informed by the literature and my own understandings and experiences. By using the categories provided by Clarke (2005), I was able to consider elements I had previously overlooked in creating the messy maps (e.g., the influence of discourse). One category, Collective Human Elements/Actors, helped me identify groups of actors with mutual involvement in opioid use and the Opioid Crisis, otherwise known as *social worlds*. In the next section I describe the social worlds/arenas maps.

Social Worlds/Arenas Maps

Following the messy and ordered situational maps, I created four different iterations of social worlds/arenas maps (Figures 4 and 5 are the first and final iterations) to capture the social groups that engage with opioid use and the Opioid Crisis, and the arena(s) to which they belong. Social worlds can be understood as collective groups of individuals who share certain characteristics (e.g., employment, educational history, background, belonging to the same social groups) that make it likely that they will hold similar values and engage in coordinated action in relation to the situation of inquiry (Clarke, 2005). Arenas can be understood as broader areas of mutual concern where different social worlds may share common beliefs and actions with other social worlds. The main difference between social worlds and arenas is the scale. Social worlds are smaller groupings of specific people that can be described as "social spheres" (e.g., police officers, lawyers, therapists; Clarke et al., 2015), whereas arenas are larger umbrella groupings that describe a shared context by which these social spheres engage with topics related the situation of inquiry. For example, in the situation of opioid use and the Opioid Crisis, the social world of "lawyers" exists within the Legal arena because lawyers engage with opioid use in the context of the legality of opioids and related discourses.

Figure 5

First Iteration of Social Worlds/Arenas Map

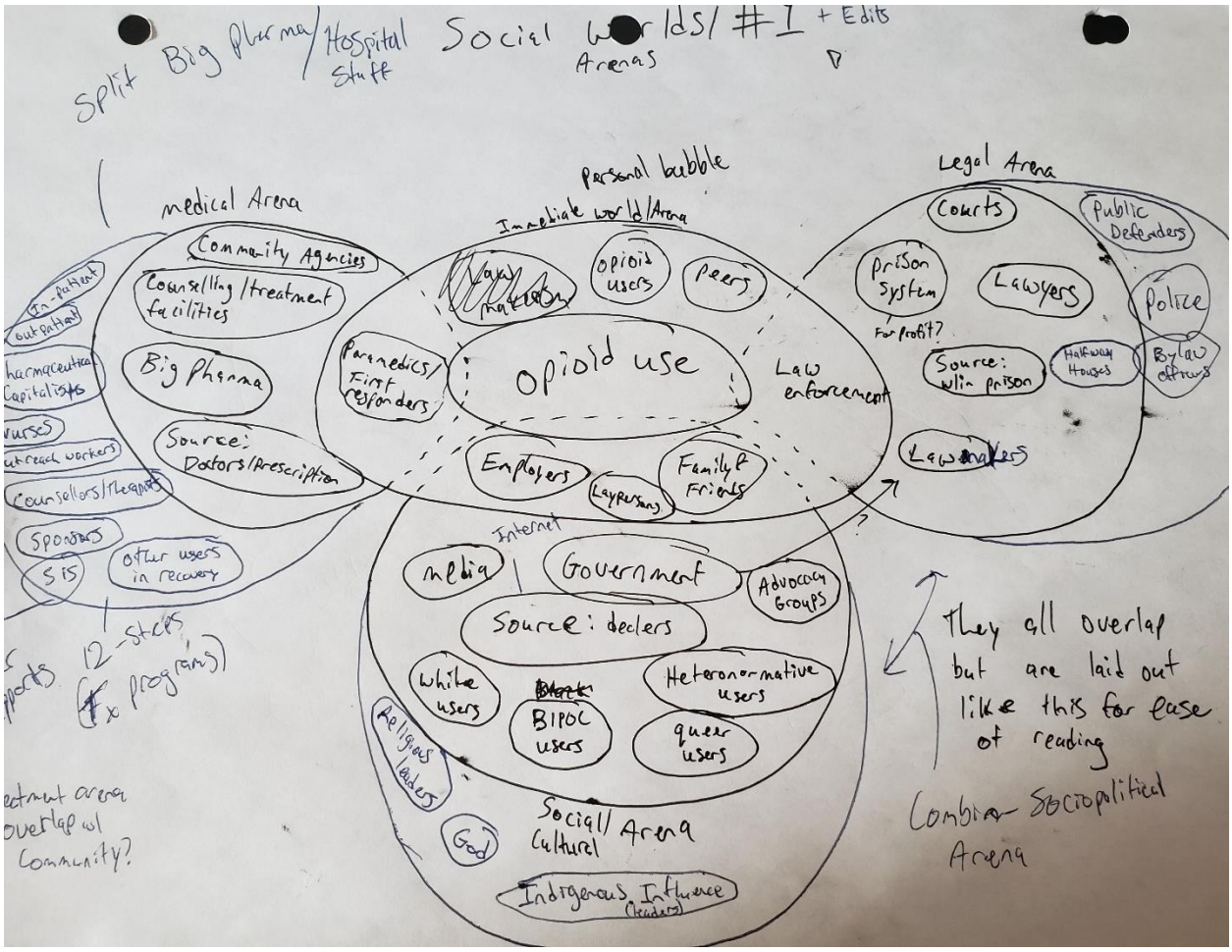
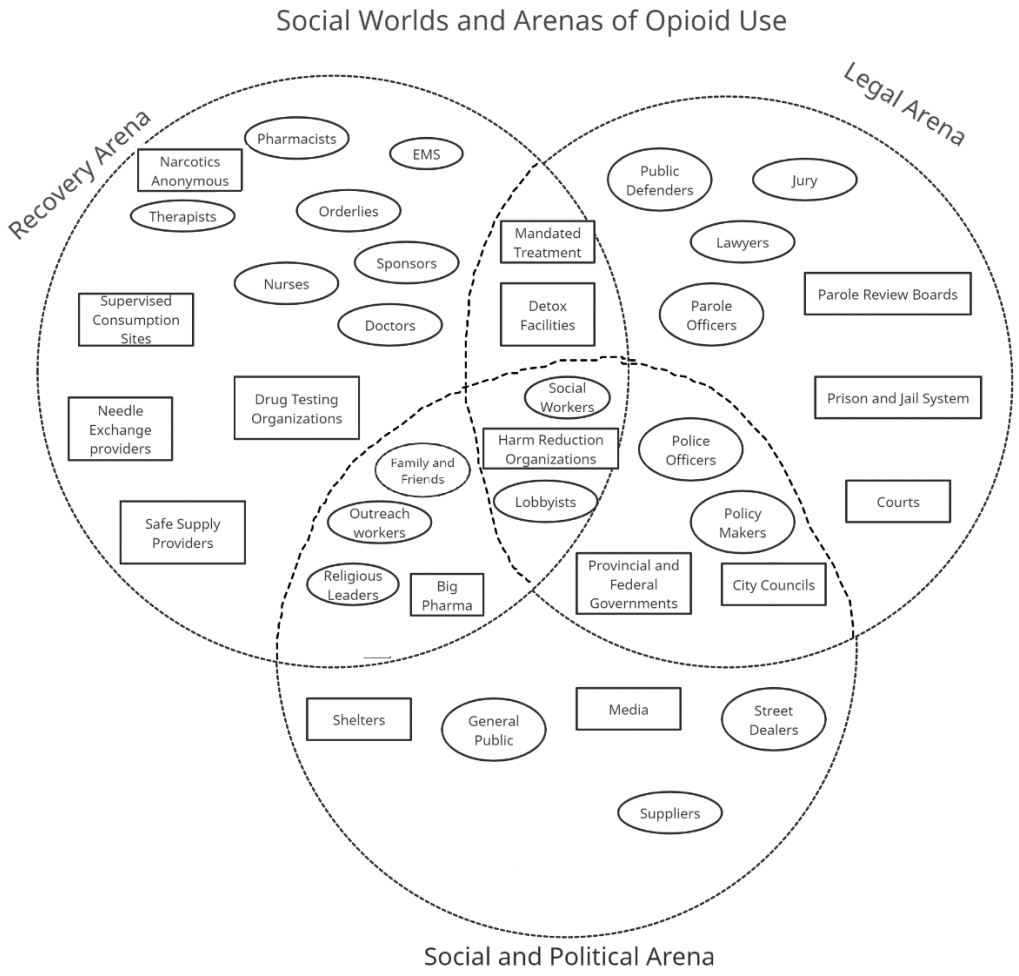


Figure 5 depicts an early iteration of the social worlds/arenas map. Using the situational and ordered maps, in addition to another review of the raw data, I gathered potential "social spheres" and considered how they were related or different from each other. For my first iteration of the social worlds/arenas map, I included some social worlds based on my literature review (e.g., pharmaceutical capitalists) that were not retained in my "final" iteration. I removed these groups from the "final" map as they were not explicitly brought up by participants. Once I identified the social worlds, I began to think about shared and overlapping contexts (i.e., arenas) for the social worlds, and how they might overlap into multiple arenas. Through this process, I decided on three arenas that best fit the social worlds – recovery, legal, and social and political arenas. Throughout the revision process, I organized social worlds and arenas to best capture frequently mentioned elements of participant data. Following several

iterations and consultations with my supervisor and research lab, this map was refined into the "final" version seen below (Figure 6).

Figure 6

"Final" Iteration of Social Worlds/Arenas Maps



In the final iteration of the social worlds/arenas map (Figure 6), the smaller ovals and rectangles represent the social worlds (i.e., collective groups of individuals with a stake in the situation) identified in the data. Rectangles and ovals are used to differentiate between social worlds that are based in institutional/societal structures and those that represent individual and collective actors, respectively. The larger circles represent the arenas where the various social worlds exist and the lens through which social worlds engage with the situation (i.e., a social world in the legal arena engages with opioid use

and the Opioid Crisis through a legal lens). The arenas have hatched borders, indicating the porous nature of each arena, allowing for social worlds to exist in multiple arenas. Arenas are depicted as overlapping due to the involvement of some social worlds in multiple arenas. Social worlds located within the borders of two arenas are social worlds that share multiple contexts for engaging with the situation of opioid use and the Opioid Crisis. For example, social workers are found within the center of the diagram because social workers are involved in treatment (recovery arena), social engagement/political advocacy (social and political arena), and the legal system (through mandated assignment; legal arena).

Social worlds that exist within two arenas are sometimes in tension based on conflicting perspectives when a social world draws from different discourses associated with each arena and hold different perspectives. For example, one police officer might draw from a discourse of criminalization, whereas another might adopt a harm reduction approach, resulting in tension regarding how to engage with the situation. Tensions also occur for opioid users themselves, who may draw upon various discourses and personal experience when engaging with or talking about opioid use. These tensions are explored in more depth in the section focused on positional maps.

The "final" version of the social worlds/arenas map illustrates three different arenas comprised of many of social worlds within each arena. All arenas overlap, allowing for social worlds to exist within more than one arena. Next, I provide details on each arena.

Social and Political Arena

The social and political arena is made up of various groups involved with opioid use and the Opioid Crisis from social and political lenses. The social worlds included within this arena were identified from participant data exclusively. I placed media within this arena due to the use of social and political discourses surrounding opioid use by journalists. Participants noted that the media often perpetuates stigmatization and misinforms audiences of incidents related to opioid use. Many survey

participants noted how the media presents polarizing and sensationalized depictions of opioid use. For example, survey participant #51 wrote:

> I think the media makes it worse, it makes people look down on addiction. There needs to be more education and a positive spin on getting help and talking about it and not it just being scary and overwhelming. Not everyone is a 'junky' and shouldn't be labeled as one.

Furthermore, sensationalized and often defamatory reporting from the media can perpetuate fear towards opioid users among the general population. I included shelters in this arena to represent opioid users experiencing housing insecurity. Addressing and supporting people experiencing homelessness is a form of social action and thus shelters fit within this arena. Opioid dealers and suppliers are also placed in the social and political arena because of their involvement in active opioid use (through the social interaction involved in selling opioids) as well as the political nature of laws restricting their activities involving the sale of illicit substances.

The social and political arena is situated beside the legal and recovery arenas because of these arenas overlap and influence each other. Some participants described community members and community organizations as important to their recovery (social involvement with recovery), while others emphasized the role of the legal system and lawmakers who pass substance-related legislation that impacts community engagement (social and political involvement in the legal system). For example, survey participant #35 wrote, "The local community addiction team and other community resources like [Narcotics Anonymous] NA has always been around and I have used it plenty to help." In contrast, survey participant #1 wrote:

> Many individuals depend on strong pain killers to ensure their quality of life and continued functionality. The needs of those individuals is often overlooked in the current environment. Decisions about drug use, indeed health care system use, should always be "patient-centric". Not

provider-of-system-centric, and certainly not driven by political concerns which often destroy existing community services.

Both sentiments rely on interactions between social and political, recovery, and legal arenas. The overlapping area between the social and political arena and recovery arena contains social worlds such as family and friends, religious leaders, Big Pharma, and outreach workers, all of which take up both social, political, and recovery perspectives in the context of opioid use and the Opioid Crisis. Family and friends are included in this overlapping area because participants described their families and friends in the contexts of providing or withdrawing social supports throughout opioid use and recovery. Interview participant Liam described his family support in his survey response, "My family has always been there for me, my mom is in recovery so they never turned there back on me for a second and were quick to try to help me when I made the call." In contrast, survey participant #31 wrote, "I lost many friends, and my father's side of my family. It got to the point where they'd just call me a junkie and avoid me."

Religious leaders are found in this overlapping area due to the role of faith in some individuals' recovery. Outreach workers are found in this area because their role as community workers engaging with users on the frontlines, while working towards helping individuals who wish to begin recovery. Big pharma is found in this area due to the utilization of pharmaceutical medications in recovery and the political influence these large corporations have on the general public and lawmakers.

Legal Arena

The legal arena is comprised of several social worlds and collective actors that share a mutual concern regarding the legality and enforcement of laws surrounding opioid use. Relevant stakeholders (i.e., social worlds) within the legal arena include lawyers, public defenders, courts, juries, parole review boards, parole officers, and the prison/jail system. The social worlds within this arena are connected through the processes of the criminal justice system and are therefore more likely to share perspectives stemming from a background in criminal justice. As a result, opioid users encounter many of these

social worlds under circumstances related to the criminalization or legality of opioid use. Opioid users may be arrested or charged with crimes related to opioid use. There may be a variety of perspectives taken by individual members of each social world, however, based on participant data, most interactions between opioid users and these social worlds were described as harmful. When asked about experiences with the legal system and police officers, Survey participant #41 wrote:

> Horrible. The first time while I was dead on the floor they searched the room of the house I was in (not mine) locking owners out and found an old needle under the couch and charged me with possession of heroin, possession of drug instruments. The next overdose didn't go over too well either. I came to after narcan screaming at the police without realizing I was telling them off and they took me to jail for 4 days before I could get out. Which helped me stop using IV but not get clean.

This quote directly describes harmful practices by police officers experienced by this participant. Rather than attending to the person in medical distress, they opted to find any form of evidence to warrant criminal charges. Another example of negative interactions with police officers is described by Survey participant #63's writing:

> i was searched, pulled over, maaaaaany times. dogs, etc. been to jail three times, two heroin possessions and one DUI cops are mean, don't care, and treat addicts like dirt. (i am also a human trafficking victim who was not looked for because i was a known addict) so i really. don't. like. cops. or the entire system. haven't had good experiences.

The overlapping area between the Legal and Social and Political arenas contains social worlds such as police officers, policy makers, city councils, and provincial and federal governments, all of which interact with social and political elements in different ways. Police officers interact with opioid users directly, by having to enforce laws (an extension of political influence and implementation of legal rulings on substance use), therefore relating this social world to both the legal and social and political

arenas. Policy makers, provincial and federal governments, and city councils all engage with opioid use through political means – these social worlds contribute to development and implementation of laws that directly affect opioid users (e.g., criminalization of opioid possession) and change policies which can impact opioid user's social determinants of health (i.e., income, housing, access to affordable healthcare).

The legal arena also overlaps with the recovery arena due to the influence of policy on substance use and mandates for treatment. I included mandated treatment facilities and detox facilities because they are often legally enforced. Based on participant data, mandated in-patient treatment and the use of detox facilities are relatively common outcomes of criminal charges for an opioid-related crime. Many participants described this outcome as helpful (e.g., support while facing withdrawal and increased access to treatment), even if they weren't interested in treatment at the time:

> the cops and EMS revived me after an overdose, and i was forced into treatment (inpatient and outpatient treatment centers) . . . All were positive experiences (with the medical professionals) even though I was not interested in continuing treatments or using them correctly (Survey participant #2).

Recovery Arena

The recovery arena is made up of social worlds with a mutual concern regarding opioid use recovery. I revised this arena several times based on consultation with colleagues, which invited consideration of explicitly noting abstinence and harm reduction in the name of the arena. I ended up retaining the name "Recovery Arena" to honour and privilege the perspectives of the participants. Most of the participants expressed an inclusive understanding of recovery by describing various forms of recovery as acceptable and useful for individuals in need (i.e., a recovery-oriented approach). Therefore, "recovery" was a more inclusive label for this arena because it reflected participant descriptions and perspectives most accurately.

Supervised consumption sites, Safe Supply providers, needle exchange providers, substance testing organizations, nurses, doctors, therapists, pharmacists, orderlies, and EMS personnel are all social worlds that engage with recovery, abstinence, and/or harm reduction. Commonly, participants were supportive of these social worlds intervening in their opioid use considering the collaborative nature of these interactions. For example, participants described Safe Supply (i.e., providing clean opioids as an alternative to contaminated street opioids) as an essential service for preventing overdose and death from opioid use. Interview participant Liam said:

> If some people could just go to the clinic and get clean heroin, not only would the government make plenty of money from that, but also like I think it would stop a lot of people from from dying, which I think should be the ultimate goal here is to stop people from dying and stop crime and keep money out of the hands of, even more so keep money out of the hands of violent criminals.

Social workers and lobbyists are social worlds located in the centre of the diagram due to their overlap in each arena. In addition to providing recovery support, social workers support living conditions for many opioid users (e.g., housing, access to healthcare, and access to food) and engage with users through the legal system. A social worker might have an opioid user as a client through legal proceedings, involvement in the medical system, or provide counselling and support. Lobbyists represent individuals or groups that lobby government for political change to benefit certain groups. Lobbyists may come from pharmaceutical companies, harm reduction organizations, police unions, etc., and work to influence policies centered on opioid use and recovery. Lobbyists engage with the social and political arena directly through their political influence. Lobbyists also engage with the legal and recovery arenas through attempts to change laws and policies related to opioid use in ways that can either harm or benefit opioid users (e.g., lobbying to change policies on substances that criminalize opioid possession or mandate treatment).

Given that some social worlds exist within several arenas, it is common for social worlds to conflict in terms of how they position themselves within a discourse involving more than one arena. This results in tensions for social worlds who find themselves torn between different positions (e.g., positions supporting harm reduction or abstinence in the context of recovery-related discourses). Opioid users also experience tensions based on interactions with the various social worlds and arenas. In the next section, I depict tensions described by participants of this study in positional maps.

Positional Maps

The final procedure in SA mapping is creating positional maps. Positional maps are used to identify and explore the various positions (i.e., potential perspectives on issues) expressed in the data, in relation to the situation of inquiry (i.e., opioid use and the Opioid Crisis). Positional maps depict common, less common, marginalized, and silent (i.e., absent) positions in the data (Clarke, 2005). These maps do not represent social worlds, arenas, or any specific actors related to the situation of inquiry, but rather positions one might take or adopt on an issue or concern. It is important to note that even though the maps themselves do not explicitly represent social worlds and arenas, it is from within these arenas and through the experiences of social worlds that positionality is located. In my mapping, I relied heavily on the participant data and most of the positions plotted on the maps are directly rooted in quotations from participants. In line with social constructionism (Gergen, 1985; Gergen, 2009), I chose to privilege the exact wording and perspectives of the participants over traditionally expressed perspectives that may exist in the literature. As a result, some positions use terms and language often rejected for lacking inclusivity and respect (e.g., “addict”). Person-first language is used in all contexts aside from explicit quotations from participants and their related positions mapped on positional maps.

I created positional maps using vertical and horizontal axes, with each axis representing a range (e.g., less to more) or spectrum of different positions related to the topic of the map. I created many versions of maps by hand to allow my iterative process to continue through this stage of mapping. The

final versions of these maps are presented in this section. Positions that have an asterisk beside the numeral indicates a silent position (i.e., a missing position that I did not observe in the data). Missing positions are important to outline in the context of these maps as they represent perspectives that are pertinent to the topic of the map (and perspectives held by others) but were not noted explicitly by the participants of this study.

To construct the positional maps, I returned to the data and previous maps to identify contested issues and sites of tension within the data (Clarke, 2005). By reviewing the survey data and interview transcripts, I identified specific positions related to each site of tension that I previously identified. Throughout the process of developing these maps, I met with my research lab and supervisor on multiple occasions to discuss potential tensions, positions, and how I might plot the complexity and diverse perspectives from the data. A memo written on October 25th, 2021 provides an example:

> When considering my recovery pathway map with Tanya, we were struggling to determine the best way to express both 12-step/abstinence perspectives as well as harm reduction-focused perspectives within one map. After considering how there is diversity amongst even perspectives of abstinence only and people who adhere to 12-step programs, it might be beneficial to allow two maps to be made. One map can focus on the respect people receive versus whether they are abstinent or only trying to follow the 12 steps and another map can focus on the respect people receive versus different levels of harm reduction. But then I wonder if there was another way to express both perspectives while retaining only one map. I will play around with it and ask for some feedback once I have come up with something.

I originally created ten maps that depicted positions related to opioid use and the Opioid Crisis. However, following further review and consultation with my lab members and supervisor, we determined that ten maps were not required to adequately capture the existing positions, but rather they

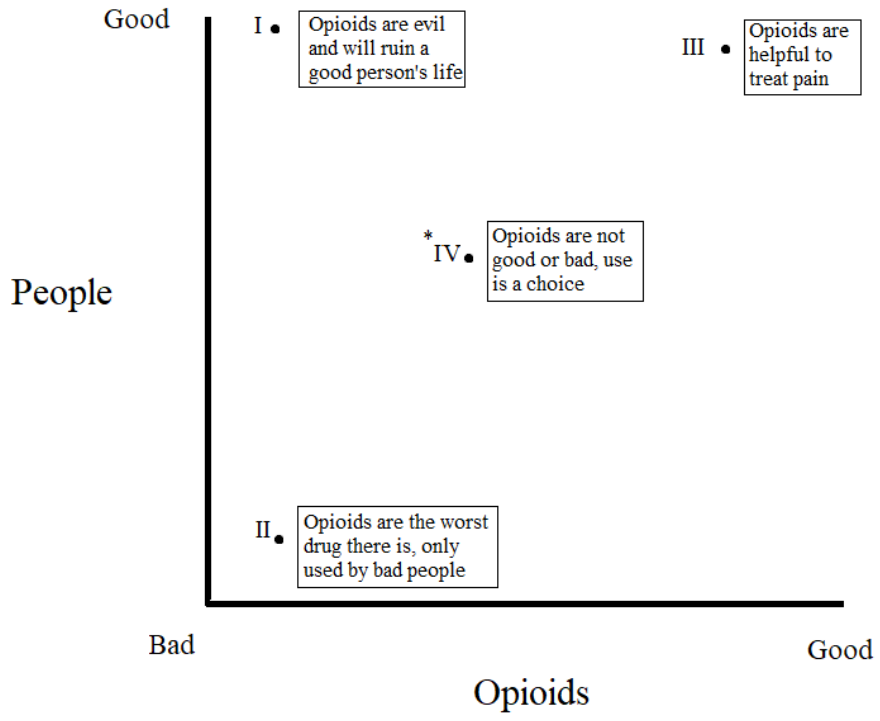
added unneeded redundancy to the findings. Therefore, I combined and cut out several positional maps to result in four positional maps.

Positional Map 1: Locating Morality in Opioid Use

In positional map 1, I illustrate the various positions held by participants regarding morality in opioid use. For positional map 1, morality is described on a dichotomous "good" to "bad" scale, representing positive and negative positions regarding morality, respectively. The horizontal axis represents the possible range of positions in relation to the morality of opioids themselves, whereas the vertical axis represents the possible range of positions in relation to the morality of the person. I plotted all positions according to how they each related to both the morality of the person and opioids.

Figure 7

Locating Morality in Opioid Use



Position I: Opioids are evil and will ruin a good person's life

The first position on this map (Opioids are evil and will ruin a good person's life) describes a perspective that views opioids as inherently "evil" and can ruin an individual's life. This position is located in the top left corner of the map and was demonstrated by interview participant Derek, who described opioids as follows:

> I think they're at their root they're evil, or they're close to evil. If you want to think of it in like a moral spectrum, I think there's just a darkness to them that can consume, like, you know the person within.

This quotation places opioid use on a moral spectrum, with opioids described as evil and able to change a person due to the inherent darkness that comes from opioids. This perspective places all the weight of the morality of opioid use on the substance, rather than the individual who uses the substance. In this position, opioids are "bad" and the people are "good."

Position II: Opioids are the worst drug there is, only used by bad people

The second position (Opioids are the worst drug there is, only used by bad people) describes opioids and the individuals who use them as both morally at fault. This position is located in the bottom left because both people and opioids are considered "bad." While describing the impact of their opioid use on their relationships and family, survey participant #33 wrote, "Opioid use is really bad people doing a really bad drug. I'm still repairing my relationship with my family." This participant attributed moral condemnation of opioid use to both the person and the substance by describing both the people and the substance as "really bad." This participant went on to state that opioid use negatively impacted their family and other relationships: "It completely destroyed every relationship I ever had." In this position, both the people and the opioids are viewed as "bad."

Position III: Opioids are helpful to treat pain

The third position (Opioids are helpful to treat pain) views opioids as helpful in treating pain. Both opioids and the individuals using them are deemed morally "good." This position is located in the

top right of the map because it describes the people and opioids in a positive light. This perspective was taken up by many participants talking about the beginning of their opioid use and some following treatment. Survey participant #1 wrote, “I used opioids out of necessity, to control severe acute pain and to control chronic pain (peripheral neuropathy), and also because they were uniquely effective.” In this quote, the participant described a positive use of opioids, pain relief. Therefore, this position describes both the people and the opioids as morally “good.”

(MISSING) Position IV: Opioids are not good or bad, use is a choice

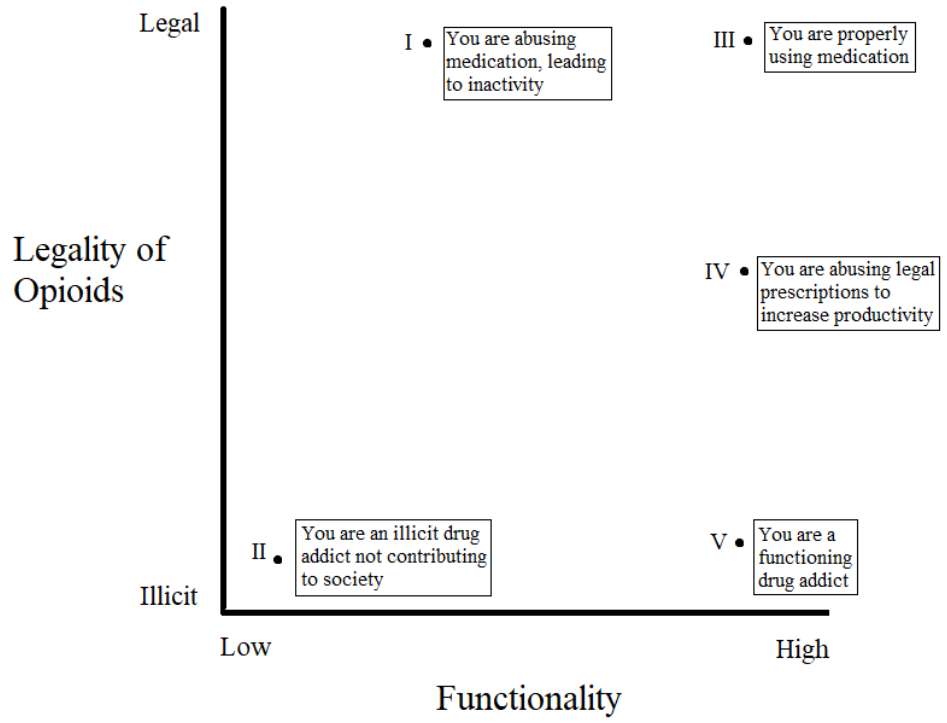
The fourth position (Opioids are not good or bad, use is a choice) on this map is a missing position that I identified concerning the morality of opioid use. I located this position in the center of the map and describes a neutral perspective that places the person and substance in the middle in terms of morality, neither good nor bad. A fictional participant holding this perspective might say, “both opioids and the people that use them are not good or bad, they are people just trying to get through life.” Those adopting this position might use opioids without feeling morally bound.

Positional Map 2: The Functionality of the User in Relation to Legality

In positional map 2 (see Figure 8), I illustrate the positions held by participants concerning the functionality of opioid use from a legal perspective. The horizontal axis describes one’s ability to function while using opioids (low to high). The vertical axis represents a spectrum of legality of opioids (illicit to legal), describing whether the individual is using opioids legally or illegally.

Figure 8

The Functionality of the User in Relation to Legality



Position I: You are abusing medication, leading to inactivity

The first position (You are abusing medication, leading to inactivity) states that when someone abuses their prescribed opioid medication, it may result in lowered "functionality." This position is located to the right of the lower end of the horizontal axis because when individuals abuse medication, they may still function to a limited extent, but perhaps not to full capabilities. The most common example of this position is someone who uses prescribed opioids outside of doctor recommendations. Survey participant #66 wrote:

> [I] used opioids for eight years, it has been four years since I misused my prescription medications . . . I was no longer anxious or afraid of the world around me, but I just didn't do much of anything . . . Misusing my prescription was what really led to my addiction.

In this example, participant #66 described how their abuse of medication reduced their ability to function (i.e., not doing much of anything) and subsequently resulted in addiction.

Position II: You are an illicit drug addict not contributing to society

The second position describes illicit opioid users as "drug addicts" that do not contribute to society. This quote and the label of the position was taken directly from survey participant #1, who used prescription opioids for over 30 years, reported no experience of addiction, but recognized that "other" opioid users did not contribute to society. In describing other users, he wrote:

> To put it simply, opioids make it easier to live life when in acute or chronic pain. I do believe many other users have similar reasons, but some are just illicit drug addicts who don't contribute to society so who knows their reasons for use.

This position is located in the bottom left corner of the map (illicit, not functional) because he described other "illicit" users as "not contributing to society."

Position III: You are properly using medication

The third position (You are properly using medication) describes using opioids as prescribed and as required to support normal functioning. This position is located in the top right corner of the map because it describes legal opioid use, as prescribed, resulting in normal functioning. Survey participant #1 positioned himself in this role when he wrote, "I managed my opioid usage in a very disciplined fashion, never straying from my prescribed dose and often using far less than was prescribed." This position describes a very specific and regulated method of using opioids, the intended use as prescribed.

Position IV: You are abusing legal prescriptions to increase productivity

The fourth position (You are abusing legal prescriptions to increase productivity) explores a grey area of legal opioid use, as the opioids were not purchased illegally, but were used outside of the prescription. In the following quote, Cara described opioids from a friend's prescription that were used for increasing productivity (functionality):

> One day at work I asked him if I could try some. He gave me a tiny piece of roxy and I thought what's this gonna do? I was high as a fucking kite, but I was focused on work. From then on, I began using pills with him because it made me work better and more productive.

This position was plotted on the middle right side of this graph, in the middle of legal and illicit on the vertical axis, and high in terms of functionality on the horizontal axis. It was placed here because the opioids were "misused" from a prescription, not illegally sourced, and were viewed as increasing productivity and ability to do work.

Position V: You are a functioning drug addict

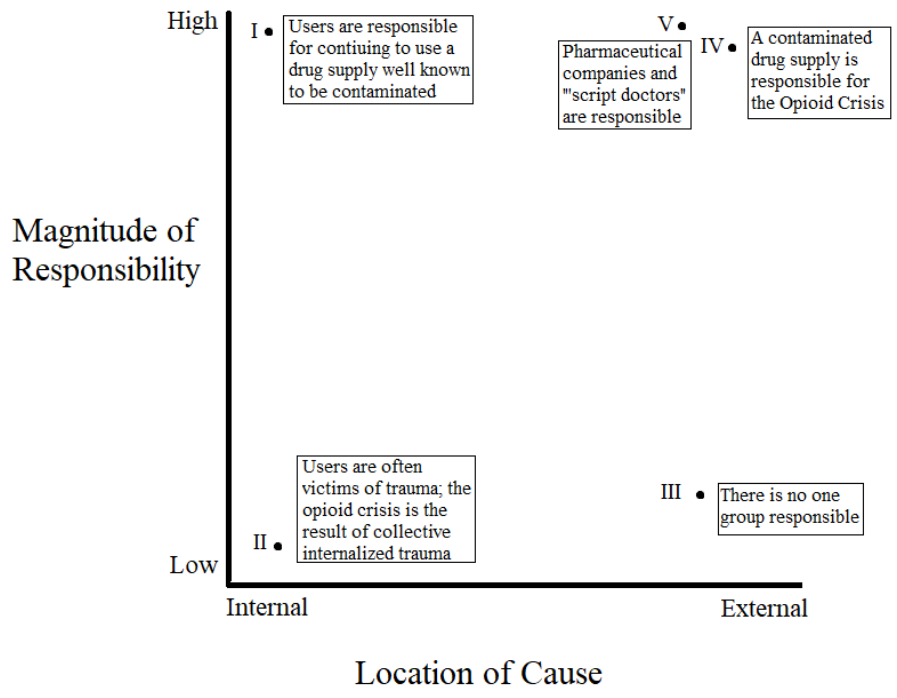
The fifth position describes participants' experiences of being a "functioning drug addict." In this perspective, an individual can use illicit opioids while maintaining their functionality in life and at work. In her interview Cara described moving on from prescription pills to heroin, "From then on I was a heroin addict, a functioning addict for a while though." This quote describes Cara's progression in use and a change in her perspective. She acknowledged that she was addicted to opioids, but that she was still able to function and do her job for a while. This position is in the bottom right corner, in the illicit end of the vertical axis and the high functionality end of the horizontal axis. It is located here because Cara shifted from using legally prescribed opioids outside of the bounds of a prescription to purchasing illicit heroin, all while maintaining her employment and describing herself as a "functioning addict" while using opioids at work.

Positional Map 3: Causality of the Opioid Crisis

In Positional map 3 (see Figure 9), I illustrate the various positions held by participants when describing the causality of the Opioid Crisis. The horizontal axis represents the location of cause placed either internally or externally to the user. Internal refers to opioid users locating causality within the individuals, whereas external refers causality of the Opioid Crisis placed on external sources (e.g., pharmaceutical companies pushing opioids). The vertical axis represents the magnitude (from low to high) of responsibility placed on the specific cause of the Opioid Crisis.

Figure 9

Causality of the Opioid Crisis



Position I: Users are responsible for continuing to use a drug supply well known to be contaminated

The first position describes a perspective suggesting that users are responsible for continued use of a contaminated supply of substances. This perspective locates causation internally because the opioid user makes the choice to continue to use a contaminated supply while knowing it is contaminated. This perspective was taken from survey participant #43 who stated:

> People don't realize what they are getting into, and too many people are continuing to use a contaminated supply and either end up dying quickly from overdoses, or destroying their lives slowly from addiction and all that goes along with it.

This position is located in the top left corner of the map, indicating a high magnitude of responsibility (on the vertical axis) on opioid users themselves (an internal location of causation found on the horizontal axis) by stating that users are responsible for continuing to use a supply of substances known to be contaminated.

Position II: The Opioid Crisis is a result of collective internalized trauma

In the second position (The Opioid Crisis is a result of collective internalized trauma), the causality is placed on collective internalized trauma. When asked about his perspective on the Opioid Crisis, Derek said:

> Growing up in a world that's, you know, quickly kind of becoming more and more chaotic and harder to, you know feel like it's, like you can succeed and have a comfortable life and I think all those forces, play into this kind of stress and pain and kind of chronic trauma that that we experienced and then you take an opioid and you just don't feel it for a little bit.

This position is located in the bottom left corner because it locates causation internally in the trauma of the individual (left side of the horizontal axis), but the magnitude of responsibility (vertical axis) is low, because the opioid user is just trying to cope.

Position III: There is no one group responsible

In the third position (There is no one group responsible for the Opioid Crisis), causality of the Opioid Crisis is not focused on any group in particular. This perspective was held by many participants. Survey participant #78 wrote, "I believe the 'Opioid Crisis' is a symptom of a larger problem and that if it weren't opioids, it would be something else (e.g., benzos). No one party is responsible for this." This quote describes the perspective that the Opioid Crisis is not caused by people individually but may be a symptom of larger systemic and structural problems such as inequity in access to healthcare. This position is located in the bottom right corner of this map as participants located causality for the Opioid Crisis on larger external (right side of horizontal axis) bodies (e.g., government policies, systemic discrimination) with a low magnitude of personal responsibility (vertical axis).

Position IV: A contaminated drug supply is responsible for the Opioid Crisis

The fourth position suggests that the causality of the Opioid Crisis can be attributed to a contaminated supply of substances due to dealers improperly cutting opioids. This position was quite common, with a large portion of survey and interview participants attributing responsibility to dealers.

When asked about the Opioid Crisis in the survey, Liam wrote, “People were now consuming extremely deadly batches of substances that were cut by some dealer on his kitchen counter. There was no reliable dosing anymore, people would use their normal amount and OD by mistake.” This quote provides a specific example of one location of cause for the Opioid Crisis, emphasizing that the Opioid Crisis may be the result of improper cutting by street dealers. The fourth position is located in the top right corner of this map. This position locates the cause of the Opioid Crisis external (right side of horizontal axis) to the individual. A high magnitude of responsibility (vertical axis) for the causality of the Opioid Crisis is placed on the state of the illicit substance market and street dealers that cut (i.e., mix other substances with opioids to increase profits) improperly.

Position V: Pharmaceutical companies and “’script doctors” are responsible

The fifth position on this map describes the causality of the Opioid Crisis placed on the pharmaceutical industry and doctors who are eager or willing to prescribe opioids. This position was one of the most common perspectives expressed by respondents to the survey and some interviewed participants. Interview participant James said:

> It just breaks my heart. You know I’ve been through that. I know exactly what it’s like, you know . . . I 100% believe that there is a crisis and 100% believe a lot of it is due to doctors prescribing it when we shouldn’t be, or you know, them eager to prescribe it . . . I think something radically has to change in regards to that.

In this quote, James directly locates the causality of the Opioid Crisis on the overprescribing of opioids by doctors without mentioning the opioid user as a potential cause. Additionally, survey participant #50 wrote, “This is a crisis of capitalism taking advantage of the weak. I can't imagine a reality where the billions generated by the pharmaceutical industry aren't playing a part in keeping these pills in rotation.” In this quote, the participant is attributing the widespread circulation and use of prescription opioids to the pharmaceutical companies who make a profit off the widespread use of prescription opioids. This

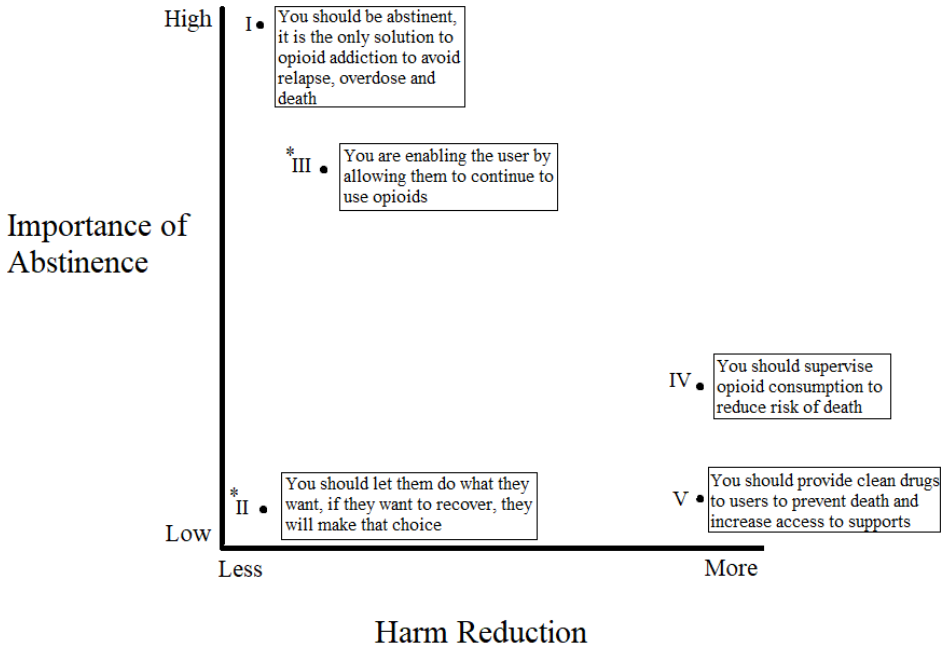
position describes an external (right side of horizontal axis) source of causality for the Opioid Crisis, placing a high magnitude of responsibility (vertical axis) on pharmaceutical companies (i.e., big pharma) and "'script docs" a term used to refer to doctors who are more eager or likely to prescribe opioids.

Positional Map 4: Approaches to Recovery from Opioid Use

Positional map 4 (see Figure 10) illustrates the different positions taken by participants when talking about the role of abstinence and harm reduction in recovery. The vertical axis refers to the magnitude of importance of abstinence in recovery from low to high. Abstinence refers to one's choice to cease engaging with or abstain from using opioids. The horizontal axis represents a continuum of harm reduction, from less to more. In this context, harm reduction refers to practices that minimizes the risk of harm to individuals who use substances (e.g., needle exchange programs, Safe Supply, supervised consumption sites, etc.).

Figure 10

Approaches to Recovery from Opioid Use



Position I: You should be abstinent, it is the only solution to opioid addiction to avoid relapse, overdose, and death

The first position (You should be abstinent, it is the only solution to opioid addiction to avoid relapse, overdose, and death) states that abstinence is the only solution to opioid addiction and recovery. This perspective was held by several survey participants whose sentiments are captured in the response of survey participant #91:

> No matter what someone has done in their addiction, that will never truly define who they are. We are completely different when we're clean and sober and we should all strive for this otherwise we will inevitably go back to our old ways.

This quote emphasizes that abstinence (i.e., being clean and sober) is the only possible solution to solve opioid addiction. It leaves no room for other recovery approaches, aside from total and complete cessation of all substance use. From this perspective, no harm reduction is feasible, otherwise opioid users will "inevitably go back to [their] old ways" (survey participant #91). This position is located in the top left corner because it is associated with high levels of abstinence (high on the vertical axis) and low harm reduction (low on the horizontal axis).

(MISSING) Position II: You should let them do what they want, if they want to recover, they will make that choice

This second position (You should let them do what they want, if they want to recover, they will make that choice) is a missing position I identified. When considering recovery, participants provided methods or suggestions for optimal recovery, but no participants mentioned a lack thereof or a "Laissez-faire" approach (i.e., let it be). Someone holding this position might say, "opioid users made the choice to use opioids in the first place, leave them be and if they want to recover, they can make that choice to use the resources available to them." This position is located in the bottom left corner of this map, with a low importance of abstinence (vertical axis) and low level of harm reduction (horizontal axis).

(MISSING) Position III: You are enabling the user by allowing them to continue to use opioids

The third position (You are enabling the user by allowing them to continue to use opioids) is another missing position I identified while plotting this map. Individuals who do not support harm reduction may ascribe to this position and view harm reduction as enabling opioid users to continue using opioids. This position might be found in discourses of abstinence only methods of recovery. Someone holding this perspective might say, "supervised consumption sites only serve to enable further substance use instead of helping opioid users recover from their addictions." This position, located in the top left corner, views the importance of abstinence as high (high on vertical axis) and the level of harm reduction as low (horizontal axis).

Position IV: You should supervise opioid consumption to reduce risk of death

The fourth position (You should supervise opioid consumption to reduce risk of death and increase access to resources) describes a perspective strongly based in harm reduction, suggesting that if opioid consumption is supervised by medical professionals, it will reduce risk of death. This perspective assumes that individuals will use substances; therefore, it is best to provide a safe space to prevent harm. This perspective was shared by many survey and interview participants. Interview participant Derek expressed his belief that supervised consumptions sites are a good thing, but do not solve the problem. He said, "I believe in supervised consumption, but that is not a solution to ending substance use, like, it will help you stay alive but it's not going to fix the problem." This quote supports the idea of supervised consumption sites as a means of harm reduction to prevent death, but not as something that can fix addiction. This position is located on the bottom right corner of the map, on the higher end of harm reduction (horizontal axis) and low end of the abstinence (vertical axis).

Position V: You should provide clean drugs to users to prevent death and increase access to supports

The fifth position (You should provide clean drugs to users to prevent death and increase access to supports) describes an approach to recovery expressed by many participants in both the survey and

interview portions of the data. This position is in support of Safe Supply, a harm reduction program focusing on the distribution of clean substances to substance users as a means of preventing overdose and death due to the contamination of illicit substances. By providing a safe supply of opioids, individuals are thought to have greater opportunity and likelihood of seeking treatment due to the accessibility of resources when receiving their safe supply. Survey participant #34 wrote:

> Harm reduction including safe supply, needle exchanges, funding of detox, medical detox, rehab and aftercare needs to be dramatically increased to stop all this death. I've never met an active addict that was healthy. Hell, if we got some of these services i bet we could get actual help.

This quote describes an additional potential positive impact of Safe Supply – removing the necessity of crime that Bill felt he was required to engage with to get opioids. This position is located on the bottom right (low on vertical axis, high on horizonal axis) of the map due to the lack of abstinence and high levels of harm reduction.

Chapter Summary

In this chapter I described the results of the mapping techniques used in SA. I included early and "final" iterations of the situational and social worlds/arenas maps, an ordered map, early and "final" social worlds/arenas maps, and four positional maps. I used messy situational maps to articulate and visually display the complexity of the situation of opioid use and the Opioid Crisis. Next, I used messy maps to create the organized ordered map to more clearly outline different elements related to opioid use and the Opioid Crisis. Following the ordered map, I developed social worlds/arenas maps with the goal of identifying relevant stakeholders in the situation as well as the larger contexts (i.e., arenas) of opioid use and the Opioid Crisis. Finally, based on these maps and participant data, I created four positional maps that described various positions taken up by participants regarding pertinent topics of tension related to opioid use and the Opioid Crisis. In Chapter 5, I review the findings of this study in

connection to the current literature and discuss implications, strengths and limitations, and future directions of this research.

Chapter 5: Discussion

In this final chapter, I review the current study and summarize key findings in relation to current literature. This is followed by a discussion of the implications of these findings on counselling psychology practice, discussion of social justice and the influence of my own positionality on the study, and a summary of strengths, limitations, and future directions for this research. The purpose of this study was to explore and articulate the complex situation of opioid use and the Opioid Crisis, from the perspectives of former opioid users. My overarching research question was: *How is the complex situation of opioid use and the Opioid Crisis represented by former opioid users?* I collected survey data from 83 participants and interviewed six participants. I used Clarke's (2005) Situational Analysis (SA) to represent the complexities and contested nature of the situation of inquiry (opioid use and the Opioid Crisis) from the perspectives of participants.

Key Findings

Based on the mapping processes reported in Chapter 4, I identified the follow three key findings: (a) relational pathways highlight multiplicity in the treatment of opioid use, (b) opioid use and the Opioid Crisis are a complex and contested situation, and (c) sites of tension in opioid use and the Opioid Crisis (i.e., locating morality in opioid use, the functionality and utility of opioids in relation to legality, causality of the Opioid Crisis, and approaches to recovery from opioid use).

Relational Pathways Highlight Multiplicity in the Treatment of Opioid Use

Situational maps were developed to elucidate the complexity of the situation of opioid use and the Opioid Crisis. From the "final" situational map (Figure 4), and the subsequent relational analyses, I identified a potential relationship between opioid use, the media, stigma, and shame. From the perspective of participants, the media often disparages opioid users with harmful labels such as "junkies" or portrays opioids users in a non-sympathetic light. This falls in line with research by McGinty et al. (2019) that examined stigmatization of opioid users by the media and suggested that

societal stigmatization and harmful public messaging from the media is associated with shame and discourages opioid users from seeking treatment (McGinty et al., 2019). The potential consequences of such stigmatization (e.g., shame and further opioid use), could lead to further barriers for opioid users in accessing resources such as needle exchanges and supervised consumption sites. Directly related to these consequences is the second relational pathway from the messy situational map, which described a relationship between opioid use, the type of opioid used, stigmatization, and treatment outcomes.

The relationship between the type of opioid used, stigmatization, and treatment outcomes was a common connection described by participants in survey responses, often in the context of public opinion. The type of opioid used made a difference in stigmatization experienced by opioid users, creating a form of hierarchy of stigmatization based on opioid type. Within this hierarchy, prescription opioid users reportedly experienced the least stigmatization and illicit opioid users experienced higher stigmatization. Current research into stigmatization mirrored these findings of varying levels of stigmatization experienced based on the type of opioid used (Weeks & Stenstrom, 2020). Using vignettes portraying different forms of opioid use, Weeks and Stenstrom (2020) measured lower levels of stigmatization associated with prescribed prescription opioids use versus non-prescribed prescription opioid use. Additionally, lower levels of stigmatization were associated with both forms of prescription opioid use versus heroin use (Weeks & Stenstrom, 2020).

Similarly, Goodyear and Chavanne (2021) examined differences in stigmatization based on type of opioid and found that transitions from prescription opioid use to illicit heroin use was associated with increased levels of stigmatization. This research and the findings of the current study support the idea that opioid users may experience or be involved with the creation and maintenance of a social hierarchy based on the type of opioid used (i.e., prescribed prescription opioids at the top [least stigmatization experienced], followed by non-prescribed prescription opioid use, followed by illicit opioid use experiencing the most stigmatization). Higher levels of stigmatization is associated with poorer

treatment outcomes and barriers to accessing treatment (Ezell et al., 2021). In line with the second relational pathway, potential consequences of stigmatization may include lower utilization of harm reduction and treatment services, further harmful opioid use, and continued stigmatization of opioid users.

In the third relational pathway from the messy situational map, I described a relationship between opioid use; addiction; treatment outcomes; and abstinence, lapse, relapse, and recovery. This pathway described potential trajectories of treatment for maladaptive opioid use, describing the recovery process involving periods of abstinence, lapse, and relapse. This finding is echoed by research on opioid use treatment trajectories (Eastwood et al., 2018), where authors described the pathways of five groups of heroin users, most of which included periods of lapse and relapse as well as abstinence. The relational pathways from the current study describe the non-linear nature of the treatment of opioid use, highlighting that there is not a single path towards recovery, but rather that opioid users may experience periods of lapse and relapse when they choose to strive for abstinence in their treatment. In line with the recovery-oriented approach to treatment (Mental Health Commission of Canada, 2015), the non-linear nature of treatment trajectories suggests that interventions should be tailored to the individual seeking treatment so that they can guide the therapeutic process. Non-linear treatment trajectories also speaks to the growing literature on multiple pathways in recovery (Borkman et al., 2016; NCADD, 2018), positing there are multiple pathways towards recovery (e.g., abstinence, natural recovery, mutual aid groups such as Narcotics Anonymous, faith-based recovery, cultural recovery, SMART recovery, etc.). Given the findings of this relational pathway, it is important to consider that multiple pathways to recovery exist and lapse and relapse are common experiences for opioid users in recovery. From a counselling psychology perspective, rigid approaches or disheartening comments towards opioid users in treatment that lapsed or relapsed are ultimately unhelpful and may serve to discourage opioid users in recovery or their pursual of treatment.

In the final relational pathway, I described a relationship between SES, access to healthcare, and subsequent treatment outcomes. This pathway speaks to impacts of lower SES and housing insecurity on treatment outcomes. The influence of SES on treatment outcomes was commonly discussed within the context of survey responses and interviews, with participants describing poor housing conditions and low SES as aspects of their lives that negatively influenced their opioid use and potential treatment outcomes. It has been previously demonstrated in the literature that lower SES is associated with increased opioid-related harms (Cairncross et al., 2018) and poorer access to healthcare options (Lueckmann et al., 2021; Olah et al., 2013). Furthermore, research supports the notion that opioid users experience disproportionate inequities in terms of social determinants of health (Kerman et al., 2020). Results from the current study further highlight the disparity in access to healthcare for opioid users who are of lower SES (Lueckmann et al., 2021; Olah et al., 2013).

Opioid Use and the Opioid Crisis are a Complex and Contested Situation

I created the social worlds/arenas maps to identify stakeholders in the complex situation of opioid use and the Opioid Crisis. Through this mapping process, I identified three arenas: recovery, social and political, and legal arenas. I chose these arenas due to the shared context of the social worlds therein. Social worlds such as therapists, doctors, nurses, the general public, media, family and friends, lawyers, etc. could be sorted into individual categories, while other social worlds such as police officers, religious leaders, social workers, etc. needed to be sorted into overlapping areas as they engaged with opioid use and the Opioid Crisis from multiple contexts (i.e., recovery and legal arenas). The sheer number of potential stakeholders identified as social worlds in this study highlight inherent complexity in the situation from research-analytic, legal, treatment, and policy perspectives. Most importantly, however, it highlights complexity for the opioid user and their chosen recovery pathway. When engaging in recovery, people are implicated in and interacting with many social worlds, each with

different perspectives which may influence and impact their recovery process (e.g., increased or decreased likelihood of lapse or relapse).

In addition to the complexity of the situation depicted by the social worlds/arenas map, the social worlds within the overlapping areas of the arenas represented stakeholders that belong to more than one arena. Since they can be sorted into more than one arena, they likely face tensions or conflict in perspectives on opioid use and the Opioid Crisis. These tensions arise from conflicts between different discourses (and positions taken up) within the social worlds.

Sites of Tension in Opioid Use and the Opioid Crisis

Using positional maps, I depicted various perspectives held by participants on a given site of tension identified through the social worlds/arenas map. Each map outlined multiple perspectives, based on participant quotes where applicable, describing complexity within each topic. Using positional maps, I represented four sites of tension: locating morality in opioid use, the functionality of the user in relation to legality, causality of the Opioid Crisis, and approaches to recovery from opioid use.

Locating Morality in Opioid Use. Morality in opioid use is a site of tension defined by a range of positions from "bad" to "good," in reference to opioids and the people using them. Various perspectives were expressed by participants, including calling opioids "evil," labelling both opioids and the people as "bad," a neutral position positing that opioid use is a choice rather than "good" or "bad," and acknowledging the helpfulness of opioids for the treatment of pain (i.e., a "good" moral stance on opioids and the people who use them). Based on positional map 1 (Figure 7), former opioid users may cast moral judgements onto other opioid users and opioids themselves. This finding is similar to results of a study by McCradden et al. (2019), where the authors concluded that opioid users experience stigma from their own in-groups (i.e., other opioid users; self-stigma). In the context of positional map 1 (Figure 7), participants of the current study morally judged other opioid users for their own choices (e.g., "opioids are the worst drug there is, only used by bad people"). This is important to consider given the

negative impact of stigmatization on opioid users, which could lead to further harms associated with opioid use.

The Functionality of the User in Relation to Legality. Functionality and utility in opioid use is a site of tension defined by a range of perspectives from "low" to "high" in relation to the both the functionality of the user and legality of the substance. Positions varied from disparaging comments regarding low functionality of users (e.g., "you are an illicit drug addict not contributing to society") to positive opinions regarding legal opioids (e.g., "you are properly using medication"). Other perspectives expressed were negatively framed but considered the functionality of the user as positive (e.g., "you are a functioning drug addict"). In positional map 2 (Figure 8), participants described both legal and illicit opioids within the context of a functioning user, however if either functionality was low or illicit opioids were used, the user was disparaged as abusing medication or labelled an "addict." Interestingly, in the context of functionality and utility of opioid use, participants of this study described other opioid users in a similar way to how Sibley et al. (2020, p. 2285) described the identity label of the "addict-other." Sibley et al. (2020) used this label to refer to the identity of substance users that carry socially ascribed characteristics such as being immoral and blameworthy. This is relevant due to the potential impacts of holding negatively framed opinions on intragroup members (i.e., self-stigma). Correspondingly, self-stigma would involve the use of words such as "addict" or "junkie," specifically when opioid users describe other users, themselves, and their self-worth (Sibley et al., 2020). This was observed in the current study, with some participants describing themselves or others as "addicts" (see Figure 8 for example) based on whether they used legally obtained opioids and whether they could function or do work while using opioids.

Similar to the relational pathways involving stigmatization, the findings from positional map 2 (Figure 8) align with the well-documented associations between societal stigmatization and self-stigma on poorer health outcomes (Kennedy-Hendricks et al., 2017; McCradden et al., 2019). Furthermore,

researchers have previously provided evidence for the existence of direct harms caused by the stigmatization of marginalized populations and specifically opioid users (e.g., reduced access to treatment services or increases in opioid use; Ezell et al., 2021; Kennedy-Hendricks et al., 2017; McGinty et al., 2019; Perry et al., 2020). The existence of rampant experiences of stigmatization, both self-stigma and societal stigma, as reported by the participants of the current study, adds to the literature highlighting inequities in how opioid users are treated. Addressing both the stigmatization experienced by opioid users and the perpetuation of self-stigma may be two methods of reducing opioid-related harms.

Causality of the Opioid Crisis. The causality of the Opioid Crisis is a site of tension defined on a spectrum of "internal" to "external" locations of cause and magnitude of responsibility from "low" to "high." Internally located positions vary between high responsibility (e.g., "users are responsible for continuing to use a drug supply well known to be contaminated) and low responsibility (e.g., "users are often victims of trauma; the Opioid Crisis is the result of collective internalized trauma") placed on opioid users. Participants who placed a high magnitude of responsibility externally reported that pharmaceutical companies marketing opioids, doctors more willing to prescribe opioids (e.g., "Pharmaceutical companies and 'script doctors are responsible"), and dealers improperly cutting the supply of illicit substances (e.g., "the Opioid Crisis is due to a contaminated drug supply because of improper cutting") were responsible for the Opioid Crisis. One position that externally located a low magnitude of responsibility described no one group as responsible for the Opioid Crisis.

Throughout this study, I positioned the Opioid Crisis as a deeply complex situation, comprised of various related and interconnected components such as the contamination of the illicit supply of substances and over prescribing of opioids, each contributing to what is termed the "Opioid Crisis." When asked about the Opioid Crisis, participants provided a wide variety of responses regarding what the term "Opioid Crisis" refers to and what comprises the Opioid Crisis. These perspectives were

captured in the situational map (Figure 4), as well as relational pathways between the Opioid Crisis and elements such as the criminalization of addiction, contaminants, access to healthcare, pharmaceutical companies, etc. Positions regarding the causality of the Opioid Crisis held by the participants were explicitly expressed through positional map 3 (Figure 9). A dominant narrative in the literature describes the Opioid Crisis as a public health crisis characterized by a sharp increase in overdose deaths (Jalali et al., 2020) originally thought to be fueled by the overprescribing and marketing of opioid analgesics (Volkow & Blanco, 2021). While this understanding of the Opioid Crisis is currently one of the dominant academic understandings and is only *one* position expressed in Figure 9 (position V, "pharmaceutical companies and 'script doctors are responsible"), it may not fully capture the complexity of the opioid crisis as understood by many participants of this study, other opioid users, and other researchers.

Based on the messy situational map and positional map 3 (Figure 9), relevant elements related to the Opioid Crisis include but are not limited to, contaminated illicit opioids, pharmaceutical companies pushing opioids, discriminatory governmental policies, criminalization of opioids, criminalization of addiction, stigmatization from the general public, and media perpetuation of stigma. Some participants described the Opioid Crisis as a symptom of a larger shared problem (i.e., systemic societal issues), noting if it were not opioids, it would be something else causing a "crisis." Others described the Opioid Crisis as a result of a larger crisis of general human suffering that causes people to turn to substance use (e.g., collective trauma). From the perspectives of the participants of this study, the complex situation of the Opioid Crisis is understood as resulting from both internal and external sources related to opioid use. However, from an SC perspective, the Opioid Crisis (as a complex topic) cannot simply be the result of two sources – the Opioid Crisis is more likely the result of the various contextual interactions and complex relationships between all the people, non-human elements, and the various contexts involved in the Opioid Crisis.

Findings from the current study suggest that while the dominant academic understanding of the Opioid Crisis is one valid understanding, there are multiple conceptualizations of the intricacies of the Opioid Crisis. Recent research has provided further evidence supporting the relationship between the marketing of OxyContin (i.e., oxycodone, a prescription opioid) and inadequate oversight by governmental bodies with a substantial share of opioid overdose deaths over the last two decades (Alpert et al., 2022). However, other researchers published a paper discussing misinterpretations of the Opioid Crisis, positing that several other causes are especially pertinent in the current context of the Opioid Crisis. Bettinger et al. (2022) suggested that in the last decade there has been a skewed narrative suggesting opioid prescribing practices of doctors is the primary cause of the Opioid Crisis. Many other factors are often overlooked as leading causes and maintaining factors of the Opioid Crisis, including the impacts of fentanyl and fentanyl analogues (Jones et al., 2020; O'Donnell et al., 2021), increasing rates of polysubstance use (Timko et al., 2018), continued poor access to medication-assisted treatment and behavioural health supports (Substance Abuse and Mental Health Services Administration, 2020), and restriction or reductions of legitimate opioid access (Agnoli et al., 2021; Bettinger et al., 2022). The lack of consensus in the literature mirrors what I found in the current study, there is not one primary cause of the Opioid Crisis, it is a deeply complex and contested situation involving the contextual interactions of all elements of the situation.

Approaches to Recovery from Opioid Use. The last site of tension that I focused on was the approach to recovery from opioid use, defined by a range of positions based on the importance of abstinence from "low" to "high" and amount of harm reduction supported from "less" to "more." Some positions explicitly referenced harm reduction approaches to recovery (e.g., "you should provide clean drugs to users to prevent death and increase access to supports" and "you should supervise opioid consumption to lower risk of death") and others explicitly referenced abstinence (e.g., "you should be abstinent, it is the only solution to opioid addiction to avoid relapse, overdose, and death"). In addition

to the perspectives of participants, I identified two silent viewpoints on this site of tension – "you are enabling the user by allowing them to continue to use opioids" and "you should let them do what they want, if they want to recover, they will make that choice."

Positional map 4 (Figure 10) described participant perspectives of recovery and treatment. Participants reported that abstinence and harm reduction are both helpful and unhelpful in recovery; an abstinence approach may work for some individuals and a harm reduction approach may work for other individuals. In the context of treatment and recovery, the most effective way of facilitating recovery may be to use the of treatment that most strongly connects to the individual in recovery. In other words, and in line with the recovery-oriented approach (Mental Health Commission of Canada, 2015), the individual seeking treatment (i.e., the client) is the one who should guide the treatment process, set their own goals, and utilize treatment options as they see fit.

Recovery is a complex and multifaceted concept with numerous definitions depending on the context (e.g., recovery in the contexts of drug use, medical procedures, mental health, etc.). Recovery has been defined in many ways, as researchers have struggled to find consensus on a definition to capture the intricacies and nuance of recovery across various contexts. In terms of mental health and addiction, Ashford et al. (2019) defined recovery, based on meetings with various recovery researchers, as "an individualized, intentional, dynamic, and relational process involving sustained efforts to improve wellness" (p. 183). In the context of opioid use, "wellness" is a term that depends on the individual characteristics and desires of each opioid user. For example, for someone experiencing homelessness and using opioids, wellness might include receiving housing or shelter. While this may not directly address substance use, it is one component of wellness that contributes to recovery. This is consistent with the recovery-oriented approach to treatment which strives to support the recovery of the whole person rather than an "addiction" or specific "mental health concern" (Ness et al., 2014). While each

participant in the current study talked about recovery differently, there were commonalities. The two most common understandings included abstinence and harm reduction.

The Role of Abstinence. Understanding abstinence can be a complicated task when considering its connection to religion and 12-step models of recovery (e.g., Narcotics Anonymous). Abstinence, from the perspectives of the most participants of this study, is the complete and total separation of the person in recovery from all forms of substance use. Commonly, participants phrased abstinence as being "clean and sober" while some also explicitly used the words abstinent or abstinence. Presumably, from the abstinence-only perspective of recovery, there is no room for other methods of recovery such as harm reduction or medication-assisted treatments like methadone or suboxone. However, this was not the case for some participants who ascribed to the abstinence model of recovery. Participant James, from Chapter 4, described himself as a Christian man that believed in abstinence, but maintained his abstinence using suboxone. His understanding was that medications like suboxone or methadone, commonly used in opioid agonist therapy, are not "substances of abuse," but rather a pillar of support that prevent him from using other substances. His conceptualization is important considering qualitative research suggesting that peers of clients who engage in opioid agonist therapy (such as taking methadone) stigmatized them for not being "clean" (i.e., abstinent; McCradden et al., 2019, p. 209). Based on the findings of McCradden et al. (2019), while hardline proponents of abstinence do not tolerate medication-assisted treatment as a part of abstinence, this tolerance may be exactly what some users in recovery need. Findings from the current study suggest that while abstinence-only definitions of recovery are helpful for some individuals, they may be unhelpful for others who have different conceptualizations of abstinence.

The Role of Harm Reduction. Harm reduction was described by some participants of this study as an approach that aims to reduce the harms of continued substance use in both recovery and active substance use. Participants commonly discussed harm reduction as working "with" opioid users versus

imposing a medical model or abstinence-only methods of recovery. This understanding corresponds well with Chan et al. (2022) who defines harm reduction as “an approach to reduce the risk of harms to an individual using substances without requiring abstinence” (p. 201). Participants described harm reduction in terms of support for supervised consumption sites and support for Safe Supply (i.e., the dispersal of clean substances to users) as means of reducing harms associated with opioid use (see positional map 4; Figure 10).

Currently, within the literature, there is discussion focused on the utility of supervised consumption sites. The use of supervised consumption sites may help address inequities regarding social determinants of health through rebuilding connections to healthcare services (Kerman et al., 2020). While research on Safe Supply is limited, some think that providing clean substances to users may reduce negative impacts (e.g., overdose and death) the toxic supply of illicit substances and make safe opioid use available for opioid users at heightened risk of overdose associated with illicit market contamination (Ivsins et al., 2020). Much of the existing literature and the perspectives of some participants of the current study position harm reduction at odds with abstinence approaches to recovery, but these two methods do not necessarily need to be antagonistic towards each other in recovery.

Implications for Counselling Psychology Practice

Based on the findings of the current study, there are several implications for counselling practice. First, considering the relational pathway showing that low SES and housing insecurity impacts treatment outcomes, it is important for therapists to explore the complexity of the client’s situation, including barriers clients face when attempting to access treatment services. . Counselling psychologists and other healthcare workers should aim to place more emphasis on identifying whether a client seeking treatment for opioid use also struggles with barriers to accessing healthcare and advocate to help improve equity in access, quality, and amount of treatment received.

Second, based on the relational pathways describing stigmatization experienced by opioid users (from their own in-groups and other groups [e.g., journalists in the media]), it is vital that counselling psychologists reflect on their own assumptions, biases, and ways of discussing sensitive topics related to opioid use to avoid further stigmatizing the client. Further stigmatization of opioid users may reduce the likelihood of clients returning for continued support, increase the likelihood of lapse or relapse, and increase opioid-related mortality. In this context, counselling psychologists might consult with clients about their preferences regarding the use of person-first language (e.g., person who uses opioids) versus using negatively framed language (e.g., heroin addict). Opioid users may prefer the use of specific terminology when discussing themselves and opioid use in a therapeutic setting, based on their own approach to recovery and their experiences. Given the widespread occurrence of stigmatization of opioid users, counselling psychologists must be sensitive to clients who report experiences of stigmatization and avoid further stigmatization in therapy.

Finally, in terms of approaches to recovery, this study found that participants relate to a wide variety of perspectives on what entails "recovery." Some view abstinence as the only feasible form of recovery, while others view a harm reduction approach as equally valid, with some in between those two perspectives. Given these findings, it is important that counselling psychologists work collaboratively with their clients to determine what recovery could "look like" for them. Rather than imposing their own perspective of what will work for the client (e.g., rigidity in abstinence-based approaches) counselling psychologists can collaborate with clients to determine how they want to navigate their recovery. Based on the findings of this study, each client is located in a complex situation involving various social worlds and elements that add complexity to their personal situation. It is the role of the counsellor, in collaboration with the client, to tease apart the complexity to figure out what recovery options best serve the client in reaching their treatment goals on an individual level.

Researchers have posited the use of situational mapping procedures themselves as therapeutic tools to increase client understanding of the complexity of their lives and to open up possibilities for different understandings and avenues for recovery (Mudry et al., 2021). For example, therapists may use situational mapping to examine all relevant actors, elements, and social worlds for the client. From there, the client can observe the complexity of their situation, decide which areas to tackle and how to conceptualize their own situation. The client and counsellor, together, can collaboratively determine which approach to counselling best suits the client in that situation (e.g., Indigenous approaches, manualized approaches, etc.).

Recovery is a complex, ongoing process, involving interactions between personal characteristics of the person and their family, their own and others' perspectives, and interactions with various stakeholders. With this understanding, one method of recovery may not be the "best" method for every individual, falling in line the recovery-oriented approach to treatment (Mental Health Commission of Canada, 2015). When working with individuals seeking treatment, from a recovery-oriented perspective, counsellors should strive to adapt the therapeutic goals to the individual's preferences by centering the client as the agent of their own recovery (Ness et al., 2014). For example, when working with an Indigenous client, the counsellor should let the client lead the therapeutic process. If the client is connected to their culture and is interested in traditional Indigenous practices (e.g., smudging) or Indigenous approaches to therapy (e.g., use of healing lodges), then the therapist should support and facilitate these endeavors. Each person in recovery from opioid use will have their own culture, experiences, perspectives, and beliefs. Rather than defining recovery with rigid definitions, recovery must be broadly understood as unique processes that facilitate a satisfying, hopeful, and contributing lifestyle, even with ongoing mental health or substance use struggles (Mental Health Commission of Canada, 2015).

My Positionality and Reflections Following the Research Process

One of the most important aspects of working in the field of counselling psychology is including social justice teachings and practices throughout my work. In the context of this study, the aspects of social justice I chose to emphasize were equity, participation, and diversity. The process of striving for social justice within this study was difficult for me, partly due to my social locations (White, male, SES, etc.) and background in quantitative research with its lack of social justice considerations. My previous research experience never involved considering concepts such as equity for participants or demographic representation in sampling as it was not deemed essential for the creation of research products. By engaging with critical aspects of qualitative research and literature, discussions with my supervisor and thesis examining committee, and personal reflexivity throughout this process (including the identity map), I have taken steps towards becoming a more critically oriented reflexive, qualitative researcher. However, this is an ongoing process, and I am still learning how exactly I can best articulate myself in this manner while considering aspects of social justice in my writing and research.

I also believe that connecting with the qualitative side of research has influenced both my counselling practice and research process. For example, I have learned be more contextual (grounded in social, cultural, economic, systemic considerations) by leaning into the messiness of a given situation, rather than isolating specific areas of inquiry to explore (more typical in psychology research). This holds true for working with clients in practice (e.g., leaning into complexity of their lives versus identifying specific psychological constructs) and in research (e.g., articulating complexity of a research topic versus compartmentalizing my research into deterministic variables). Additionally, I have learned to be more cautious about language and embrace my clients' and participants' intersectionalities and their preference of language. My own positionality directly influences the language I use in both my speaking and writing, and therefore I must consider my reasoning for why I write or speak a certain way, as this will directly impact how others communicate with me relationally. Furthermore, I need to be intentional in my choice of language and make adjustments to my regular lexicon.

However, I admittedly did not fully adhere to these principles as much as I intended. Specifically, one major misstep in this study was my initial use of a recruitment poster (See Appendix A) which featured the phrase “They’re just junkies!” as a means of being provocative, to pique interest, and get people “fired up” and ready to participate in the study. Looking back on the use of this poster and the subsequent reaction from one participant, I feel shameful of my use of this language. It undoubtedly influenced whether other individuals would participate in my study, as I used derogatory language when referring to the population I was aiming to research. One potential participant had the courage to email me and call me out for my use of this harmful language. At the time, I was defensive and was not as open to her perspective as I should have been. I responded to her explaining that the poster was approved by the University of Calgary Research Ethics Board and that my intentions were to be provocative to pull in participants and to attract individuals who may hold those stigmatizing views. I invited her to share her experiences and perspective in an interview, however she declined.

Upon reflection, I realized that while using what I thought was simply a provocative recruitment poster meant to provoke discussion and passionate responses, I was stigmatizing the potential participants of this study merely through exposure to the poster. After I received this email from the potential participant, I consulted with my supervisor and discussed the next steps, eventually decided on removing the poster entirely as it was directly harmful to the participants. I initially came from the privileged position of an academic wanting to provoke discussion, not marginalize or stigmatize the participants. Unfortunately, damage was likely already done and this may have turned off some potential participants and limited my sample even further (despite my desires to have a demographically representative sample). Furthermore, I know at least one person (i.e., the one who emailed me) was offended or hurt by my poster, meaning there were likely other who also felt that way but did not advocate for themselves.

Finally, one additional area of note regarding my positionality's influence on my writing and research analysis process is the emphasis on the role of the healthcare system in this study. While I was aware of how the healthcare system is intimately tied to opioid use and recovery, I may have placed a heavier emphasis on standard healthcare system practices due to ongoing health concerns involving my own family members. The process of managing and working through the protocols of the healthcare system were and continue to be frustrating in my personal life, leaving more negative impressions in my mind based on recent experiences. During this research process, I considered how challenging it has been for my own family to navigate the healthcare system, and we do not face the same marginalization and stigmatization as opioid users. Some of the more negative experiences and feelings I hold may have influenced my writing style regarding the healthcare system.

Strengths and Limitations

There are several strengths of the current study: it is the first to use of SA in understanding how opioid users represent their understanding of opioid use and the Opioid Crisis, it used multiple forms of data, and was well-suited to explore the complex situation of opioid use and the Opioid Crisis. First, this study is the first of its kind to explore and articulate how former opioid users represent opioid use and the Opioid Crisis using SA mapping processes. This study allowed me to map the complex situation of opioid use and the Opioid Crisis, including all related elements (e.g., individual actors, social worlds, etc.); making an important contribution to the field. I was able to depict positions on topics that were silent among the data to draw attention to the complexity of the situation and a wide breadth of potential positions inherent in opioid use and the Opioid Crisis. Furthermore, this study amplified the voices of former opioid users, a population often ignored in research and society as a whole. Rather than perpetuating dominant voices (e.g., medical model) this study allowed for traditionally silenced perspectives to be privileged.

Second, I analyzed two forms of data, survey and interview data, to best capture the experiences of the participants. The addition of qualitative interviews invited richer descriptions of the experiences shared by participants. This created more accurate and credible (Shenton, 2004) representations of their experiences and perceptions of opioid use and the Opioid Crisis through the triangulation of the data.

Finally, SA was well-suited to examine and depict the complexity of the situation of opioid use and the Opioid Crisis. SA invited the articulation of the complexity of opioid use and the Opioid Crisis, creating a more wholistic understanding of the situation, beyond what could be observed through a different methodology. SA acknowledges that opioid use and the Opioid Crisis occurs within complexity and does not suggest that one conclusion is "correct." Instead, SA aims to articulate a wide breadth of available conceptualizations.

Clarke (2005) described the use of her analytic mapping techniques as a guide for conducting research, with flexibility in terms of data analysis, allowing the researcher to adjust based on their needs. The iterative nature of revising situational, social worlds/arenas, and positional maps meant that I returned to older versions of maps in a non-linear or procedural manner, thus placing the onus on myself to use the SA analytic steps in ways that best suited the current study's goals. The flexibility made it possible for me to repeatedly review and revise iterations of the maps and consult with colleagues until they were deemed sufficient. I also maintained memos regarding research thoughts and progress due to the analytic process of SA. These memos allowed me to critically analyze the data whenever I returned, without being lost in the inherent complexity of the various iterations of the maps I created.

While there are many strengths to the current study, it was not without limitations. First, the majority of the participants (63%) in this study identified as male. While 37% of the total number of survey responders identified as female, only 17% completed the survey including the open-ended survey questions. In terms of interviews, only one female-identifying participant, Cara, indicated interest in being interviewed for this study. As a result, the perspectives of women in the context of opioid use and

the Opioid Crisis is limited. As a result, this study's findings may display a skewed gendered experience of opioid use and the Opioid Crisis (e.g., female experience, stigmatization of women who use substance, or opioid use and recovery in context of pregnancy or motherhood). The lower level of participation by women and non-binary people in this study may explained by my sampling method (i.e., less women use reddit.com than men) and stigma attached to women who use (Campbell, 2000). Results would have likely differed if other genders participated in the survey and proceeded to be interviewed.

Second, with participants in mind, I aimed to study a diverse sample that was representative of the demographics of opioid user populations. Unfortunately, my sample was very homogenous and was more so representative of dominant populations (e.g., White people). Despite the overrepresentation of opioid use and impacts of the Opioid Crisis among BIPOC communities in the literature (see literature review), perspectives of BIPOC populations were not articulated in this study. Experiences regarding the interactions between oppression, intergenerational trauma, and opioid use and the Opioid Crisis were missed because of the lack of representation of BIPOC populations in this study. Moreover, differences in interactions with various stakeholders in the situation (e.g., police officers) with BIPOC populations could not be expressed in this study. Results would have likely differed if the participant sample captured the perspectives of BIPOC communities. Part of this could have been the original poster, which might have served to stigmatize and therefore limit potential participation. My recruitment choice, stemming from my positionality (i.e., as a previously productivity-oriented quantitative researcher) also influenced the sample collected for this study. Specifically, I chose to have the vast majority of participants sourced from reddit.com, as I am familiar with the website and use it occasionally in a recreational context. If I were to have chosen to continue to recruit until I had a demographically representative sample, I could have sent recruitment materials to consumer advocate groups (e.g., Moms Stop the Harm), other social media sites (e.g., Facebook groups), organizations focused on addiction and recovery (e.g., Alberta Addiction and Mental Health Research Hub), addiction treatment centers (e.g.,

Recovery Acres Society), Indigenous practice-focused treatment centers (e.g., Sunrise Healing Lodge), and used snowball sampling. I could have continued to recruit for additional participants until I had members of non-dominant populations represented in the dataset. Instead, I chose not to pursue any further data collection due to perceived time constraints and the need to begin data analysis to meet target milestones for completing this project.

Finally, the flexibility of SA can also be argued as a limitation. SA's descriptions of the process of conducting an analysis are very flexible. This allowed me to iteratively analyze the maps I created as I felt worked best. However, the lack of step-by-step directions for conducting the research could be challenging for novice researchers. In situations where a more rigid approach to research and data analysis is desired, SA may not be a suitable theory-method package. To address this limitation, SA encourages researchers to use memoing and journaling to keep track of thoughts, analytic procedures, and decisions regarding what to retain or remove from maps. Due to my memoing, I was able to retain an understanding of my own procedures for conducting a SA study.

Future Directions

In this study, I aimed to explore and articulate the complexity inherent in opioid use and the Opioid Crisis. Further research in this area might be helpful to explore the implications of different understandings of opioid use and the Opioid Crisis and related governmental policies. First, SA was a useful methodology in this project and further research on opioid use and the Opioid Crisis using SA would serve to fully capture the intricacies and heterogeneities of the situation in future studies. The results from this study are based on my individual analysis in consultation with my research team; a different researcher and different team may lead to different results.

Second, the current study used data from a rather unrepresentative sample of opioid users in terms of demographics. Future studies with different/more purposive sampling strategies would enhance the diversity and representativeness of findings. Future studies on this topic could capture greater

complexity of the situation, but also increase overall understanding of what comprises opioid use and the Opioid Crisis from the perspectives of diverse opioid users.

Third, further research is warranted on the perspectives of other stakeholders in the situation such as healthcare workers (i.e., doctors and nurses), addictions counsellors, and law enforcement such as police officers, bylaw officers, and security guards. Most of the participants in this study engaged with the healthcare and justice systems at some point during their recovery. Participants shared perspectives and ideas they assumed were the views or opinions of healthcare workers and police officers. These assumptions were based on their personal interactions or what they overheard. The actual perspectives of these stakeholders involved in the situation are needed to fully capture the complexity of opioid use and the Opioid Crisis.

Finally, based on the findings that abstinence and harm reduction methods of recovery are both supported and opposed by participants of this study, further research using SA could be conducted to explore views on abstinence and harm reduction specifically. Both methods of recovery are inherently complex based on the various ways of implementing these practices and how individuals relate to each practice. This complexity begs further inquiry using methodologies suited to manage and articulate complexity, such as SA.

References

Agnoli, A., Xing, G., Tancredi, D. J., Magnan, E., Jerant, A., & Fenton, J. J. (2021). Association of Dose Tapering with Overdose or Mental Health Crisis among Patients Prescribed Long-term Opioids. *JAMA - Journal of the American Medical Association*, *326*(5), 411–419. https://doi.org/10.1001/jama.2021.11013

Ahern, J., Stuber, J., Galea, S., & Stat. (2007). Stigma, discrimination and the health of illicit drug users. *Drug and Alcohol Dependence*, *88*(2–3), 188–196. https://doi.org/10.1016/j.drugalcdep.2006.10.014

Aidala, A., Cross, J. E., Stall, R., Harre, D., & Sumartojo, E. (2005). Housing status and HIV risk behaviors: Implications for prevention and policy. *AIDS and Behavior*, *9*(3), 251–265. https://doi.org/10.1007/s10461-005-9000-7

Allie-Turco, P., Brewer, J., Fetcho, S., Johansson, S., Smith, B., & Waters-Barham, T. (2021). *Racial Trauma: Definition, Impact, and Emerging Strategies* (Vol. 16, Issue 3).

Alpert, A. E., Evans, W. N., Lieber, E. M. J., & Powell, D. (2022). Origins of the Opioid Crisis and Its Enduring Impacts. *The Quarterly Journal of Economics*, *137*(2), 1139–1179. https://doi.org/https://doi.org/10.1093/qje/qjab043

Bailey, L. (2005). Control and desire: The issue of identity in popular discourses of addiction. *Addiction Research and Theory*, *13*(6), 535–543. https://doi.org/10.1080/16066350500338195

BC Coroners Service. (2020). *Illicit Drug Toxicity Deaths in BC: January 1st, 2010-January 31st, 2020*. 1–22. https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf

Belzak, L., & Halverson, J. (2018). The opioid crisis in Canada: A national perspective. *Health Promotion and Chronic Disease Prevention in Canada*, *38*(6), 224–233. https://doi.org/10.24095/hpcdp.38.6.02

Bettinger, J. J., Amarquaye, W., Fudin, J., & Schatman, M. E. (2022). Misinterpretation of the " Overdose Crisis " Continues to Fuel Misunderstanding of the Role of Prescription Opioids. *Journal of Pain Research*, *15*, 949–958. https://doi.org/http://www.doi.org/10.2147/JPR.S367753

Bøg, M., Filges, T., Brännström, L., Jørgensen, A. K., & Fredrikksson, M. K. (2017). 12-Step Programs for Reducing Illicit Drug Use. *Campbell Systematic Reviews*, *13*(1), 1–149. https://doi.org/10.4073/csr.2017.2

Bombay, A., Matheson, K., & Anisman, H. (2009). Intergenerational Trauma: Convergence of Multiple Processes among First Nations peoples in Canada. *Journal of Aboriginal Health*, *5*(3), 6–47. https://doi.org/https://doi.org/10.3138/ijih.v5i3.28987

Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effects of Indian Residential Schools: ImplicationS for the concept of historical trauma. *Transcultural Psychiatry*, *51*(3), 320–338. https://doi.org/10.1177/1363461513503380

Borkman, T. J., Stunz, A., & Kaskutas, L. A. (2016). Developing an Experiential Definition of Recovery: Participatory Research with Recovering Substance Abusers from Multiple Pathways. *Substance Use & Misuse*, *51*(9), 1116–1129. http://doi.org/10.3109/10826084.2016.1160119

Bright, S. J., Marsh, A., Smith, L. M., & Bishop, B. (2008). What can we say about substance use? Dominant discourses and narratives emergent from Australian media. *Addiction Research and Theory*, *16*(2), 135–148. https://doi.org/10.1080/16066350701794972

British Columbia Coroners Service. (2021). *Illicit Drug Toxicity Deaths in BC: January 1, 2011 - April 30, 2021*. 1–26. https://www2.gov.bc.ca/gov/content/life-

Brownstein, M. J. (1993). A brief history of opiates, opioid peptides, and opioid receptors. *Proceedings of the National Academy of Sciences of the United States of America*, *90*(12), 5391–5393. https://www.mendeley.com/viewer/?fileId=2748b363-305f-4311-6a3c-171b74a43332&documentId=6b4dc5ca-8403-3307-9265-ceb50db3e6ec

Bruneau, J., Ahamad, K., Goyer, M. È., Poulin, G., Selby, P., Fischer, B., Wild, T. C., & Wood, E. (2018). Management of opioid use disorders: A national clinical practice guideline. *Cmaj*, *190*(9), E247–E257. https://doi.org/10.1503/cmaj.170958

Burgess, D. J., van Ryn, M., Crowley-Matoka, M., & Malat, J. (2006). Understanding the provider contribution to race/ethnicity disparities in pain treatment: Insights from dual process models of stereotyping. *Pain Medicine*, *7*(2), 119–134. https://doi.org/10.1111/j.1526-4637.2006.00105.x

Burr, V. (2003). *Social Constructionism (2nd Ed.)*. Routledge.

Burr, V. (2015). *Social Contructionism* (3rd ed.).

Cairncross, Z. F., Herring, J., van Ingen, T., Smith, B. T., Leece, P., Schwartz, B., & Hohenadel, K. (2018). Relation between opioid-related harms and socioeconomic inequalities in Ontario: a population-based descriptive study. *CMAJ Open*, *6*(4), E478–E485. https://doi.org/10.9778/cmajo.20180084

Campbell, N. D. (2000). *Using Women: Gender, Drug Policy, and Social Justice*. Routledge.

Canadian Center on Substance Use and Addiction. (2020). Prescription Opioids. In *Canadian Drug Summary* (Issue July). https://doi.org/10.1007/978-3-319-24612-3_302038

Canadian Centre on Substance Use Costs and Harms Scientific Working Group. (2018). *Canadian Substance Use Costs and Harms (2007-2014)*. https://www.ccsa.ca/sites/default/files/2019-04/CSUCH-Canadian-Substance-Use-Costs-Harms-Report-2018-en.pdf

Canadian Public Health Association. (2016). *The Opioid Crisis in Canada*. https://www.cpha.ca/sites/default/files/uploads/policy/positionstatements/opioid-positionstatement-e.pdf

Carrière, G., Garner, R., Sanmartin, C., & C, S. (2018). Social and economic characteristics of those experiencing hospitalizations due to opioid poisonings. In *Health Reports* (Vol. 29, Issue 10). https://www150.statcan.gc.ca/n1/en/pub/82-003-x/2018010/article/00002-eng.pdf?st=9cwe3Qyi

Carrillo, J. E., Carrillo, V. A., Perez, H. R., Salas-Lopez, D., Natale-Pereira, A., & Byron, A. T. (2011). Defining and targeting health care access barriers. *Journal of Health Care for the Poor and Underserved*, *22*(2), 562–575. https://doi.org/10.1353/hpu.2011.0037

Carter, R. T. (2007). Racism and Psychological and Emotional Injury: Recognizing and Assessing Race-Based Traumatic Stress. *The Counseling Psychologist*, *35*(1), 13–105. https://doi.org/10.1177/0011000006292033

Chan, C. A., Canver, B., McNeil, R., & Sue, K. L. (2022). Harm Reduction in Health Care Settings. *Medical Clinics of North America*, *106*(1), 201–217. https://doi.org/10.1016/j.mcna.2021.09.002

Cicero, T. J., & Ellis, M. S. (2017). The prescription opioid epidemic: A review of qualitative studies on the progression from initial use to abuse. *Dialogues in Clinical Neuroscience*, *19*(3), 259–269.

Clarke, A. (2005). *Situational Analysis: Grounded Theory After the Postmodern Turn* (p. 365). SAGE Publications.

Clarke, A. (2017). *Situational Analysis: Grounded Theory After the Interpretive Turn.* SAGE Publications.

Clarke, A. E., Friese, C., & Washburn, R. S. (2015). Situational Analysis in Practice: Mapping Research with Grounded Theory. In *Sage Publications*. Lost Coast Press.

Coffin, P. O., Galea, S., Ahern, J., Leon, A. C., Vlahov, D., & Tardiff, K. (2003). Opiates, cocaine and alcohol combinations in accidental drug overdose deaths in New York City, 1990-98. *Addiction*, *98*(6), 739–747. https://doi.org/10.1046/j.1360-0443.2003.00376.x

Collins, A. B., Boyd, J., Cooper, H. L. F., & McNeil, R. (2019). The intersectional risk environment of people who use drugs. *Social Science and Medicine*, *234*(September 2018), 112384. https://doi.org/10.1016/j.socscimed.2019.112384

Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *American Psychologist*, *74*(1), 1–5.

https://doi.org/10.1037/amp0000442

Crenshaw, K. (1991). Stanford Law Review Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color. *Source: Stanford Law Review*, *43*(6), 1241–1299.

Dinh, M., & Oliver, M. (2021). *Trauma and Addiction Medicine*. https://doi.org/https://doi.org/10.1007/978-3-030-36391-8_79

Donroe, J. H., & Tetrault, J. M. (2018). Narrowing the treatment gap in managing opioid use disorder. *Cmaj*, *190*(9), E236–E237. https://doi.org/10.1503/cmaj.180209

Eastwood, B., Strang, J., & Marsden, J. (2018). Continuous opioid substitution treatment over five years: Heroin use trajectories and outcomes. *Drug and Alcohol Dependence*, *188*, 200–208. https://doi.org/10.1016/j.drugalcdep.2018.03.052

Eibl, J. K., Morin, K., Leinonen, E., & Marsh, D. C. (2017). The State of Opioid Agonist Therapy in Canada 20 Years after Federal Oversight. *Canadian Journal of Psychiatry*, *62*(7), 444–450. https://doi.org/10.1177/0706743717711167

Emilio Carrillo, J., Carrillo, V. A., Perez, H. R., Salas-Lopez, D., Natale-Pereira, A., & Byron, A. T. (2011). Defining and targeting health care access barriers. *Journal of Health Care for the Poor and Underserved*, *22*(2), 562–575. https://doi.org/10.1353/hpu.2011.0037

Entress, R. M. (2021). The intersection of race and opioid use disorder treatment: A quantitative analysis. *Journal of Substance Abuse Treatment*, *131*(September 2020), 108589. https://doi.org/10.1016/j.jsat.2021.108589

Ezell, J. M., Walters, S., Friedman, S. R., Bolinski, R., Jenkins, W. D., Schneider, J., Link, B., & Pho, M. T. (2021). Stigmatize the use, not the user? Attitudes on opioid use, drug injection, treatment, and overdose prevention in rural communities. *Social Science and Medicine*, *268*, 113470. https://doi.org/10.1016/j.socscimed.2020.113470

Fairgrieve, C., Nosova, E., Milloy, M.-J., Fairbairn, N., DeBeck, K., Ahamad, K., Wood, E., Kerr, T., & Hayashi, K. (2020). Temporal changes in non-fatal opioid overdose patterns among people who use drugs in a Canadian setting. *Substance Abuse*, *0*(0), 1–8. https://doi.org/10.1080/08897077.2019.1677280

Fischer, B., Rehm, J. & Tyndall, M. (2016). Effective Canadian policy to reduce harms from prescription opioids: learning from past failures. *Cmaj*, *188*(17–18), 1240–1244. https://doi.org/10.1503/cmaj.160356

Gergen, K. J. (1985). *The Social Constructionist Movement in Modern Psychology*. *40*(3), 266–275. https://doi.org/https://doi.org/10.1037/0003-066X.40.3.266

Gergen, K. J. (2009). *Relational Being: Beyond self and community*. Oxford University Press.

Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Aldine.

Goodyear, K., & Chavanne, D. (2021). Stigma and policy preference toward individuals who transition from prescription opioids to heroin. *Addictive Behaviors*, *115*, 106784. https://doi.org/10.1016/j.addbeh.2020.106784

Haghdoost, A. A. (2012). Complexity of the socioeconomic status and its disparity as a determinant of health. *International Journal of Preventive Medicine*, *3*(2), 75–76.

Hayashi, K., Milloy, M. J., Lysyshyn, M., DeBeck, K., Nosova, E., Wood, E., & Kerr, T. (2018). Substance use patterns associated with recent exposure to fentanyl among people who inject drugs in Vancouver, Canada: A cross-sectional urine toxicology screening study. *Drug and Alcohol Dependence*, *183*, 1–6. https://doi.org/10.1016/j.drugalcdep.2017.10.020

Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the United States of America*, *113*(16),

4296–4301. https://doi.org/10.1073/pnas.1516047113

Homan, P., Brown, T. H., & King, B. (2021). Structural Intersectionality as a New Direction for Health Disparities Research. *Journal of Health and Social Behavior*, *62*(3), 350–370. https://doi.org/10.1177/00221465211032947

Ickowicz, S., Wood, E., Dong, H., Nguyen, P., Small, W., Kerr, T., Montaner, J. S. G., & Milloy, M. J. (2017). Association between public injecting and drug-related harm among HIV-positive people who use injection drugs in a Canadian setting: A longitudinal analysis. *Drug and Alcohol Dependence*, *180*, 33–38. https://doi.org/10.1016/j.drugalcdep.2017.07.016

International Narcotics Control Board. (2009). Report of the International Narcotics Control Board for 2009. In *Null: Vol. null* (Issue February).

Jacobson, D., & Mustafa, N. (2019). Social identity map: A reflexivity tool for practicing explicit positionality in critical qualitative research. *International Journal of Qualitative Methods*, *18*, 1–12. https://doi.org/10.1177/1609406919870075

Jalali, M. S., Botticelli, M., Hwang, R. C., Koh, H. K., & McHugh, R. K. (2020). The opioid crisis: A contextual, social-ecological framework. *Health Research Policy and Systems*, *18*(1), 1–9. https://doi.org/10.1186/s12961-020-00596-8

Jones, C. M., Bekheet, F., Park, J. N., & Alexander, G. C. (2020). The Evolving Overdose Epidemic: Synthetic Opioids and Rising Stimulant-Related Harms. *Epidemiologic Reviews*, *42*(1), 154–166. https://doi.org/10.1093/epirev/mxaa011

Kabir, R., & Zaidi, S. T. (2022). *Implicit Bias Against BIPOC Patients in Clinical Settings : A Qualitative Review*. *2*(1), 28–46.

Kennedy-Hendricks, A., Barry, C. L., Gollust, S. E., Ensminger, M. E., Chisolm, M. S., & McGinty, E. E. (2017). Social stigma toward persons with prescription opioid use disorder: Associations with public support for punitive and public health-oriented policies. *Psychiatric Services*, *68*(5), 462–

469. https://doi.org/10.1176/appi.ps.201600056

Kerman, N., Manoni-Millar, S., Cormier, L., Cahill, T., & Sylvestre, J. (2020). "It's not just injecting drugs": Supervised consumption sites and the social determinants of health. *Drug and Alcohol Dependence, 213*. https://doi.org/10.1016/j.drugalcdep.2020.108078

Kim, H. S., Lee, S., & Kim, J. H. (2018). Real-world evidence versus randomized controlled trial: Clinical research based on electronic medical records. *Journal of Korean Medical Science*, *33*(34), 1–7. https://doi.org/10.3346/jkms.2018.33.e213

Kim, J., Kim, M., Shin, Y., Kim, B., & Kim, S. (2021). The Role of Trauma in Addiction and Recovery: A Qualitative Meta-Synthesis. *Stress*, *29*(1), 45–59. https://doi.org/10.17547/kjsr.2021.29.1.45

Kline, A., Mattern, D., Cooperman, N., Dooley-Budsock, P., Williams, J. M., & Borys, S. (2020). "A Blessing and a Curse:" Opioid Users' Perspectives on Naloxone and the Epidemic of Opioid Overdose. *Substance Use and Misuse*, *55*(8), 1280–1287. https://doi.org/10.1080/10826084.2020.1735437

Kulesza, M. (2013). Substance Use Related Stigma: What we Know and the Way Forward. *Journal of Addictive Behaviors Therapy & Rehabilitation*, *02*(02). https://doi.org/10.4172/2324-9005.1000106

Lavallee, L. F., & Poole, J. M. (2010). Beyond recovery: Colonization, health and healing for indigenous people in Canada. *International Journal of Mental Health and Addiction*, *8*(2), 271–281. https://doi.org/10.1007/s11469-009-9239-8

Linton, S. L., Celentano, D. D., Kirk, G. D., & Mehta, S. H. (2013). The longitudinal association between homelessness, injection drug use, and injection-related risk behavior among persons with a history of injection drug use in Baltimore, MD. *Drug and Alcohol Dependence*, *132*(3), 457–465. https://doi.org/10.1016/j.drugalcdep.2013.03.009

Lippold, K. M., Jones, C. M., O', E., Olsen, M., & Giroir, B. P. (2019). *Morbidity and Mortality Weekly Report Racial/Ethnic and Age Group Differences in Opioid and Synthetic Opioid-Involved*

Overdose Deaths Among Adults Aged ≥18 Years in Metropolitan Areas-United States, 2015-2017. *68*(43), 2015–2017. https://www.cdc.gov/

Lipsitz, G. (2016). *White Privilege: Essential Readings on the Other Side of Racism* (P. S. Rothenberg (ed.); 2nd ed.). Worth Publishers.

Logan, D. E., & Marlatt, G. A. (2010). Harm reduction therapy: A practice-friendly review of research. *Journal of Clinical Psychology*, *66*(2), 201–214. https://doi.org/10.1002/jclp.20669

Loppie, S., Reading, C., & Leeuw, S. De. (2014). Social Determinants of Health: Aboriginal Experiences with Racism and its Impacts. *National Collaborating Centre for Indigenous Health*, 1–12.

Lueckmann, S. L., Hoebel, J., Roick, J., Markert, J., Spallek, J., von dem Knesebeck, O., & Richter, M. (2021). Socioeconomic inequalities in primary-care and specialist physician visits: a systematic review. *International Journal for Equity in Health*, *20*(1), 1–19. https://doi.org/10.1186/s12939-020-01375-1

Marsh, T. N., Coholic, D., Cote-Meek, S., & Najavits, L. M. (2015). Blending Aboriginal and Western healing methods to treat intergenerational trauma with substance use disorder in Aboriginal peoples who live in Northeastern Ontario, Canada. *Harm Reduction Journal*, *12*(1), 1–12. https://doi.org/10.1186/s12954-015-0046-1

McCradden, M. D., Vasileva, D., Orchanian-Cheff, A., & Buchman, D. Z. (2019). Ambiguous identities of drugs and people: A scoping review of opioid-related stigma. *International Journal of Drug Policy*, *74*, 205–215. https://doi.org/10.1016/j.drugpo.2019.10.005

McGinty, E. E., Stone, E. M., Kennedy-Hendricks, A., & Barry, C. L. (2019). Stigmatizing language in news media coverage of the opioid epidemic: Implications for public health. *Preventive Medicine*, *124*(March), 110–114. https://doi.org/10.1016/j.ypmed.2019.03.018

McGovern, L., Miller, G., & Hughes-Cromwick, P. (2014). The Relative Contribution of Multiple

Determinants to Health Outcomes. In *Health Affairs: Vol. August 21*. www.healthaffairs.org

Mental Health Commission of Canada. (2015). *Guidelines for recovery-oriented practice*. www.mentalhealthcommission.ca

Menzies, K. (2019). Understanding the Australian Aboriginal experience of collective, historical and intergenerational trauma. *International Social Work, 62*(6), 1522–1534. https://doi.org/10.1177/0020872819870585

Milaney, K., Passi, J., Zaretsky, L., Liu, T., O'Gorman, C. M., Hill, L., & Dutton, D. (2021). Drug use, homelessness and health: responding to the opioid overdose crisis with housing and harm reduction services. *Harm Reduction Journal, 18*(1), 1–10. https://doi.org/10.1186/s12954-021-00539-8

Moroz, N., Moroz, I., & D'Angelo, M. S. (2020). Mental health services in Canada: Barriers and cost-effective solutions to increase access. *Healthcare Management Forum, 33*(6), 282–287. https://doi.org/10.1177/0840470420933911

Mudry, T. E. (2021). Addiction and recovery as social practice. *The Palgrave Encyclopedia of Critical Perspectives on Mental Health*.

Mudry, Tanya E., Vegter, V., & Strong, T. (2021). Situational analysis mapping for transformative thinking, conceptualisation and dialogues in counselling practice. *Counselling and Psychotherapy Research, 21*(3), 644–651. https://doi.org/10.1002/capr.12351

NCADD. (2018). *Multiple pathways of recovery : A guide for individuals and families*.

Ness, O., Borg, M., Davidson, L., & Davidson, L. (2014). Facilitators and barriers in dual recovery: A literature review of first-person perspectives. *Advances in Dual Diagnosis, 7*(3), 107–117. https://doi.org/10.1108/ADD-02-2014-0007

Netherland, J., & Hansen, H. B. (2017). The War on Drugs That Wasn't: Wasted Whiteness, "Dirty Doctors," and Race in Media Coverage of Prescription Opioid Misuse. *Culture, Medicine, and Psychiatry, 40*(4), 664–686. https://doi.org/10.1007/s11013-016-9496-5

Nishnawbe Aski Nation. (2012). *NAN CHIEFS CALL FOR IMMEDIATE ASSISTANCE AS REGION BRACES FOR MAJOR HEALTH CATASTROPHE*. http://www.nan.on.ca/upload/documents/nr-feb-15-pda-health.pdf

O'Donnell, J., Tanz, L. J., Gladden, R. M., Davis, N. L., & Bitting, J. (2021). Trends in and Characteristics of Drug Overdose Deaths Involving Illicitly Manufactured Fentanyls — United States, 2019–2020. In *Morbidity and Mortality Weekly Report* (Vol. 70, Issue 50). https://doi.org/10.15585/mmwr.mm7050e3

Olah, M., Gaisaino, G., & Hwang, S. (2013). The effect of socioeconomic status on access to primary care: an Audit Study. *Canadian Medical Association Journal*, *185*(6), 263–270.

Osei Baah, F., Teitelman, A. M., & Riegel, B. (2019). Marginalization: Conceptualizing patient vulnerabilities in the framework of social determinants of health – An integrative review. *Nursing Inquiry*, *26*(1), e12268. https://doi.org/http://www.doi.org/10.1111/nin.12268

Park, Y. S., Konge, L., & Artino, A. R. (2020). The Positivism Paradigm of Research. *Academic Medicine*, *95*, 690–694. https://doi.org/10.1097/ACM.0000000000003093

Perry, B. L., Pescosolido, B. A., & Krendl, A. C. (2020). The unique nature of public stigma toward non-medical prescription opioid use and dependence: a national study. *Addiction*, *115*(12), 2317–2326. https://doi.org/10.1111/add.15069

Persmark, A., Wemrell, M., Evans, C., Subramanian, S. . V. ., Leckie, G., & Merlo, J. (2019). Intersectional inequalities and the U . S . opioid crisis: Challenging dominant narratives and revealing heterogeneities. *Critical Public Health*, *30*(4), 398–414. https://doi.org/https://doi.org/10.1080/09581596.2019.1626002

Pletcher, M. J., Kertesz, S. G., Kohn, M. A., & Gonzales, R. (2008). Trends in opioid prescribing by race/ethnicity for patients seeking care in US emergency departments. *JAMA - Journal of the American Medical Association*, *299*(1), 70–78. https://doi.org/10.1001/jama.2007.64

Probst, C., & Rehm, J. (2018). Alcohol use, opioid overdose and socioeconomic status in Canada: A threat to life expectancy? *Canadian Medical Association Journal*, *190*(44), E1294–E1295. https://doi.org/10.1503/cmaj.180806

Public Health Agency of Canada. (2021). *Apparent Opioid and Stimulant Toxicity Deaths* (Issue June). https://health-infobase.canada.ca/src/doc/SRHD/UpdateDeathsMarch2021.pdf

Rhodes, T., Stimson, G. V., Moore, D., & Bourgois, P. (2010). Qualitative social research in addictions publishing: Creating an enabling journal environment. *International Journal of Drug Policy*, *21*(6), 441–444. https://doi.org/10.1016/j.drugpo.2010.10.002.Qualitative

Rieb, L. M., Samaan, Z., Furlan, A. D., Rabheru, K., Feldman, S., Hung, L., Budd, G., & Coleman, D. (2020). Canadian guidelines on opioid use disorder among older adults. *Canadian Geriatrics Journal*, *23*(1), 123–134. https://doi.org/10.5770/cgj.23.420

Rieder, T. N. (2018). There's Never Just One Side to the Story: Why America Must Stop Swinging the Opioid Pendulum. *Narrative Inquiry in Bioethics*, *8*(3), 225–231. https://doi.org/10.1353/nib.2018.0071

Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review*, *24*(2), 143–155. https://doi.org/10.1080/09595230500102434

Rowan, M., Poole, N., Shea, B., Gone, J. P., Mykota, D., Farag, M., Hall, C. H., Mushquash, C., & Dell, C. (2014). Cultural interventions to treat addictions in indigenous populations: Findings from a scoping study. *Substance Abuse: Treatment, Prevention, and Policy*, *9*(1). https://doi.org/10.1186/1747-597X-9-34

Services, A. H. (2019). *Harm Reduction: Recovery-Oriented Care*.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*, 63–75. https://doi.org/10.3233/EFI-2004-22201

Sibley, A. L., Schalkoff, C. A., Richard, E. L., Piscalko, H. M., Brook, D. L., Lancaster, K. E., Miller,

W. C., & Go, V. F. (2020). “I Was Raised in Addiction”: Constructions of the Self and the Other in Discourses of Addiction and Recovery. *Qualitative Health Research*, *30*(14), 2278–2290. https://doi.org/10.1177/1049732320948829

Simms, M. C., Mcdaniel, M., Fyffe, S. D., & Lowenstein, C. (2015). *Structural Barriers to Racial Equity in Pittsburgh: Expanding Economic Opportunity for African American Men and Boys*. *October*, 1–56. https://www.fatherhood.gov/research-and-resources/structural-barriers-racial-equity-pittsburgh-expanding-economic-opportunity

Singh, S., Martins, D., Khuu, W., Tadrous, M., Gomes, T., & Juurlink, D. (2018). Characteristics of Opioid-Related Deaths in Ontario, Canada: Leveraging the Drug and Drug/Alcohol Related Death (DDARD) Database. *International Journal of Population Data Science*, *3*(3), 197. https://doi.org/10.23889/ijpds.v3i4.790

Singhal, A., Tien, Y. Y., & Hsia, R. Y. (2016). Racial-ethnic disparities in opioid prescriptions at emergency department visits for conditions commonly associated with prescription drug abuse. *PLoS ONE*, *11*(8), 1–14. https://doi.org/10.1371/journal.pone.0159224

Srivastava, A., Kahan, M., & Nader, M. (2017). Primary care management of opioid use disorders: Abstinence, methadone, or buprenorphine-naloxone? *Canadian Family Physician Medecin de Famille Canadien*, *63*(3), 200–205. http://www.ncbi.nlm.nih.gov/pubmed/28292795%0Ahttp://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=PMC5349718

Strong, T., Chondros, K., & Vegter, V. (2018). Medicalizing tensions in counselor education? *European Journal of Psychotherapy and Counselling*, *20*(2), 220–243. https://doi.org/10.1080/13642537.2018.1459765

Stuber, J., Meyer, I., & Link, B. (2008). Stigma, prejudice, discrimination and health. *Social Science and Medicine*, *67*(3), 351–3577. https://doi.org/10.1016/j.socscimed.2008.03.023. Stigma,

Substance Abuse and Mental Health Services Administration. (2020). Substance Abuse and Mental Health Services Administration: The Opioid Crisis and the Black/African American Population: An Urgent Issue. In *Publication No. PEP20-05-02-001*.

Sudhir, P. M. (2018). Cognitive behavioural interventions in addictive disorders. *Indian Journal of Psychiatry*, *4*, S479–S484. https://doi.org/10.4103/psychiatry.IndianJPsychiatry

Taha, S. (2018). *Best Practices across the Continuum of Care for the Treatment of Opioid Use Disorder* (Issue August). www.ccsa.ca•www.ccdus.ca

Thomas, N., van de Ven, K., & Mulrooney, K. J. D. (2020). The impact of rurality on opioid-related harms: A systematic review of qualitative research. *International Journal of Drug Policy*, *85*(xxxx), 102607. https://doi.org/10.1016/j.drugpo.2019.11.015

Thompson, R. G., Wall, M. M., Greenstein, E., Grant, B. F., & Hasin, D. S. (2013). Substance-use disorders and poverty as prospective predictors of first-time homelessness in the United States. *American Journal of Public Health*, *103*(SUPPL. 2), 282–288. https://doi.org/10.2105/AJPH.2013.301302

Timko, C., Han, X., Woodhead, E., Alexandra, S., & Cucciare, M. A. (2018). Polysubstance Use by Stimulant Users:Health Outcomes Over Three Years. *Journal of Studies on Alcohol and Drugs*, *79*, 799–807. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6240007/pdf/jsad.2018.79.799.pdf

Tofighi, B., Sindhu, S. S., Chemi, C., Lewis, C. F., Dickson, V. V., & Lee, J. D. (2019). Perspectives on the HIV continuum of care among adult opioid users in New York City: A qualitative study. *Harm Reduction Journal*, *16*(1), 1–9. https://doi.org/10.1186/s12954-019-0329-z

Tompsett, C. J., Domoff, S. E., & Toro, P. A. (2013). Peer Substance Use and Homelessness Predicting Substance Abuse from Adolescence Through Early Adulthood. *American Journal of Community Psychology*, *51*(1), 1–15. https://doi.org/10.1007/s10464-013-9569-3.

Trescot, A. M., Boswell, M. V., Atluri, S. L., Hansen, H. C., Deer, T. R., Abdi, S., Jasper, J. F., Singh,

V., Jordan, A. E., Johnson, B. W., Cicala, R. S., Dunbar, E. E., Helm, S., Varley, K. G., Suchdev, P. K., Swicegood, J. R., Calodney, A. K., Ogoke, B. A., Minore, W. S., & Manchikanti, L. (2006). Opioid guidelines in the management of chronic non-cancer pain. *Pain Physician*, *9*(1), 1–40. https://doi.org/10.36076/ppj.2006/9/2

United Nations Office on Drugs and Crime. (2020). *COVID-19 and the drug supply chain: from production and trafficking to use*.

Volkow, N. D., & Blanco, C. (2021). The changing opioid crisis: development, challenges and opportunities. *Molecular Psychiatry*, *26*(1), 218–233. https://doi.org/10.1038/s41380-020-0661-4

Weeks, C., & Stenstrom, D. M. (2020). Stigmatization of opioid addiction based on prescription, sex and age. *Addictive Behaviors*, *108*(May), 106469. https://doi.org/10.1016/j.addbeh.2020.106469

Wells, C., Dolcine, B., & Frey, N. (2019). *Programs for the Treatment of Opioid Addiction : An Environmental Scan*.

Werb, D., Kamarulzamen, A., Meacham, M. C., Rafful, C., Fisher, B., Strathdee, S. A., & Wood, E. (2016). THE EFFECTIVENESS OF COMPULSORY DRUG TREATMENT: A SYSTEMATIC REVIEW. *International Journal of Dtug Policy*, *28*, 1–9. https://doi.org/http://doi.org/10.1016/j.drugpo.2015.12.00

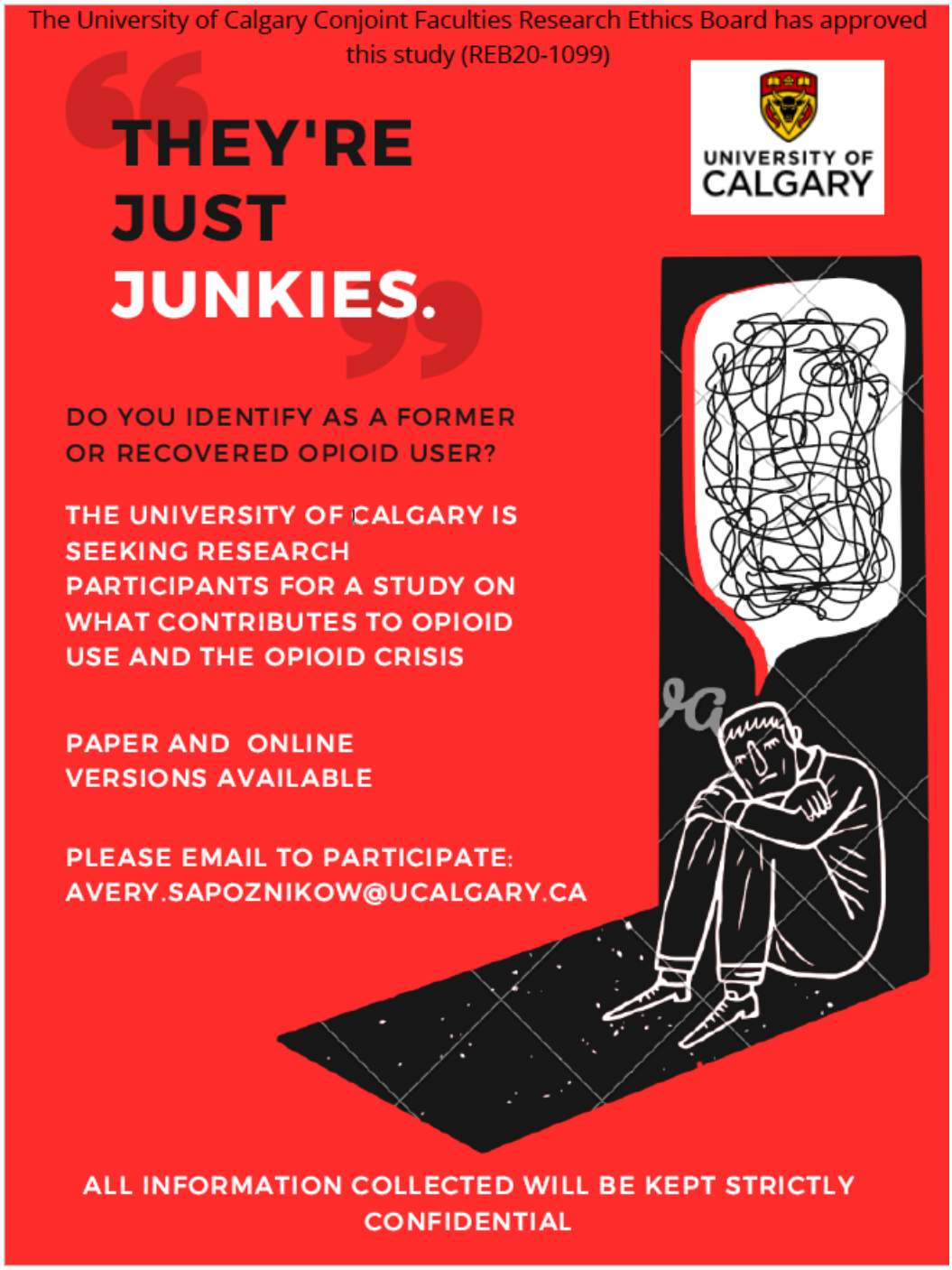
Williams, V., Boylan, A. M., & Nunan, D. (2019). Qualitative research as evidence: Expanding the paradigm for evidence-based healthcare. *BMJ Evidence-Based Medicine*, *24*(5), 168–169. https://doi.org/10.1136/bmjebm-2018-111131

Wu, L. T., Zhu, H., & Swartz, M. S. (2016). Treatment utilization among persons with opioid use disorder in the United States. *Drug and Alcohol Dependence*, *169*, 117–127. https://doi.org/10.1016/j.drugalcdep.2016.10.015

Zivanovic, R., Milloy, M. J., Hayashi, K., Dong, H., Sutherland, C., Kerr, T., & Wood, E. (2015). Impact of unstable housing on all-cause mortality among persons who inject drugs Health behavior,

health promotion and society. *BMC Public Health*, *15*(1), 1–7. https://doi.org/10.1186/s12889-015-1479-x

Appendix A: Recruitment Poster



Appendix B: Survey Questionnaire

Survey Questionnaire

Do you identify as a former or recovered opioid user? Y/N – *If no, terminate survey.*

PART 1: Demographics

1. Age: ___
2. Sex: _____
3. Gender: _____
4. Race: _____
5. Ethnicity: _____
6. Nationality: _____
7. Religion/spirituality: _____
8. Highest Education Level: _____
9. Employment Status:
    a. Employed
    b. Unemployed
    c. Disability
    d. Employment Insurance
    e. Other: _____
10. *If indicated employment:*
    What do you do for work (e.g., trades, business, academia)? _____
11. Living Arrangements: _____
12. Income: _____
13. Marital Status:
    a. Single
    b. Married
    c. Common-law
    d. Other: _____

PART 2: Open-Ended Questions about Opioid Use

1. Please describe your first experience with opioids (e.g., at what age, how, what opioid)

2. How long did you use opioids for and how long has it been since you stopped using opioids?

3. What are your reasons for using opioids? Do you believe others have similar reasons? If not, what would those reasons be?

4. How do you understand your own opioid use (i.e., what affected to your opioid use, why did you use opioids)?

5. Has your understanding of your own opioid use changed over time? If so, what caused the change and how has it changed?

6. How did your opioid use impact your close relationships (e.g., relationships with family, friends, etc.)?

7. What support systems (e.g., family, friends, medical services, community support groups, etc.) were available when you were using opioids? Why or why not did you use them?

8. What role did the healthcare community (i.e., doctors, nurses, paramedics, etc.) play in your opioid use? Please explain your experiences with the healthcare system.

9. Did you have experiences with law enforcement while you used opioids? (Yes/No) If so, please describe these experiences:

10. What were your experiences with others when you used opioids (e.g., family, friends, community members, public, others)?

11. Do you believe any aspects of your personal identity (e.g., race, gender, ethnicity, income, employment status, etc.) affected your opioid use and personal experiences while using or stopping use? If so, please explain:

12. If you are religious or spiritual, how does religion and/or spirituality play a role in your past opioid use and recovery?

13. Has your past opioid use impacted your mental health? If so, how?

14. Many people have described an ongoing “overdose crisis” or “Opioid Crisis”. Do you believe there is an Opioid Crisis? (Y/N) Please explain.

15. Do you believe that the common responses to the Opioid Crisis are harmful or helpful? What do you believe would be most helpful for current opioid users?

16. Is there anything else you would like to share? What else do you think is important for me to know?

Appendix C: Survey Consent Form

Name of Researcher, Faculty, Department, Telephone & Email:
Avery Saponikow, BSc (Hons.), MSc Counselling Psychology Student
Werklund School of Education
Department of Counselling Psychology
avery.sapoznikow@ucalgary.ca

Supervisor:
Dr. Tanya Mudry, PhD
Werklund School of Education
Department of Counselling Psychology
403-210-6995
mudryt@ucalgary.ca

Title of Project:
Exploring Opioid Use in a Canadian Context: A Situational Analysis

Sponsor:
None

The University of Calgary Conjoint Faculties Research Ethics Board has approved this study (REB20-1099)

This consent form, a copy of which has been given to you, is only part of the process of informed consent. If you want more details about anything mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The University of Calgary Conjoint Faculties Research Ethics Board has approved this research study. Participation is completely voluntary and confidential.

Purpose of the Study
The purpose of this study is to gain an understanding of the complexity of opioid use and the Opioid Crisis. To do this, we are analyzing the perspectives of adults (18+) who identify as former opioid users

What Will I Be Asked To Do

As a participant in this study, you will be asked to complete an online survey. This survey will gather information about your demographics (e.g., age, ethnicity, race, etc.), past opioid use (e.g., "At what age did you start using opioids?"), and more open-ended questions about personal experiences using opioids (e.g., "How did opioid use impact your interpersonal relationships?"). No personal identifying information will be linked to any of your responses for the survey. All responses are strictly confidential. The survey should take 30-45 minutes to complete unless you provide longer responses for the open-ended questions.

Optionally, at the end of the survey, you will have the choice to take part in a follow-up interview over the online call program, zoom. This interview may take up to an hour to complete, but also varies based on your responses. You may choose to provide an email so the researcher can contact you to pick an interview date. Emails collected through the survey are deleted following the interview. Participation in the follow-up interview is completely optional and you may change your decision at any time.

Participation in all components of this study is completely voluntary. You may refuse to participate entirely, or you may withdraw your participation in the study at any time. Furthermore, you may refuse to take part in certain parts of the study or only answer specific questions. You are able to withdraw from the study at any time without consequence.

What Type of Personal Information Will Be Collected

Should you agree to complete the survey, you will be asked to provide common demographic information (e.g., age, gender, employment status, etc.). Additionally, personal information related to past drug use will be the focus of most of the survey. Most questions are open-ended, so it is up to you to choose how much personal information you wish to provide within your responses. If any personal information (e.g., names of family members) is disclosed through these responses, it will be removed before data analysis.

Why is this research important?

Canada and the United States are currently amid an overdose epidemic. There are a many factors that contribute to opioid use (e.g., impact of government policy, the healthcare system, peer relationships, etc.) and the Opioid Crisis. This study aims to identify and explore how they are connected or not connected. This research may inform psychologists and other health workers on methods of working with opioid users.

Are there Risks or Benefits if I Participate?

No significant risks, harms, or inconveniences are anticipated for participants of this study. However, there is a minimal risk to participants from participating in this study. This risk is related to the sensitive nature of the information being collected and potentially discussed over zoom. Participants may have distressing thoughts or physical experiences (e.g., anxiety) due to talking about drug use and its impacts. There will be intimate discussion of opioid use, however the focus will be on what impacted your opioid use versus the use itself. If you choose to share potentially incriminating information, this information will be kept strictly confidential. It is up to you as the participant to decide the level of detail you wish to share while participating, as full anonymity cannot be guaranteed.

All participants will be given a list of resources with community supports before the survey. This will be sent as a part of the survey.

What Happens to the Information I Provide?
The only people who will have access to the data you provide are the principal investigator (supervisor) and the researcher. Any identifying information provided by a participant will be replaced or removed completely.

Participants are free to withdraw until one week after their participation in each component of this study. If you decide you no longer want your data to be included in this study following participation, please email the researcher at avery.sapoznikow@ucalgary.ca and your data will be removed from the data pool. After one week, data analysis will begin and all identifying information (e.g., names or emails provided) will be removed. Following this step, each survey will only be given a number, so it will be impossible to identify which responses were yours. If you do choose to withdraw within the one-week period following your participation, all your responses will be destroyed.

No one except the researcher and supervisor will be able to read or hear any of your responses. There are no names on the questionnaire. The survey results will be stored on an encrypted external hard drive. This hard drive will only be accessible by the researcher and supervisor. The data will be stored for five years before being erased, as per the University of Calgary's policy on the storage of research data.

Signatures

Your signature on this form indicates that 1) you understand to your satisfaction the information provided to you about your participation in this research project, and 2) you agree to participate in the research project.

In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from this research project at any time.

You should feel free to ask for clarification or new information throughout your participation.

I consent to participate in this research study ☐

I do not wish to participate in the research study ☐

Questions/Concerns
If you have any further questions or want clarification regarding this research and/or your participation, please contact:

Researcher:
Avery Saponikow, BSc (Hons.), MSc Counselling Psychology Student
Werklund School of Education
Department of Counselling Psychology
avery.sapoznikow@ucalgary.ca

or

Supervisor:
Dr. Tanya Mudry, PhD
Werklund School of Education
Department of Counselling Psychology
403-210-6995
mudryt@ucalgary.ca

If you have any concerns about the way you've been treated as a participant, please contact the Research Ethics Analyst, Research Services Office, University of Calgary at 403.220.6289 or 403.220.8640; email cfreb@ucalgary.ca. A copy of this consent form has been given to you to keep for your records and reference. The investigator has kept a copy of the consent form

Appendix D: Email Script for Participants Interested in Semi-Structured Interview

Script for Participants Interested in Semi-structured Interview

Hello,

Thank you for taking part in the first part of the study: Exploring Opioid Use in a Canadian Context: A Situational Analysis. You are receiving this email because you said you would be interested in taking part in a follow-up secondary interview. In this interview, I will ask you more questions regarding opioid use that are not in the survey. If you are interested, please reply to this email. A researcher will be in touch with you to set up a time for the interview shortly.

Thank you for your interest in taking part in this study.

Avery Sapoznikow, BSc (Hons.)

MSc. Counselling Psychology Student
Werklund School of Education
Department of Counselling Psychology
University of Calgary

Appendix E: Semi-Structured Interview Consent Form

Name of Researcher, Faculty, Department, Telephone & Email:
Avery Saponikow, BSc (Hons.), MSc Counselling Psychology Student
Werklund School of Education
Department of Counselling Psychology
avery.sapoznikow@ucalgary.ca

Supervisor:
Dr. Tanya Mudry, PhD
Werklund School of Education
Department of Counselling Psychology
403-210-6995
mudryt@ucalgary.ca

Title of Project:
Exploring Opioid Use in a Canadian Context: A Situational Analysis

Sponsor:
None

The University of Calgary Conjoint Faculties Research Ethics Board has approved this study (REB20-1099)

This consent form, a copy of which has been given to you, is only part of the process of informed consent. If you want more details about anything mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The University of Calgary Conjoint Faculties Research Ethics Board has approved this research study. Participation is completely voluntary and confidential.

Purpose of the Study
The purpose of this study is to gain an understanding of the complexity of opioid use and the Opioid Crisis. To do this, we are analyzing the perspectives of adults (18+) who identify as former opioid users

What Will I Be Asked To Do

As a participant in this study, you will be asked to complete a follow-up interview, over zoom, to the survey you previously completed. This interview may take up to an hour to complete, but also varies based on your responses. Participation in the follow-up interview is completely optional and you may change your decision to participate at any time.

The zoom interview will be recorded for data analysis like the open-ended responses gathered from the survey.

Participation in all components of this study is completely voluntary. You may refuse to participate entirely, or you may withdraw your participation in the study at any time. Furthermore, you may refuse to take part in certain parts of the study or only answer specific questions. You are able to withdraw from the study at any time without consequence.

What Type of Personal Information Will Be Collected

If you choose to take part in this zoom interview, the conversation will be recorded for transcription purposes. The audio recordings will be transcribed using Rev.com. Rev.com is a transcription service for research purposes that has a strict customer confidentiality policy. This tool is approved by the University of Calgary for use in research involving transcription. The audio recordings will be not be accessed by anyone except the researcher and supervisor.

Why is this research important?

Canada and the United States are currently amid an overdose epidemic. There are a many factors that contribute to opioid use (e.g., impact of government policy, the healthcare system, peer relationships, etc.) and the Opioid Crisis. This study aims to identify and explore how they are connected or not connected. This research may inform psychologists and other health workers on methods of working with opioid users.

Are there Risks or Benefits if I Participate?

No significant risks, harms, or inconveniences are anticipated for participants of this study. However, there is a minimal risk to participants from participating in this study. This risk is related to the sensitive nature of the information being collected and potentially discussed over zoom. Participants may have distressing thoughts or physical experiences (e.g., anxiety) due to talking about drug use and its impacts. There will be intimate discussion of opioid use, however the focus will be on what impacted your opioid use versus the use itself. If you choose to share potentially incriminating information, this information will be kept strictly confidential. It is up to you as the participant to decide the level of detail you wish to share while participating, as full anonymity cannot be guaranteed.

As a graduate psychology student, the researcher is required to break confidentiality if, through the interview process, you indicate a risk of harm to yourself and/or others or reveal a child/vulnerable person is or has been, or is at risk of being abused or neglected. If either of these situations occur, the researcher will be required to inform the principle investigator, Dr. Tanya Mudry, and the appropriate authorities to ensure that you and others are safe.

If you feel uncomfortable at any point during the zoom interview, you may take a break or stop the interview. All participants will be given a list of resources with community supports before the zoom interview.

What Happens to the Information I Provide?

The only people who will have access to the data you provide are the principal investigator (supervisor) and the researcher. Any identifying information provided by a participant will be replaced or removed completely.

Participants are free to withdraw until one week after their participation in each component of this study. If you decide you no longer want your data to be included in this study following participation, please email the researcher at avery.sapoznikow@ucalgary.ca and your data will be removed from the data pool. After one week, data analysis will begin and all identifying information (e.g., names or emails provided) will be removed. Following this step, each interview will only be given a number, so it will be impossible to identify which responses were yours. If you do choose to withdraw within the one-week period following your participation, all your responses will be destroyed.

No one except the researcher and supervisor will be able to read or hear any of your responses. There are no names on the interview protocol. The interview recording and data will be stored on an encrypted external hard drive. This hard drive will only be accessible by the researcher and supervisor. The data will be stored for five years before being erased, as per the University of Calgary's policy on the storage of research data.

Signatures

Your signature on this form indicates that 1) you understand to your satisfaction the information provided to you about your participation in this research project, and 2) you agree to participate in the research project.

In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from this research project at any time.

You should feel free to ask for clarification or new information throughout your participation.

Oral Consent provided:
Yes _____
No _____

Questions/Concerns
If you have any further questions or want clarification regarding this research and/or your participation, please contact:

Researcher
Avery Saponikow, BSc (Hons.), MSc Counselling Psychology Student
Werklund School of Education
Department of Counselling Psychology
avery.sapoznikow@ucalgary.ca

or

Supervisor:
Dr. Tanya Mudry, PhD
Werklund School of Education
Department of Counselling Psychology
403-210-6995
mudryt@ucalgary.ca

If you have any concerns about the way you've been treated as a participant, please contact the Research Ethics Analyst, Research Services Office, University of Calgary at 403.220.6289 or 403.220.8640; email cfreb@ucalgary.ca. A copy of this consent form has been given to you to keep for your records and reference. The investigator has kept a copy of the consent form.

Appendix F: Semi-Structured Follow-up Interview Protocol

Semi-Structured Follow-up Interview

1. To start, I am curious what your experience with opioids was like?
    a. What do you believe shaped your experience?

2. Thinking back to when you used opioids, what were your thoughts on opioid use?
    a. Have your thoughts changed? If so, in what way?
    b. What do you think caused this shift?

3. Could you tell me about a few things that made you want to use opioids and what kept you using? For example, social pressure, openness to experience, coping/self-medicating.
    a. How did <u><insert participant identified factor></u> contribute to your opioid use?

        ----------Repeat for identified factors----------

4. Tell me how you feel about opioids now.

5. Did opioid use impact your interpersonal relationships (e.g., friendships, family relationships, etc.)? If so, how?
    a. Were there any significant changes in your relationships related to your opioid use?
    b. How do you feel about that?
    c. Has stopping opioid use impacted your relationships? If so, how?

6. Tell me about your experience in stopping using opioids:
    a. What helped? (Prompt – people, places, things)
    b. What made it harder?

7. *If involvement with healthcare system indicated in survey* – In the survey you said the healthcare system was involved in your life while you used opioids.
    a. Did you feel supported?
    b. What was most helpful/harmful?
    c. Who was helpful/harmful?

8. *If involvement with law enforcement indicated in survey* – In the survey you said you were involved with law enforcement while using opioids, could you tell me more about that?

9. How do you feel other people in your life viewed your opioid use (e.g., family, friends, community members, neighbours, coworkers, etc.)?

10. When asked about the Opioid Crisis, you said <insert response>, can you tell me more about why you feel this way?

    Allow people to be fulfilled and meet their basic needs

11. *If survey response indicated that opioid use impacted their mental health* – You mentioned in the survey that past opioid use impacted your mental health, you said – *provide specific example from survey response* – tell me more about that.

12. What do you think would be important for service providers to know about opioid use (e.g., law enforcement, politicians, healthcare workers, etc.)?

13. Is there anything that we have not discussed that you think is important? What else do I need to know about opioids and opioid use?

Appendix G: Demographic Characteristics of Survey Participants

	N	Percent (%)	Mean	Median	Range
Age (Total)	83	100	34	33	18-71
18-29	34	41	25.76	26	18-29
30-49	44	53	38.28	38	30-49
50+	5	6	59.83	58.5	51-71
Gender (Total)	83	100			
Male	52	63			
Female	31	37			
Race (Total)	83	100			
White	82	99			
Latino	1	1			
Education Level (Total)	83	100			
High School	34	41			
College	16	19			
University	25	30			
Graduate School	8	10			
Income Level (Total)	83	100			
Low Income	39	47			
Middle Income	34	41			
High Income	10	12			
Religion (Total)	83	100			
Agnostic	10	12			
Atheist	31	37			
Christian/Catholic	32	39			
Other	10	12			
Martial Status (Total)	83	100			
Single	45	54			
Relationship	17	21			
Engaged/Married	21	25			