Mattering Matters:
Identifying What Influences People Who Use Drugs to Access Emergency Healthcare Services

by

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Bachelor of Nursing, University of New Brunswick, 2004

Master of Nursing, University of New Brunswick, 2020

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of

Doctor of Philosophy

in the Graduate Academic Unit of Interdisciplinary Studies

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This dissertation is accepted by the Dean of Graduate Studies

THE UNIVERSITY OF NEW BRUNSWICK

July 2026

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Abstract

People are dying on sidewalks, behind dumpsters, and in abandoned buildings. These are individuals living precariously with severe, long-term substance use disorders. They ingest, inhale, and inject toxic, contaminated substances, and their lives are shaped by overdoses, chronic illness, and poverty. This dissertation examines a cohort of individuals who use drugs and delay or avoid emergency hospital care, often resulting in severe health complications, including death.

People who use drugs (PWUD) experience complex, often tenuous relationships with healthcare systems. While they do access care, they face systemic barriers such as discrimination, long wait times, and the risk of withdrawal symptoms, however, there is a cohort who do not. Hospitals are frequently perceived as unsafe and stigmatizing environments, leading to delays or avoidance of emergency services. These patterns contribute to lower health outcomes, prolonged hospitalizations, and increased mortality. Although the literature extensively documents these barriers, little is known about their motivations, the why, how, when, and with whom that influence PWUD to access emergency healthcare.

This study used a mixed methods sequential explanatory design to explore, "What influences and motivates PWUD to access emergency healthcare services?" Conducted in Saint John, New Brunswick, the study involved two phases: Social Network Analysis (2022, n = 4) and Interpretive Description (2024, n = 40). The study examined PWUD with complex substance use and healthcare experiences, including individuals who delay, avoid, reluctantly access, or repeatedly use emergency services under conditions of extreme need. Data analysis supported by UCINET© and NetDraw© revealed that

participants had dense, insular networks with limited access to external resources, constraining their healthcare-seeking behaviour.

Interpretive analysis identified four key concepts. Pain emerged as a primary motivator for seeking emergency care. In addition, connection, understood as meaningful social bonds, and perceived self-worth, defined as belief in one's value and significance, contribute to an overall sense of mattering. Mattering, in this context, is essential for PWUD to engage with emergency healthcare services.

This study argues that mattering emerged as an important facilitator for emergency healthcare engagement among PWUD. These findings offer theoretical, clinical, educational, and policy implications for improving care for this marginalized population.

Lay Summary

People are dying alone on the streets; some having never accessed healthcare for treatable and preventable health conditions. They are living with serious drug addiction, which has significant risks, including long-term health complications and overdose death. Their lives often intersect with trauma, pain, poverty, homelessness, and mental health issues.

Although many people who use drugs (PWUD) access the healthcare system often and repeatedly, there are individuals who delay going to the hospital, or refuse, leading to serious health complications, longer admissions, and lower health outcomes including death. The literature highlights multiple barriers that prevent individuals from accessing hospital services, including longer wait times, fear of drug withdrawal, and expected discrimination by healthcare professionals. What is not well understood is what influences and motivates PWUD to go to the hospital for emergency healthcare services, despite these barriers. By understanding these motivations, we can understand why some avoid or refuse treatment altogether.

This study interviewed people in the community whose substance use met the study criteria and were considered to have severe substance use disorder (SUD). They provided information about their social networks and experiences within the healthcare system, as well as information about their thoughts, feelings, and need to access emergency services.

The findings indicate that pain is a significant factor influencing participants' decisions to seek emergency services. Experiences of connection through meaningful relationships and shared experiences, along with feelings of self-worth such as

significance and personal dignity, motivated and influenced PWUD to seek emergency care. These elements of connection and self-worth are integral components of the broader psychological construct of *mattering*, which emerged as a central influence in healthcare-seeking behaviour among this population. However, while mattering may be an important condition for accessing emergency services, it may not always be sufficient on its own.

When caring for PWUD, healthcare providers must be intentional in their efforts to ensure that connection and a sense of self-worth are integrated into the supports and services offered to people living with serious addiction. Mattering has important implications for clinical practice, policy development, education, and future research.

Dedication

This dissertation is dedicated to my parents, Percy, and Norma Wilbur, who instilled in me both a curiosity and love of learning. I thank my son Drew Chenier, for his patience, humor, and encouragement as I continued my educational journey.

This work has truly been a family endeavour.

Acknowledgement

I am profoundly grateful to the participants in my study who agreed to share their lived experiences and stories with me. Without their insight and honesty, my research would not have been possible. I would also like to acknowledge the support of the peers, staff, and volunteers at Avenue B Harm Reduction Inc. Saint John, including Julie Dingwell, Diane Kerns and Holly Richards.

I am deeply grateful to my friend and colleague, Dr. Duncan Webster, for his kindness, wisdom, and encouragement along the way. I would like to thank my friend, Moira Law, for her unwavering support and Dr. Sally Thorne, for her calm guidance and direction. I would like to extend my sincere appreciation to my friends, Opolahsomuwehs, Dr. Imelda Perley, for the gift of healing moccasins, together with Dr. Andrea Simon, who helped me see beauty while keeping me safe during my breast cancer and academic journey.

I would like to thank my Supervisor, Dr. Rob Moir, and Committee Members, Dr. Leslie Jeffrey, and Dr. Tim Christie for their support and direction throughout this process.

I would like to thank my friends and family for their patience and always being there for me, especially Catherine Hamilton, Sharon Randall, Catherine McQuade, Sonia Thorne, Anne Marie Creamer, Karen Crane, Jody Kennedy, Andrene Mosher, Isabelle MacMillan, Jan Waldschutz, Todd Ross, Britt Fowler and my aunt Marilyn Morgan and my nieces Claire and Ellen Wilbur.

It would never have happened without all of you walking beside me.

Land Acknowledgement

I respectfully acknowledge that I am a settler, as my ancestors immigrated to Canada from Ireland, France, and England. I teach and conduct research at the University of New Brunswick on the Saint John campus, situated on the beautiful unceded and unsurrendered territory of the Mi'kmaq, Wolastoqiyik, and Peskotomuhkati peoples. As a person of privilege, an ally and follower, I respectfully acknowledge the history of Canadian colonialism and its impact on Indigenous populations and the roles we all have in the healing and reconciliation between nations. Further, I acknowledge that I undertook the following research study as a non-Indigenous woman raised in a colonial setting and that my social position is accompanied by bias located in colonial perspectives. Within this research, Indigenous persons may be over-represented in the population of focus because of the impacts of colonization and ongoing cultural suppression, which include adverse childhood experiences and insufficient social supports. As a community health nurse, I encounter diverse people at the university, on the streets, and in the healthcare system. Further information on my positionality and reflexivity is included in the first chapter of this dissertation. As I reflect upon the discrepancies of support for some populations, the resulting health inequities within our society, and the impact on Canadians, I am committed to providing safe, compassionate, competent, and ethical care for all people (Truth and Reconciliation Commission, 2015a).

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List of Abbreviations

ACEs	Adverse Childhood Experiences
CADS	Canadian Alcohol and Drug Survey
CSUS	Canadian Substance Use Survey
CNCP	Chronic Non-Cancer Pain
ED	Emergency Department
EMS	Emergency Medical Services
HBM	Health Belief Model
HSB	Health-Seeking Behaviour Model
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
ID	Interpretive Description
LAMA	Leave Against Medical Advice
PCP	Primary Care Provider
PWUD	People Who Use Drugs
SNA	Social Network Analysis
SUD	Substance Use Disorder
REB	Research Ethics Board
TIC	Trauma-Informed Car

Chapter 1: Introduction

Substance use refers to the consumption of psychoactive substances that act upon the central nervous system and alter mood, perception, cognition, and behaviour (World Health Organization, 2022). These substances include alcohol, prescription medications, and illicit drugs, each of which can vary in their physiological and social impacts depending on the frequency, intensity, and context of use (Health Canada, 2024). Substance use exists along a continuum that ranges from experimental or occasional use to patterns of regular or problematic use that can result in physical, psychological, social consequences and death.

In contemporary health and nursing scholarship, substance use is understood as a multifaceted behaviour shaped by social, environmental, and structural factors rather than as a purely individual choice. Determinants such as trauma, discrimination, poverty, and limited access to equitable healthcare influence patterns of substance use and the capacity for individuals to seek or receive care (Health Canada, 2024; World Health Organization, 2022). The term substance use is preferred over stigmatizing alternatives such as abuse or addiction to align with person-centred, and harm reduction approaches that emphasize dignity, and respect within the broader social context of health (Stockwell, 2008).

Canada is currently facing an unprecedented overdose crisis (Government of Canada, 2024). This public health emergency is largely driven by an increasingly toxic and unpredictable illicit drug supply, a situation exacerbated by disruptions associated with the COVID-19 pandemic (Health Canada, Public Health Agency of Canada, & United States Department of Health and Human Services, 2022). The emergence and

widespread availability of synthetic opioids, particularly fentanyl, have intensified the crisis (Health Canada, 2024). Contamination of the street drug supply with potent and inexpensive substances has resulted in devastating consequences for people who use drugs (PWUD), placing further strain on health and social systems (Canadian Substance Use Costs and Harms Scientific Working Group, 2023).

At the center of this crisis are individuals living with complex and intersecting challenges, including substance use disorder (SUD), physical and mental illnesses, and housing instability (Hyshka et al., 2020). Although many PWUD interact with the healthcare system, this study includes those who deliberately avoid or refuse emergency healthcare services altogether, even in the presence of serious and potentially life-threatening conditions. This avoidance raises critical questions about the accessibility and acceptability of healthcare services for certain marginalized populations and forms the central focus of this study.

This dissertation makes a timely and original contribution to the literature on substance use, harm reduction, trauma-informed care (TIC), and health equity. By investigating factors that influence and motivate PWUD to access or avoid emergency healthcare services, this research offers a novel and unique perspective that shifts attention from barriers to the relational, social, and affective factors that motivate healthcare engagement. It conceptualizes healthcare-seeking as a socially embedded process shaped by structural conditions, interpersonal dynamics, and internal experiences, rather than as an isolated or purely rational act. Employing an innovative mixed methods research design that integrates Social Network Analysis (SNA) with Interpretive

Description (ID), the study generates new empirical insights and theoretical understandings. This research addresses a critical gap in the literature, and the findings have implications for the development of responsive, trauma-informed, and equitable models of care for PWUD.

Substance use remains one of the most pressing public health concerns in Canada and internationally, with far-reaching social, economic, and healthcare implications. The first chapter introduces the context, scope, and rationale for the study while identifying and defining the population at risk, PWUD. It then situates substance use in Canada, drawing on findings from the Canadian Substance Use Survey (Health Canada, 2024), and examines both the legal, illegal, and illicit substance use trends and their associated costs to individuals, the healthcare system, and society. The complex relationship between substance use and mental health, along with the associated morbidity and mortality, is discussed in relation to health and healthcare service delivery. Exploring how substance use intersects with health and healthcare systems, emphasizes the influence of stigma, discrimination, and the consequences of a fragmented healthcare system. Particular attention is given to the Canadian context, with a focus on New Brunswick, where the study was conducted, to ground the research within a localized health system and policy environment. An overview of these aspects of care underscores the clearly defined need for this investigation and leads to the presentation of the central research question, study design, and methodology. The chapter concludes by outlining the structure of the dissertation, providing a roadmap for the reader, and situating the relevance of the study within contemporary public health and healthcare discourse.

Although a growing body of literature examines addiction, treatment, and barriers to healthcare access (Health Canada, 2022; Heilig et al., 2021; Public Health Agency of Canada, 2022; United States Department of Health and Human Services, 2022), a notable gap remains with relatively few studies examining what initially motivates this high risk population who use substances to access emergency hospital care. Previous research has consistently identified systemic barriers, stigma, discrimination, and mistrust of healthcare providers as key deterrents to care engagement (Chan Carusone et al., 2019; McNeil et al., 2017). This dissertation extends this scholarship by shifting the focus from barriers or avoidance to the conditions, relationships, and internal processes that facilitate access to emergency healthcare. Specifically, it examines both internal and external motivating factors, such as pain, social connection, trust, perceived self-worth, and the influence of personal networks, which contribute to PWUD seeking emergency healthcare services.

1.1 Understanding the Population at Risk: People Who Use Drugs

The term ‘people who use drugs’ (PWUD) reflects a major linguistic and conceptual shift within substance use discourse, emphasizing dignity, reducing stigma, and acknowledging the complex health and social realities experienced by this population (Dembo et al., 1981; Stockwell, 2008). The phrase first appeared in both academic literature and drug culture during the early 1980s, coinciding with broader transformations in public health, harm reduction, and addiction advocacy (Dembo et al., 1981; Volkow, 2014). Unlike stigmatizing terms such as druggie, drug abuser, or addict, which perpetuate moral judgment and negative stereotypes, the term PWUD adopts a

person-centered and nonjudgmental approach (Lloyd, 2013). This linguistic shift reflects an understanding that individuals are not defined by their substance use but are people living with complex and chronic health conditions (American Psychiatric Association, 2022).

People who use drugs often navigate unsafe environments and systemic barriers while managing an SUD (Urbanowski et al., 2017). As a result, they face increased risks of physical and psychological health complications, leading to a disproportionate reliance on hospital-based emergency services (Bonn et al., 2020; McNeil et al., 2014; Wood, 2016). A systematic review by Lewer et al. (2020) reported that individuals using heroin, methamphetamine, or crack cocaine were between 4.8 and 7.1 times more likely to require Emergency Department (ED) care than the general population. This vulnerability represents an urgent global health concern shaped by persistent social and structural inequities (Nafeh et al., 2022; Pouille et al., 2024; Tanguay et al., 2015).

This study focuses on a smaller cohort within the broader population of PWUD; those with emergency healthcare service experiences in the past 12 months. These individuals are often unhoused, transient, experiencing mental illness and living with one or more substance use disorders. They are often very reticent to engage with others and not easily identified which makes research within this population very challenging. Building on this foundational knowledge, the study explores overall how PWUD experience emergency healthcare within the Canadian context, emphasizing personal, social, and systemic factors which influence decisions to seek care (Papalamprakopoulou

et al., 2025). Recognizing these dynamics is essential to developing compassionate, culturally safe, and effective healthcare responses for PWUD.

1.2 Patterns of Substance Use in Canada

The determination of problematic substance requires a structure professional subjective judgment with consideration pertaining to usage that interferes with quality of life, activities of daily living that may or may not cause distress in the individual and/or persons in relationship with them. To contextualize substance use in Canada, the Canadian Substance Use Survey (CSUS), formerly the Canadian Alcohol and Drugs Survey (CADS), has been conducted biennially by Health Canada in collaboration with Statistics Canada since 2008 (Health Canada, 2022). The transition from CADS to CSUS occurred during the COVID-19 pandemic, resulting in delays in data publication between 2018 and 2022.

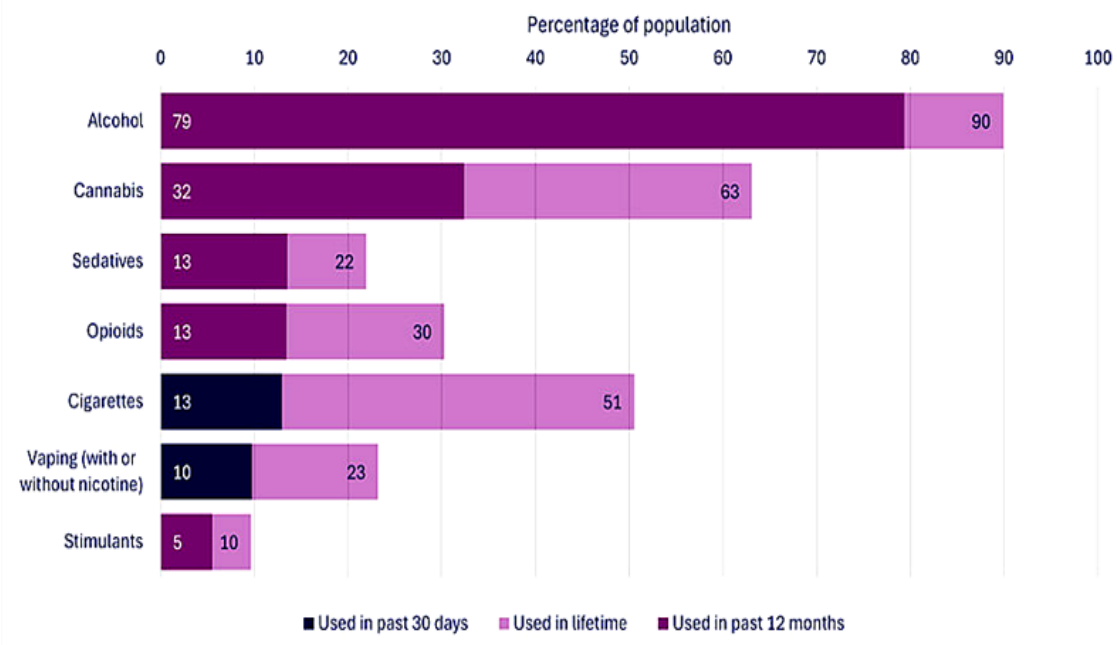
The CSUS is a key resource for monitoring trends in both legal and illegal substance use among Canadians aged 15 years and older, particularly in relation to determinants of ED utilization among PWUD (Health Canada, 2024). This survey enables national, provincial, and regional comparisons that provide insight into the relationships between substance use, physical and mental health, hospitalizations, and mortality. Such analyses reveal regional disparities and community-specific challenges, supporting evidence-informed policies and programs that reduce harms, address inequities, and improve healthcare delivery.

1.2.1 Legal Substance Use: Alcohol, Marijuana, and Prescription Drugs

The most recent CSUS (2023) surveyed 36,180 Canadians aged 15 and older using telephone-based methods. Alcohol remained the most commonly used substance in the preceding year, followed by cannabis, sedatives, opioids, and cigarettes (Health Canada, 2024). Among individuals reporting lifetime alcohol use, 88% had consumed alcohol within the past year. Usage rates among lifetime users of legal substances were 90% for alcohol, 63% for cannabis, 51% for cigarettes, 30% for opioids, and 22% for sedatives (Health Canada, 2024) and are visualized in Figure 1.

Figure 1

Canadian Population Use of Legal Substances, Lifetime and Past 12 Months



Note. Data source: Canadian Substance Use Survey (CSUS), Summary of Results for 2023, Figure 4 (CSUS, 2023).

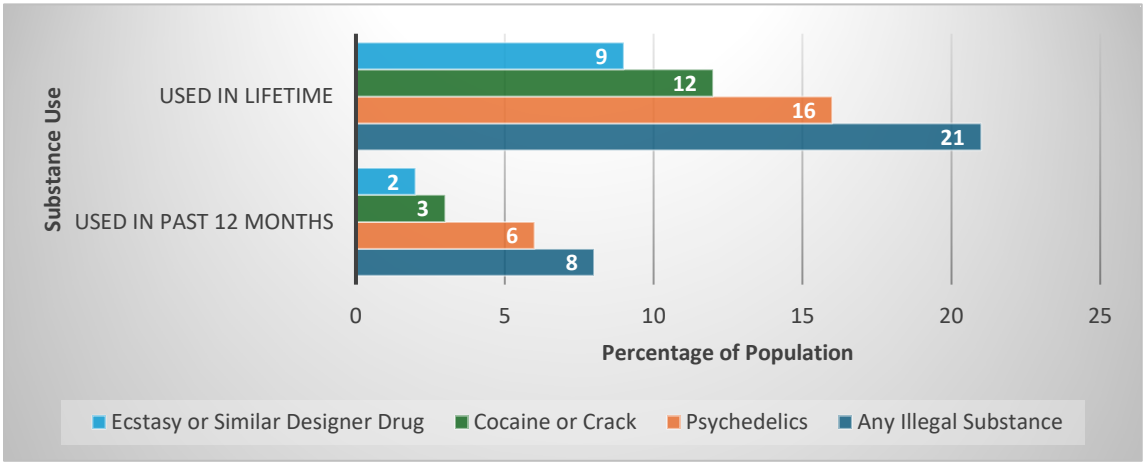
These findings indicate that alcohol continues to dominate substance use patterns, reflecting its social acceptability but also its potential for harm. Cannabis use is the second most common substance use following legalization in 2018, while ongoing sedative and opioid use raises concerns regarding dependency and prescription practices. Conversely, the steady decline in cigarette use suggests the long-term success of public health initiatives to reduce tobacco-related harm (Volkow et al. 2017).

1.2.2 Illegal and Illicit Substance Use: Trends and Challenges

In Canada, illegal substances refer to those prohibited under the Controlled Drugs and Substances Act (Government of Canada, 2022a), such as cocaine, heroin, and methamphetamine. Illicit substance use, however, includes both the use of illegal drugs and the nonmedical or unauthorized use of prescribed or legal substances (Health Canada, 2024). Therefore, while all illegal drugs are illicit, not all illicit use involves illegal substances. According to CSUS data, 21% of respondents reported lifetime use of illegal substances, with 8% reporting use in the past 12 months (see Figure 2). Psychedelics, such as LSD and psilocybin, were the most frequently reported illegal substances (16% lifetime use, 6% past 12 months), followed by cocaine or crack (12% lifetime, 3% past 12 months) and ecstasy or similar designer drugs (9% lifetime, 2% past 12 months). The relatively high reporting of psychedelics reflects shifting cultural attitudes and increasing normalization (Health Canada, 2024). In contrast, fewer than 1% of respondents reported using methamphetamine, heroin, or illicit fentanyl which contradicts causes for overdose deaths in Canada (Health Canada, 2024).

Figure 2

Prevalence of Illegal Substance Use in Canada, Lifetime and Past 12 Months



Note. Data source: Canadian Substance Use Survey (CSUS), Summary of Results for 2023, Figure 6 (CSUS, 2023).

It is important to acknowledge that telephone-based recruitment underrepresents PWUD, many of whom face financial and technological barriers that limit participation in national surveys (Humphrey et al., 2024; D. Kerns, personal communication, May 16, 2024; M. Vautour, personal communication, June 18, 2024).

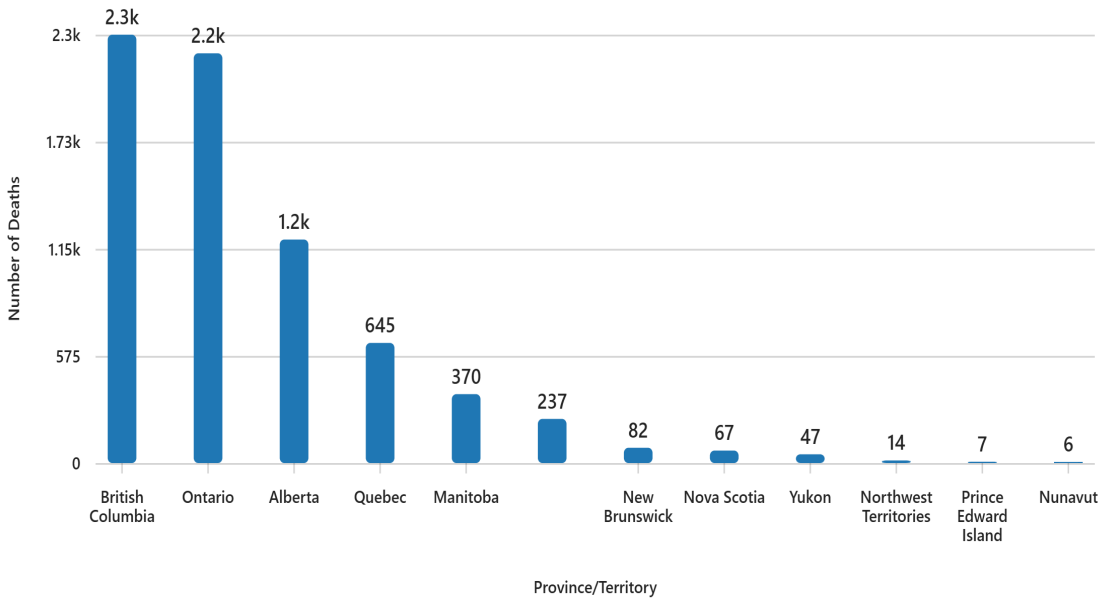
1.3 Health Consequences: Morbidity and Mortality

Substance use in Canada contributes to substantial physical, psychological, and economic harms. Both legal, illegal, and illicit substances are linked to higher rates of illness and premature death, with profound social and fiscal impacts (Aldridge et al., 2018; Lui et al., 2024). Tobacco and alcohol remain leading contributors to substance-related mortality, accounting for more than 74,000 deaths in 2020 with 46,366 attributed to tobacco, 17,098 from alcohol, and 6,491 from opioids (Health Canada, 2024).

Between January 2016 and September 2024, there were 50,928 opioid toxicity deaths in Canada (see Figure 3), primarily in British Columbia, Alberta, and Ontario (Government of Canada, 2024). Fentanyl was involved in 79% of these deaths, a 39% increase since 2016, while 82% involved nonpharmaceutical opioids and 65% involved stimulants (Health Canada, 2024). Substance use cost the Canadian economy an estimated $49.1 billion in 2020, including $22.4 billion in lost productivity and $13.4 billion in healthcare spending (Canadian Centre on Substance Use and Addiction [CCSA] & Canadian Institute for Substance Use Research [CISUR], 2023).

Figure 3

Number of Total Apparent Opioid Toxicity Deaths in 2024



Note. Data source: Data source: This update is based on data submitted to or extracted by the Public Health Agency of Canada on or before February 4, 2025. New or revised data reported after this date will be reflected in future updates. Differences may exist in case identification and reporting, type of data reported, and time period of available data. Comparisons over time and between provinces and territories should be interpreted with caution.

1.3.1 Overdose Crisis: A National Perspective

The overdose crisis in Canada has unfolded in four distinct phases (Health Canada, 2024). The first phase, spanning the 1990s to 2010, was marked by an overreliance on opioid prescriptions for pain management, which exposed many Canadians to substances with a high potential for misuse. The second phase, from 2010 to 2015, was characterized by the diversion of prescription opioids from their intended medical use and the rise of illegally manufactured opioids in the illicit market. The third phase, between 2015 and 2020, involved the widespread introduction of synthetic opioids, particularly fentanyl, into the illicit supply, leading to a sharp increase in overdose deaths. Currently, the fourth phase (2020 to present) is dominated by fentanyl, which is frequently mixed with stimulants, depressants, and other contaminants, creating a toxic, highly addictive and unpredictable drug supply (Canadian Substance Use Costs and Harms Scientific Working Group, 2023).

This crisis has intensified due to a dramatic increase in opioid toxicity deaths, which surged by 96 percent, from 3,747 deaths between April 2019 and March 2020 to 7,362 deaths during the same period the following year, coinciding with the onset of the COVID-19 pandemic (Substance Related Overdose and Mortality Surveillance Task Group, 2025). Contributing factors included disruptions to the drug supply, increased substance use related to fear, stress, and social isolation, and reduced access to harm reduction and treatment services, as well as a rise in solitary drug use (Gomes et al., 2021; Health Canada, 2022; Krausz et al., 2021). For PWUD, the contaminated supply, unsafe drug practices, and polysubstance use pose significant health risks (Bonn et al.,

2020). Treatment complexity increases when multiple substances are involved, further elevating overdose risk. In 2023, nearly half (48 percent) of accidental opioid toxicity deaths also involved stimulants, complicating both treatment and prevention strategies (McNeil et al., 2022; Volkow et al., 2017).

The overdose crisis in Canada has had a disproportionately severe effect on certain population groups, reflecting deep social and structural inequities. Men account for approximately 73% of opioid toxicity deaths since 2016, with the highest burden among those aged 30 to 49 years (Government of Canada, 2025). Recent data indicate that individuals aged 30–39 comprise the largest proportion of deaths (about 28%), confirming that younger adults remain most affected (Canadian Institute for Health Information, 2021). First Nations populations in Canada have also experienced disproportionate harm due to the opioid crisis. This unequal burden is linked to historical and ongoing colonial injustices, intergenerational trauma, systemic racism, and socioeconomic disparities (Blair & Siddiqi, 2022; Lavalley et al., 2024). In 2022, Indigenous people experienced intentional, unintentional, or undetermined exposure to drugs causing deaths at a rate 5.9 times higher than non-Indigenous people. In the first half of 2023, this disparity persisted, with First Nations people dying at six times the rate of non-Indigenous people. Indigenous women faced an even more severe impact, with a death rate 11.9 times higher than their non-Indigenous counterparts (Public Health Ontario, 2023). These findings underscore the need for culturally appropriate interventions and community-driven supports to reduce the heightened risks faced by Indigenous populations (Chiefs of Ontario & Ontario Drug Policy Research Network, 2023). African, Caribbean, and Black communities in Canada also experience elevated

vulnerability to overdose due to structural inequities, including poverty, housing insecurity, and barriers to healthcare access (Dassieu et al., 2020). Individuals with co-occurring mental health conditions or chronic pain are likewise at greater risk of overdose (Norman et al., 2011).

1.3.2 Overdose Crisis: A Provincial Perspective

Across Canada, accidental opioid overdose deaths have escalated, affecting every province and territory. However, the impact has not been experienced uniformly across regions. British Columbia, Alberta, and Ontario have consistently reported the highest numbers of overdose deaths, accounting for over 88% of all cases nationally between 2016 and 2022 (Canadian Centre on Substance Use and Addiction, 2022). Significant changes in the illicit drug supply occurred nationwide when pandemic-related restrictions disrupted the movement of people and goods within and between provinces, interfering with established drug distribution networks. As a result, the prevalence of synthetic substances, particularly highly potent opioids, increased during the period of this research (2022–2024) which included New Brunswick (Health Canada, 2023).

Building upon the national context of the overdose crisis, it is essential to consider how these complex and intersecting challenges manifest within specific regional settings. The province of New Brunswick reflects many of the same national patterns of substance use, overdose, and social inequity, yet the effects are often magnified by limited healthcare infrastructure, geographic dispersion, and gaps in harm reduction coverage. Within this provincial context, Saint John has emerged as a critical focal point, where escalating rates of substance use, overdose fatalities, and barriers to care underscore the

urgent need for targeted, evidence-informed interventions. These local realities provide the foundation for defining the research problem that guides the present study.

1.4 Defining the Research Problem

In New Brunswick, the escalating prevalence of PWUD is evidenced by increased naloxone administration rates, greater uptake of harm reduction supplies, rising EMS calls, higher hospitalization rates, and a growing number of overdose fatalities (New Brunswick Department of Health, 2024). Saint John continues to confront significant challenges related to substance use, as highlighted by the recent deaths of five individuals in a single day attributed to suspected drug toxicity (MacRae, 2024; Magee, 2024). Why individuals do not access emergency health services remains unknown. This study focuses on a smaller cohort within the broader population of PWUD; those with emergency healthcare service experiences in the past 12 months. These individuals are often unhoused, transient, experiencing mental illness and living with one or more substance use disorders. A critical impediment to effectively addressing these challenges is the lack of standardized data collection and reporting systems among formal, publicly funded entities (e.g., first responders, hospitals) and community organizations (e.g., non-profit groups). This absence of comprehensive reporting perpetuates the invisibility of health issues affecting PWUD. Establishing standardized data collection protocols would enable a more nuanced understanding of the scope and context of substance use, the associated health outcomes for PWUD, and support appropriate resource allocation for targeted interventions (Wood, 2016).

Anecdotal information from a multitude of reliable secondary stakeholders indicates that in Saint John, PWUD are dying because they will not access healthcare services (M. Vautour, personal communication, May 28, 2019; D. Kerns, personal communication, May 30, 2019; J. Dingwell, personal communication, March 20, 2021; B. Appleby, personal communication, February 27, 2020; M. Saulnier-Taylor, personal communication, February 27, 2020). This perception of the problem is further supported by similar reports in community nonprofit organizations in Moncton, New Brunswick (D. Warren, personal communication, June 15, 2024). There is less understanding and insight into the motivation of a cohort of PWUD to access emergency healthcare services hampers the formulation of evidence-based policies and effective programs customized to address this population's unique needs. Understanding the health-seeking decisions of PWUD could potentially alleviate health disparities, increase the efficacy of current harm reduction strategies, and decrease the mortality rates in this underserved population (Harris et al., 2016; Jackson et al., 2014; Kendall et al., 2017).

1.5 Research Question and Objectives

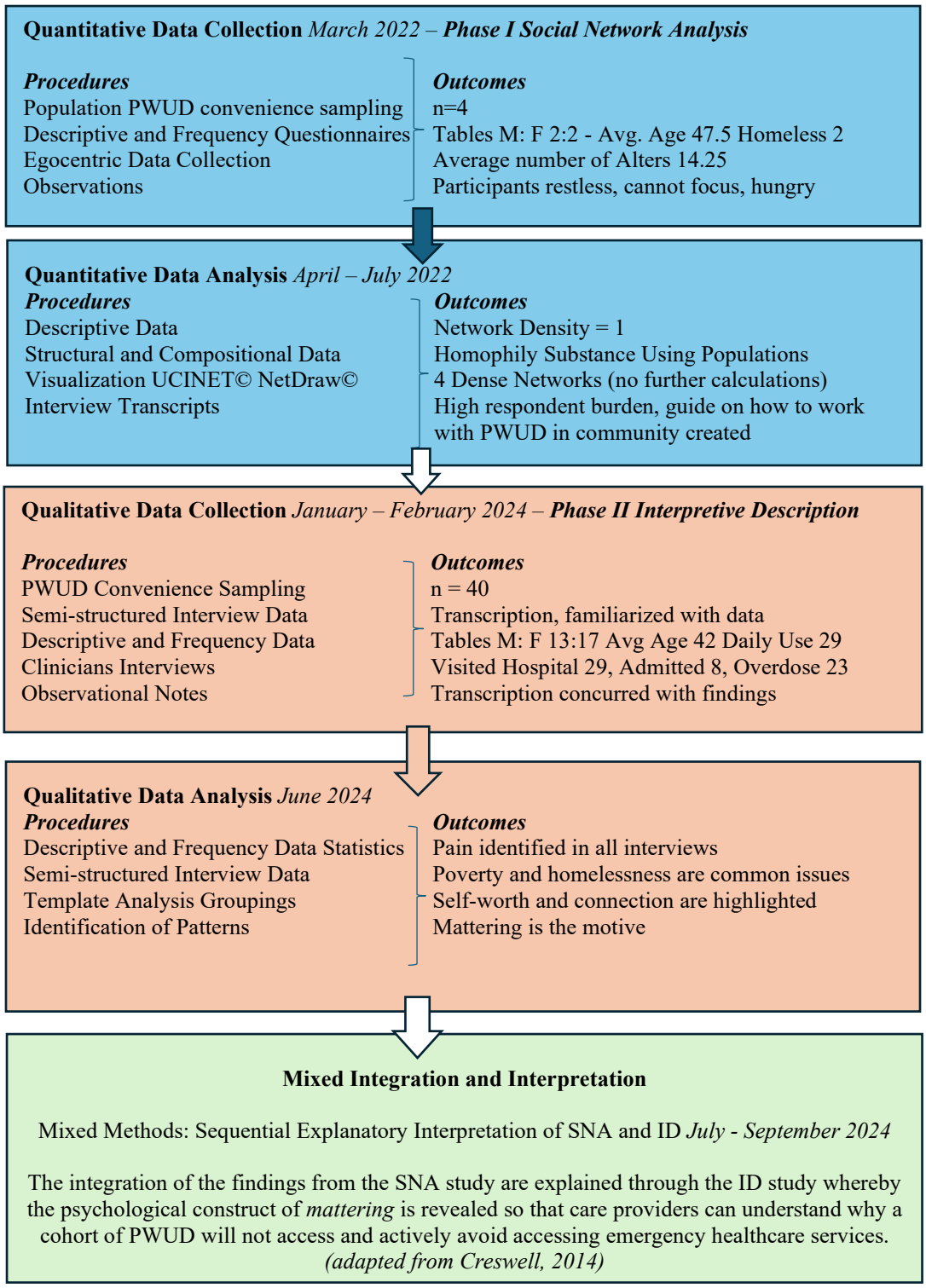
In response to the complex and multifaceted challenges facing PWUD in New Brunswick, this study seeks to explore the factors that influence healthcare-seeking behaviours before individuals decide whether to present at the ED. Accordingly, the guiding research question for this study is: “What factors influence and motivate people who use drugs to seek or avoid emergency healthcare services?”

1.6 Overview of Study Design

Substance use disorders are complex requiring interdisciplinary approaches to understand variables influencing healthcare access (Smye & Frangi, 2021). To address this phenomenon, a mixed methods research design was employed, integrating quantitative and qualitative methodologies to provide a comprehensive exploration of the research question (Morse & Field, 1995). Specifically, a sequential explanatory design was selected, allowing qualitative data to contextualize and elucidate quantitative findings obtained in the initial phase of the study (Creswell, 2014; Creswell & Creswell, 2018). This approach is suited to capture structural and experiential dimensions influencing PWUD in accessing emergency healthcare services (Figure 4).

Figure 4

Study Design: An explanatory sequential mixed methods research design using Social Network Analysis and Interpretive Description to identify the factors that motivate and influence PWUD to access emergency healthcare services.



1.6.1 Quantitative Research

Quantitative research methods involve the systematic collection and statistical analysis of numerical data to identify patterns, test hypotheses, and establish relationships among variables (Creswell & Creswell, 2018). These methods are well-suited for studies aiming to generalize findings across populations, often utilizing structured instruments such as surveys or existing datasets (Polit & Beck, 2021). Quantitative approaches emphasize objectivity and reproducibility, reflecting a positivist paradigm focused on uncovering measurable truths about social phenomena (Morse & Field, 1995). In health and social sciences, these methods enable researchers to identify trends, collect numerical data, assess risk factors, and evaluate interventions with precision and reliability.

Social Network Analysis is a quantitative approach that examines relationships, identifies patterns and structures among and between individuals, groups, or systems (Borgatti, Everett & Johnson, 2018; McCarty, 2007). By focusing on relational dynamics rather than individual attributes alone, SNA allows for the identification of network structures and social capital that influences access to resources, information, flow, and healthcare-seeking behaviours (Valente, 2010). In this study, quantitative data offer insights into the social context surrounding healthcare decisions among PWUD.

1.6.2 Qualitative Research

Qualitative inquiry complements this analysis by exploring the lived experiences, meanings, and motivations of participants (Denzin & Lincoln, 2018; Lincoln & Guba, 1985). Among various qualitative methodologies, ID was selected for its applied focus and suitability for nursing and health research (Thorne, 2008; Thorne et al., 1997). Unlike

ethnography, phenomenology, or grounded theory, ID is not theoretically driven rather it emphasizes clinically relevant insights and practical application, making it particularly appropriate for exploring the question of healthcare engagement among marginalized populations such as PWUD. Through in-depth interviews, ID facilitates the identification of internal and external motivators, relational dynamics, and patterns of healthcare utilization, producing findings that are both nuanced and actionable (Thorne, 2025; Thompson Burdine et al., 2021).

Together, the integration of SNA and ID within a sequential explanatory design enables a robust examination of both the social structures and subjective experiences influencing healthcare access. This mixed methods approach discussed in more depth in Chapter 3, provides the analytical depth and breadth necessary to understand the complexities of healthcare engagement among PWUD and informs the development of evidence-based, trauma-informed interventions tailored to the population.

1.7 Dissertation Structure

This dissertation is structured into six interconnected chapters, each building upon the last to provide a comprehensive examination of the factors that influence PWUD to access emergency healthcare services. The structure reflects a progression from contextual framing and literature synthesis to methodological design, data collection, and analysis, to an interpretation and discussion of the findings.

1.7.1 Chapter 1: Introduction

This initial chapter introduces the population of focus, PWUD and the substance use disorders that situate their experiences within both national and local contexts. It outlines the complex interplay between substance use, mental health, and the ongoing overdose crisis, highlighting how these factors contribute to disproportionate rates of morbidity and mortality among this population. PWUD are further contextualized as a vulnerable group facing systemic barriers to healthcare access. The research problem is clearly defined, emphasizing the lack of understanding regarding what factors influence PWUD to access care. In response, this guiding research question is presented, followed by a rationale for a mixed methods design. The chapter highlights why SNA and ID, are positioned as the most appropriate methods to address the identified knowledge gap and to explore the realities of PWUD.

1.7.2 Chapter 2: Literature Review

The second chapter outlines the strategy used to conduct focused literature reviews on factors influencing PWUD to seek or avoid healthcare services. While existing literature provides substantial insight into systemic barriers within healthcare, less is understood at an individual-level motivations that shape access or avoidance to healthcare among this population. The review presents foundational knowledge on addiction and substance use disorders, alongside key social determinants of health, and explores additional issues such as homelessness, poverty, stigma, trust, and pain. This integration establishes the knowledge gap underpinning the present study and lays the groundwork for the mixed methods investigation.

1.7.3 Chapter 3: Research Design

Chapter three details the methodological foundations and research design employed to address the study's primary research question. This chapter introduces a mixed methods approach, integrating SNA and ID to capture both the structural and experiential dimensions of factors that influence and motivate PWUD to access and/or avoid emergency healthcare services. The rationale for this methodological integration is explained in relation to the study's aims and the complexity of the research context. Ethical considerations are thoroughly addressed, including the informed consent process with a highly vulnerable population, confidentiality, and participant eligibility. The chapter discusses participant recruitment, the interview site, and broadly reviews the data collection procedures and analytic techniques. Attention is given to the researcher's positionality and the role of reflexivity throughout the research process, ensuring transparency and integrity in the interpretation of the findings.

1.7.4 Chapter 4: Social Network Analysis and Results

The fourth chapter presents an overview of SNA, with a focus on egocentric network analysis as a means of understanding complex social relationships among PWUD. Key terminology, types of SNA, and the strengths of this method in capturing relational dynamics are described. The chapter includes data collection procedures, ethical considerations, and the use of UCINET © and NetDraw © software for visualization and analysis. The findings from the SNA highlight important network structures and conclude with a discussion on respondent burden, density, and key relational insights.

1.7.5 Chapter 5: Interpretive Description and Results

Chapter 5 outlines the rationale for using ID to explore the lived experiences of PWUD. It describes the interview methods, and analytical procedures employed, with careful attention to ethical considerations when working with vulnerable populations. Pain emerged as a dominant theme and was commonly identified as a reason for seeking emergency care. However, findings suggest that pain alone does not explain healthcare-seeking behaviour. It is a sense of self-worth and connectedness, either to someone or something, a broader sense of the psychological construct of mattering, which served as a key motivator for accessing and engaging with emergency healthcare services. These findings are supported by the professional insights of three healthcare clinicians and offers a novel and unique contribution to the literature.

1.7.6 Chapter 6: Discussion, Recommendations, and Conclusion

The final chapter interprets the findings through the theoretical lens of mattering, particularly the roles of connection and self-worth (Flett, 2018). It situates the results within the existing academic discourse and discusses implications for healthcare education, clinical practice, and policy. The chapter also addresses the study's limitations, identifies its contributions to the field, and offers recommendations for future research. A concise summary of the dissertation's key findings and their significance to scholarly knowledge concludes the chapter.

The structure of this dissertation is intentionally designed to build a multidimensional understanding of PWUD and their interactions with emergency healthcare systems. Each chapter contributes incrementally to the development of a

comprehensive response to the central research question, offering theoretical, empirical, and practical insights. By moving from context and literature to methodological rigor and data interpretation, the dissertation culminates in a discussion that highlights the importance of connection and self-worth as core motivators for healthcare engagement. This structural organization underscores the study's contribution to bridging gaps in the literature and advancing knowledge relevant to improving care for one of Canada's most underserved and stigmatized populations in public health.

1.8 Conclusion Chapter 1

In conclusion, the introductory chapter establishes the foundational framework for the dissertation, detailing the significance, objectives, and scope of the study with a focus on PWUD in Canada. By examining prevalence, health impacts, and societal challenges associated with substance use. The following chapter provides a critical review of the literature on substance use disorders and healthcare access among PWUD, exploring both systemic and individual-level factors that shape health-seeking behaviours. It examines patterns of substance use, poverty, housing, pain, and trust. While less is understood on the motivations of PWUD who avoid or refuse care. By integrating evidence on structural inequities with insights into personal and social motivators, the literature review lays the groundwork for the study's mixed methods investigation, directly informing the research design and guiding the exploration of social networks, interpretation of lived experiences, and the sense of mattering in healthcare engagement. This synthesis situates the study within the broader discourse on harm reduction, health equity, and trauma-informed practices.

Chapter 2: Literature Review

Substance use disorders represent a complex and persistent public health challenge, shaped by interrelated biological, psychological, and social determinants. These disorders disproportionately affect structurally marginalized populations who face heightened vulnerability due to poverty, discrimination, and systemic exclusion (Deak & Johnson, 2021; Stellern et al., 2023; Witkiewitz & Tucker, 2025). Although a substantial body of literature has examined the structural and interpersonal barriers that hinder healthcare access for PWUD, comparatively less attention has been paid to the nuanced decision-making processes that shape their engagement with emergency healthcare services. Existing studies often frame healthcare avoidance as a consequence of systemic failures, such as stigma, pain dismissal, and discriminatory treatment, yet rarely explore the personal, relational, and contextual meanings that underpin these decisions. This gap is significant, particularly as individuals with an SUD are increasingly dying outside the reach of medical care, from preventable circumstances, in alleys, encampments, and other public spaces. Understanding the complex motivations that do or don't influence PWUD to access healthcare service allows for the design of responsive, equitable, and trauma-informed models of care.

While the existing literature thoroughly documents structural, interpersonal, and systemic barriers to healthcare for PWUD, there are very few studies that have explicitly examined why individuals will not seek access to care, even in situations of acute, life-threatening need. The avoidance, reluctance, or refusal to seek healthcare is not merely a passive reaction to external obstacles; rather, it can be a deliberate and informed act

shaped by trauma, lived experience, and self-preservation. Such refusals can have devastating consequences, including death, a reality well known to front line emergency responders and community health nurses, yet insufficiently addressed in academic scholarship.

Existing research to date has primarily emphasized barriers to care rather than the motivations behind avoidance. Studies by McNeil et al. (2014, 2021), Sutherland et al. (2024), and Treloar et al. (2025) demonstrate that prior experiences of stigmatization, suspicion, and the dismissal of pain significantly influence future disengagement from healthcare. Participants in these studies described being refused pain management, labeled as drug-seeking, or treated as less than human experiences that foster a sense of self-protection through disengagement. Rather than being irrational or self-destructive, this behaviour often represents a rational response to repeated trauma within the healthcare system (Pauly et al., 2015; Pauly et al., 2023).

Few scholars have moved beyond these established themes to investigate how PWUD interpret and rationalize decisions to avoid care. Boyd et al. (2018) describe how structural violence, mistrust, and persistent exclusion foster a form of learned avoidance, understood as a survival mechanism in response to chronic disrespect and denial. Similarly, Collins et al. (2018) argue that repeated harmful encounters with healthcare systems cultivate institutional betrayal, whereby the very institutions meant to provide care become sources of harm. In such contexts, refusal can be seen as an act of autonomy, control, and at times, resistance.

Kendall et al. (2017) further suggest that the cumulative effects of dismissive or discriminatory care experiences are reinforced through informal social networks, which circulate negative narratives about hospitals and providers, thereby normalizing avoidance as a protective strategy. Urbanoski et al. (2017) highlight the erosion of hope as a profound psychological and existential influence on care. McNeil et al. (2014) illustrates how some PWUD come to believe they are undeserving of care or that their lives lack sufficient value to warrant medical attention. These findings align with broader scholarship on mattering and perceived insignificance (Elliott et al., 2005; Flett, 2023).

This study seeks to address the research question: What factors motivate and influence PWUD to access emergency healthcare services? Through the integration of SNA and ID, this research moves beyond barriers to care and critically examines the relationships and the experiential contexts that inform emergency healthcare access or avoidance among PWUD. A significant gap in the literature was identified and there are few studies that explore how social networks influence PWUD to access emergency healthcare services. Furthermore, research that directly explores PWUD perspectives on why they choose to seek or not to seek care, even in situations involving life-threatening risk, remains extremely limited. Existing scholarship predominantly focuses on barriers, provider perspectives, general access issues, or structural determinants of health, leaving the personal and contextual motivations of PWUD underexamined. This unique study centres the social networks, contexts and lived experiences of PWUD to generate a richer, more empathetic understanding of the influences that encourage or discourage engagement with emergency healthcare services. It will approach moments of care refusal not as pathological or irrational acts, as many uninformed members of the broader

public may characterize such decisions, but rather these are meaningful and context-bound decisions by the most vulnerable members of our society. This novel perspective is essential for informing trauma-informed, culturally safe, and values-based interventions that seek to restore trust and meaningfully reconnect PWUD with emergency healthcare services. The findings from this study contribute to a more comprehensive understanding of mattering and care engagement to support the development of pragmatic, responsive and compassionate health system strategies for a complex and structurally vulnerable population.

To contextualize this study and address these identified gaps, the literature review is organized into several key sections. It begins by outlining the literature search strategy used to inform this review, followed by a definition of the study population of PWUD, and a discussion of substance use as a medically defined diagnosis and how it is classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). The review then explores the multiple interrelated factors that influence substance use in Canada, including systemic, social, and economic risk factors that result cumulative harms. Attention is paid to the intersections of homelessness, poverty, childhood trauma, mental health, stigma, and pain, which compound the health-related harms experienced by PWUD. Subsequent sections examine the Canadian healthcare system, in terms of the roles of primary care, emergency, and hospital-based services, and the phenomenon to leave against medical advice. The chapter also highlights emerging evidence on the significance of connection, self-worth, and mattering may have in shaping health behaviours. Collectively, the literature review establishes the theoretical foundation that informs and supports the mixed methods approach employed in this dissertation.

2.1 Literature Review Search Strategy

Developing the search strategy was an iterative process, refined over time with three searches conducted from September 2020 to May 2024 in the CINAHL, SocINDEX, PsycINFO, EMBASE, and PubMed databases. The search strategy primarily combined database subject headings, free-text keywords, and synonyms. Medical subject heading (MeSH) terms were identified for the PubMed search and adapted to corresponding subject terms in the EBSCO (CINAHL, SocINDEX, PsycINFO) and EMBASE databases.

Keywords were searched for each corresponding subject heading and supplemented with relevant free-text terms using Boolean operators AND and OR and truncation with * for words such as motivation and decision. The most common search terms included “people who use drugs,” “people who inject drugs,” “drug abusers,” “substance use,” “people with drug addiction” and “illicit drug use” in combination with “motivation,” “decision making,” “health-seeking.” “help-seeking,” “health behaviours,” “social choice,” “patient attitude,” “patient acceptance,” “belief,” and “medical care.” Methodology terms were also searched in combination with keywords “qualitative research,” and “qualitative interviews.” The search results were limited to articles written in English, available in full text, and published since 2000. The database searches were complemented by searching Google Scholar © and a manual review of books, citation tracking, reference lists of relevant articles, theses, and dissertations. The abstracts were reviewed for relevancy and applicability and maintained within a database. To specifically examine the relevance of self-worth and social connection as potential

motivators for healthcare access, a distinct literature search was conducted using additional keywords such as “self-worth,” “interpersonal connection,” “relatedness,” and “social support,” in combination with substance use related terminology. This focused search aimed to identify theoretical and empirical literature on the role of psychosocial variables in healthcare engagement among PWUD. This final in-depth and extensive search was conducted as similar studies in the published literature were not identified. A separate search of the same databases was executed to examine the origins of the terminology ‘people who use drugs.’ A specific person or organization that coined the term was not identified; however, the research tool Elicit located several associated journal articles from the 1980’s that highlighted the shift from “junkie” and “addict” to a more person-centred language.

2.2 Defining the Study Population: People Who Use Drugs

The term PWUD has evolved considerably over the past two decades and continues to be defined variably across institutional, clinical, and research contexts (McNeil et al., 2021; Oviedo-Joekes et al., 2009; Tyndall et al., 2013). Definitions may encompass a wide spectrum of substances, including legal substances such as alcohol and cannabis, as well as illegal or unregulated substances such as opioids and methamphetamines (Maghsoudi et al., 2022; Perri et al., 2023). This definitional variability holds significant implications for research, policy development, and clinical practice.

From a public health perspective, organizations such as the World Health Organization (WHO) the National Institutes of Health (NIH) emphasize the broad health

risks and systemic consequences associated with substance use, including its impact on physical and mental well-being (NIH, 2018; WHO, 2016). Health Canada (2023) builds upon these approaches by incorporating diagnostic frameworks such as the Diagnostic and Statistical Manual of Mental Disorders with Text Revisions (DSM-5-TR) and the International Classification of Diseases (ICD-10). There has been a perennial debate in the literature as to the relative contribution of socially constructed factors compared to medical models that depend on more rigid measurement of SUD. This alignment reflects a shift toward understanding substance use as a complex health condition requiring integrated and non-punitive interventions.

At the severe end of the substance use spectrum lies addiction, defined clinically as an SUD. It is characterized by compulsive substance use despite harmful consequences and is associated with significant neurobiological changes in the brain's reward, motivation, and self-regulation systems (National Institute on Drug Abuse [NIDA], 2020). These changes are shaped by an interplay of genetic, psychological, environmental, and social factors. The DSM-5-TR, the most current edition published by the American Psychiatric Association (APA, 2022), offers diagnostic criteria for an SUD and other substance-related disorders, reinforcing the need for multifaceted, evidence-based responses which is discussed later in this chapter.

Canadian research and harm reduction initiatives have played a pivotal role in reframing the discourse on substance use. The North American Opiate Medication Initiative (NAOMI), conducted in Vancouver, was the first heroin-assisted treatment trial in North America and marked a significant departure from criminalization toward health-

focused care (Oviedo-Joekes et al., 2009). Similarly, Insite, Canada's first legally sanctioned supervised injection site, has been instrumental in demonstrating the public health value of harm reduction strategies (McNeil et al., 2022; Tyndall et al., 2013). The legalization of cannabis in Canada in 2018 further prompted national reconsideration of drug policy, contributing to a broader cultural shift toward compassionate and evidence-based approaches.

Academic scholarship has significantly advanced a broader understanding of PWUD, particularly through research on harm reduction, policy reform, stigma, and the social determinants of health (Buxton et al., 2017; Kerr et al., 2005; Pauly et al., 2013; Wood et al., 2006). Recent literature emphasizes the need for individualized, context-sensitive approaches to care. Kostenuik et al. (2022) highlight the importance of tailoring public health strategies to reflect the heterogeneous experiences of PWUD. In alignment with this perspective, Yakovenko et al. (2024) revised the Canadian national clinical practice guidelines for opioid use disorder to promote equitable and evidence-based care. Key recommendations include offering both methadone and Suboxone © as first-line treatments, reserving slow-release oral morphine as a second-line option, avoiding standalone withdrawal management due to its associated risks, and ensuring that access to opioid agonist therapy is not contingent on psychosocial interventions. These guidelines underscore a harm reduction approach that integrates flexible, person-centred care with access to essential supports such as take-home naloxone and sterile consumption equipment. Despite these varied contributions, the absence of a unified, standardized definition of PWUD remains a challenge. A more consistent definition would enhance the comparability of research findings, foster interdisciplinary

collaboration, and support the development of more effective policies and care strategies that prioritize equity and reduce harm.

The present study focuses on a subset of PWUD who live with an SUD and frequently engage in high-risk practices such as ingesting, inhaling, or injecting unregulated or diverted substances. These individuals often experience acute health crises and either avoid or refuse timely and appropriate access to emergency healthcare services (Simon et al., 2020; Strike et al., 2020). Their care is further compromised by structural vulnerabilities, including housing instability, criminalization, and stigma, all of which can limit their engagement with healthcare and exacerbate health disparities.

In summary, defining PWUD will require a multidisciplinary, evidence-informed approach that integrates clinical, public health, and social justice perspectives. This study adopts a definition that reflects both diagnostic frameworks and lived realities, recognizing substance use as a multidimensional phenomenon that necessitates inclusive, compassionate, and context-specific interventions (Simon et al., 2020; Strike et al., 2020).

2.3 Diagnostic Criteria and Substance Use Disorders

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, with recent text revisions (2022) is commonly referred to as the DSM-5-TR, and highlights ten separate classes of potentially addictive drugs that qualify as substances, alcohol; cannabis; opioids; sedatives, hypnotics or anxiolytics; stimulants (such as cocaine and amphetamines); tobacco; inhalants; hallucinogens (including phencyclidine and other

psychedelic substances); caffeine (not currently recognized as a formal substance use disorder); and other or unknown substances.

In Canada, the widespread availability of both prescription and street drugs has significantly contributed to the rise in overdose deaths, particularly those involving opioids. Opioids such as fentanyl, hydromorphone (Dilaudid ©), and oxycodone (Percocet © available in combination with acetaminophen) are commonly prescribed for pain management are also heavily used in the illicit market (Health Canada, 2024). The increasing presence of synthetic opioids, such as fentanyl and its analogues (e.g., carfentanil), has exacerbated the overdose crisis, as users are often unaware of the drug's potency, leading to fatal overdoses (Health Canada, 2024). Benzodiazepines, such as Xanax © and Ativan ©, are also frequently misused, often in combination with opioids, which increases the risk of respiratory depression and overdose (Imtiaz et al., 2021). Stimulants, including methamphetamines, cocaine, and Ritalin ©, are widely available through illicit means and are frequently mixed with opioids, creating dangerous poly-drug combinations, or "speedballs," which significantly contribute to fatal overdoses (Health Canada, 2024). Stimulants, although prescribed for attention deficit hyperactivity disorder (ADHD), are commonly diverted for non-medical use, further contributing to stimulant-related overdose risks, especially when combined with other substances such as opioids. Alcohol, although legal, remains a substantial contributor to overdose deaths, particularly with binge drinking or alcohol poisoning. Cannabis is now legally available for recreational use in Canada, and while its overdose risk remains low, its regulation reflects broader public health considerations (Government of Canada, 2018). Prior to legalization, it was widely accessible in the illicit market. The combination of

prescription drugs being diverted into the street market and illicit drugs flooding Canada have compounded the challenges healthcare systems face in addressing overdose treatment and prevention (Imtiaz et al., 2021). Unfortunately, in some cases these addictive substances were given as prescriptions for an acute condition, which created a dependency and eventually led to a drug overdose death (Bedene et al., 2022; Chan et al., 2021). The widespread availability and misuse of these substances have contributed to escalating overdose rates and complex patterns of polysubstance use, which are explored in the following section on factors influencing substance use in Canada.

2.4 Factors Influencing Substance Use in Canada

Overdose rates in Canada have increased exponentially since 2016 (Health Canada, 2024). In the past two decades, the rate of drug overdose deaths in Canada has significantly increased, driven primarily by the rise in opioid use and the introduction of potent synthetic opioids such as fentanyl. In Canada, there were 1,199 drug overdose deaths reported in 2010 and by 2020, the number of drug overdose deaths had escalated dramatically to 6,151 deaths (Health Canada, 2024). In 2023, British Columbia recorded 2,511 deaths due to toxic, unregulated drugs, which includes opioid-related fatalities. This was the highest annual total ever reported by the BC Coroner's Service, averaging about 6.9 deaths per day. The crisis continues to be driven primarily by illicit fentanyl, detected in more than 85% of toxicology tests alone (British Columbia Coroner's Service, 2024).

Imtiaz et al. (2021) conducted a systematic review to examine the impact of the novel coronavirus disease (COVID-19) pandemic on drug overdose-related deaths in the

United States and Canada. Their review highlighted the exacerbation of overdose deaths, particularly involving opioids like fentanyl, due to the increased presence of other substances such as stimulants and benzodiazepines. The authors found that the disruption of social support systems, isolation, and a more toxic drug supply during the pandemic contributed significantly to the rise in overdose mortality. Health Canada (2024) similarly reports that polysubstance use, particularly the combination of opioids and stimulants, has continued to drive overdose deaths, with the unpredictability of these drugs, with stimulants masking the sedation of opioids, further complicating the situation, and increasing fatality risks. As of 2023, stimulants were involved in half of the opioid toxicity deaths in Canada (Public Health Agency of Canada, 2022). Individuals who habitually use these addictive substances, medical opioids, are often assessed for an SUD (Boness et al., 2021).

2.5 Medical Opioid Use: Trends and Implications

Canada ranks among the highest consumers of medical opioid therapies globally (Jayawardana et al., 2021). St. Martin and Lacroix (2024) reported that more than 20 million opioid prescriptions were dispensed, which equates to approximately one prescription for every nine adults, placing Canada second only to the United States in opioid consumption. The 2017 Canadian Guidelines for Opioid Therapy and Chronic Non-Cancer Pain recommend against prescribing opioids to patients with a history of substance use, even when alternative pharmacotherapies are ineffective (Belzak & Halverson, 2018; Busse et al., 2017). While intended to reduce misuse, these restrictions limit therapeutic options for PWUD experiencing chronic noncancer pain (CNCP) and

exacerbate challenges in pain management for a population already facing significant barriers to care.

Healthcare providers often approach PWUD with skepticism, questioning the legitimacy of reported pain due to concerns about drug seeking behaviours (Baldacchino et al., 2012). This distrust has led to stricter prescribing practices and heightened surveillance measures, such as urine drug testing and prescription monitoring programs (National Academies of Sciences, Engineering, and Medicine, 2017). Although these strategies aim to mitigate risk, they frequently result in undertreatment and reinforce stigma, leaving individuals with legitimate pain labeled as drug seeking (Busse et al., 2017; Centers for Disease Control and Prevention [CDC], 2016; Ti et al., 2015).

A systematic review by Voon et al. (2018) found that CNCP prevalence among individuals who misuse prescription opioids ranges from 48% to 60%, compared to 11% to 19% in the general population. Clinical management strategies identified in the literature include pain assessment tools, urine drug testing, prescription drug monitoring programs, and opioid agonist therapies. However, evidence regarding the effectiveness and clinical utility of these strategies remains inconsistent. Building on this, Dassieu et al. (2020) conducted a qualitative study revealing that PWUD often experience compounded stigma for both substance use and chronic pain. To avoid judgment and maintain perceived resilience, some individuals reported engaging in physically demanding activities despite severe pain, often using substances such as cocaine or heroin to manage symptoms and meet social expectations of strength.

The substance use landscape continues to evolve, shifting from the peak of opioid prescribing in 2016 to the current prevalence of illicit, toxic synthetic opioids combined with psychostimulants and benzodiazepines (Ciccarone, 2021; Health Canada, 2022). Many communities invest heavily in harm reduction programs to support individuals living with acute addiction (Doucet & Porter, 2023; Childs et al., 2021; Levengood et al., 2021). Although the benefits of harm reduction are well documented, there is limited research on how engagement with these services influences subsequent access to formal healthcare, including the ED. The evolving opioid landscape and persistent barriers to pain management for PWUD highlight multiple risk factors associations with chronic substance use.

2.6 Systemic and Individual Risk Factors

A complex set of systemic and individual risk factors often interact in ways that intensify health inequities among PWUD and consequently impact their motivations to access emergency healthcare services. Some risk factors are recognized as social or environmental elements, such as homelessness and poverty, which have a significant influence on the health of PWUD (Gaetz et al., 2017; Woodhall-Melnik et al., 2018). Other risk factors are more individualized, such as high levels of stigma or low levels of trust that impact the ability of PWUD to feel safe to navigate or understand healthcare services (Pauly et al., 2013; van Boekel et al., 2013). For instance, there are various types of pain associated with substance use that can negatively affect PWUD well-being. The pain of past experiences can be a precipitating risk factor for substance use or may present as a chronic concurrent disorder (Voon et al., 2018). Both systemic and individual

risk factors negatively impact well-being, health outcomes, and have been consistently implicated in PWUD accessing or avoiding emergency healthcare services (Heidari et al., 2023; Russell et al., 2021; Voon et al., 2021). However, the specific relevance of these factors to PWUD accessing or avoiding emergency healthcare services remains underexplored and is a central focus of the present research. Among these systemic factors, homelessness emerges as a particularly influential determinant, compounding health risks, and barriers to care, as discussed in the next subsection.

2.6.1 Homelessness and Substance Use

Canada's National Housing Strategy's Reaching Home initiative defines homelessness as the absence of stable, permanent, and appropriate housing, which includes living unsheltered, in emergency shelters, or in temporary arrangements such as couch surfing or staying with friends and family (Gaetz et al., 2017). Findings from the *Everyone Counts* national point-in-time survey, conducted between 2020 and 2022 across 66 communities, revealed that 18% of respondents attributed their most recent housing loss to substance use issues (Government of Canada, 2022b). Homelessness rates from point-in-time counts are inherently flawed due to the very nature of collecting the information but they are the best measures that currently exists (Pin et al., 2024). This represents a decline from the 25.1% reported in the 2018 survey, suggesting a potential shift in the perceived or reported contributors to homelessness over time. Several factors may help explain this reduction. Differences in survey methodology or question phrasing between data collection periods, changes in the demographic composition of the homeless population shaped by housing interventions and service availability may also

have affected how individuals understood or reported the causes of their homelessness. Expanded access to harm reduction initiatives and substance use treatment services may have lessened the direct impact of substance use on housing instability for some individuals. Moreover, the COVID-19 pandemic significantly disrupted patterns of homelessness, with emergency housing measures temporarily sheltering many individuals, potentially altering who was surveyed and under what conditions. Additionally, stigma and social desirability bias may have influenced participants' willingness to disclose substance use as a contributing factor. While the observed decline is notable, further research is necessary to fully understand the complex interplay of these contributing elements (Government of Canada, 2022b).

Homelessness operates along a continuum that includes (1) absolute homelessness, characterized by living on the streets or in shelters; (2) hidden homelessness, involving reliance on informal accommodations, institutionalization, or incarceration; and (3) relative homelessness, marked by substandard living conditions or imminent housing loss (Echenberg & Munn-Rivard, 2020). On any given night, approximately 25,000 - 35,000 Canadians experience absolute homelessness, and an estimated 50,000 or more rely on informal housing arrangements, contributing to hidden homelessness (Canadian Observatory on Homelessness, 2024). Further, it is estimated that one in ten Canadians, approximately 2.3 million people, will experience homelessness over their lifetime, significantly impacting health and social outcomes, particularly among PWUD (Echenberg & Munn-Rivard, 2020; Feng et al., 2013).

Homelessness functions as both a cause and consequence of substance use, creating a cycle that significantly compounds barriers to healthcare access (Woodhall-Melnik et al., 2018). It further exposes PWUD to increased harms such as overdose, infectious disease, exposure to the elements, and criminalization. A systematic review by Miller et al. (2021) found that homelessness significantly limits the effectiveness of traditional treatment models for PWUD, emphasizing the need for integrated, housing-first, wrap around and harm reduction approaches to improve health and social outcomes for this population. Homelessness has been increasingly recognized as a public health crisis, requiring policy frameworks that engage individuals with lived experience to develop solutions addressing housing affordability, social inclusion, and economic stability (Woodhall-Melnik et al., 2018). The Housing First model advocates for comprehensive support systems for PWUD to break cycles of poverty and homelessness, foster healthier communities, and reduce reliance on emergency healthcare services (Woodhall-Melnik et al., 2018; WHO, 2022).

Homelessness is not only strongly associated with elevated rates of substance use but also related to a greater dependence on ED services for healthcare services (Voon et al, 2018). In 2017, Kendall and colleagues demonstrated that in a matched cohort study of PWUD in Ontario, Canada, it was found that PWUD accessed emergency healthcare services seven to eight times more frequently than the general population; frequently seeking care for issues such as substance use, mental health crises, or preventable conditions worsened by unstable living environments (Government of Canada, 2022a; Doran et al., 2018; Grinman et al., 2010; Palepu et al., 2013). For PWUD, accessing healthcare services is challenging and is particularly complex for individuals

experiencing homelessness, who frequently present with both acute and complex health needs. This population experiences disproportionately high rates of substance use-related complications, including skin and soft tissue infections, endocarditis, and drug poisoning or overdose (McNeil et al., Mosseler et al., 2020; 2021; Barker et al., 2015). The instability of homelessness undermines access to healthcare, while criminalization policies further exacerbate vulnerabilities by exposing individuals to harassment or incarceration for survival activities such as sex trade, panhandling or sleeping in public spaces (Aldridge et al., 2018; Gaetz et al., 2014). Addressing homelessness through targeted public health initiatives is critical for improving health outcomes and reducing emergency healthcare dependence among PWUD (MacKinnon et al., 2022; Ruiz et al., 2022). This is also integral to understanding whether it directly or indirectly influences their decisions to seek emergency healthcare services. Closely linked to homelessness is poverty, which not only contributes to housing instability but also perpetuates substance use, poor health outcomes, and implications for access to healthcare services (Dasgupta et al., 2021). The following section examines this relationship in greater detail.

2.6.2 Poverty and Substance Use

Poverty is a critical determinant of health and a major contributor to homelessness (Goldshear et al., 2025). It also plays a significant role in perpetuating substance use and adverse health outcomes among PWUD (Mitra et al., 2023). Poverty increases vulnerability to food insecurity, violence, and exploitation, compounding mental health challenges and substance use disorders (McNeil et al., 2021; Almquist & Walker, 2022). Economic inequality further limits the ability to secure stable and safe housing (Baxter et

al., 2019). Existing literature underscores the intersection of homelessness, mental health issues, substance use, and systemic socioeconomic barriers that perpetuate cycles of poverty and exclusion (Feng et al., 2013; Weissman, 2016; Woodhall-Melnik et al., 2018). Intergenerational poverty creates cycles of marginalization, making it increasingly difficult for individuals such as PWUD to access essential resources and services (Gaetz et al., 2014).

Poverty, homelessness, and food insecurity place significant strain on non-profit organizations and emergency health services (Power et al., 2021). Although the link between poverty and health service utilization among PWUD is well documented, the specific mechanisms through which poverty shapes access to and experiences within emergency healthcare settings remain underexplored. Existing studies suggest that poverty, compounded by housing instability, stigma, and criminalization, can lead to delayed care, increased ED use, and heightened risk of long-term health consequences (Miller et al., 2021). These findings illustrate that poverty acts not merely as a background condition but as an active force shaping health-seeking behaviours and access to care.

Canadian studies further demonstrate that PWUD experiencing poverty and housing insecurity are more likely to present to the ED for preventable or unmanaged health issues, often as a last resort rather than as part of routine or preventive care (Kendall et al., 2017; Palepu et al., 2013). Many of these encounters are marked by tension, trauma, and mistrust, shaped by histories of marginalization and inadequate treatment. While poverty and homelessness create structural barriers to care, stigma and

discrimination introduce relational and societal obstacles that further undermine health-seeking behaviours among PWUD. The following section explores how trust, stigma, and related dynamics shape these interactions.

2.6.3 Trust, Stigma, Discrimination and Substance Use

Despite recognition that an SUD is a medical condition, PWUD continue to experience pervasive stigma and discrimination (Nolen et al., 2023; Sibley et al., 2023). Lack of trust, stigma, and discrimination significantly influence health and well-being by shaping interactions with healthcare systems and broader society (Lafferty et al., 2023). Trust, defined as confidence in the reliability and intentions of others, is essential for fostering positive healthcare relationships (Hall et al., 2002; Lennox et al., 2021). Stigma, characterized by negative attitudes and beliefs that discredit individuals, perpetuates stereotyping and shame, leading PWUD to avoid or disengage from formal healthcare services (Ahern, 2007; van Boekel et al., 2013). Discrimination, more behavioural and action-oriented than stigma, manifests through observable acts of unfair treatment and exclusion (Link & Phelan, 2001).

Stangl et al. (2019) developed the Health and Stigma Discrimination Framework, which conceptualizes how stigma operates and influences social and health outcomes. Table 1 adapts this framework for PWUD, illustrating the intersection of stigma and systemic barriers (Weber et al., 2021).

Table 1

Stigma and Impact on the Health Behaviour of PWUD

Source of Stigma	Result of Stigma
Individual	A person living with an SUD believes they are a bad person because they use substances, and they understand it is harmful to their health and well-being.
Interpersonal	They lose the support of friends and family members due to their substance use. This loss causes them to feel isolated, alone, depressed, and at increased risk of overdose.
Organizational	A healthcare institution obtains a toxicology screening blood sample with positive results. They use discriminatory language in their interactions with the PWUD and do not offer any care or support for an SUD. The individual loses trust in the healthcare providers and healthcare system.
Community	A mental health centre refuses to offer mental health support unless the person is sober and no longer using substances.
Public Policy	Criminalization of substance use, and involvement of social services and justice decreases which in turn increases their risk of overdose, morbidity, and mortality.

Together, stigma and discrimination create systemic barriers that erode trust and exacerbate health inequities for PWUD (Baxter et al., 2019). Fear of judgment and punitive responses often leads individuals to conceal substance use or withhold critical health information (Lennox et al., 2021). Further, internalizing negative societal attitudes undermines self-esteem, self-efficacy, and sense of agency, producing feelings of shame, guilt, and worthlessness (Luoma et al., 2017). This internalized stigma deters help-seeking behaviours, as individuals may perceive themselves as undeserving of care,

reinforcing isolation and hopelessness (Corrigan et al., 2010). Consequently, healthcare encounters become fraught with tension and mistrust, hindering effective communication between PWUD and providers (Earnshaw et al., 2013) thereby directly affecting decisions to access healthcare services. Healthcare providers may hold biased assumptions that lead to neglect, inadequate pain management, or outright refusal of treatment (Mayer et al., 2023; Raja et al., 2020). These experiences erode trust, discourage care seeking, and reinforce health inequities (Gomes et al., 2021). However, despite extensive documentation of ED utilization among PWUD, a critical gap remains in understanding the personal and social factors that motivate individuals to seek emergency healthcare (Bonn et al., 2020; Kendall et al., 2017; Kerr et al., 2005).

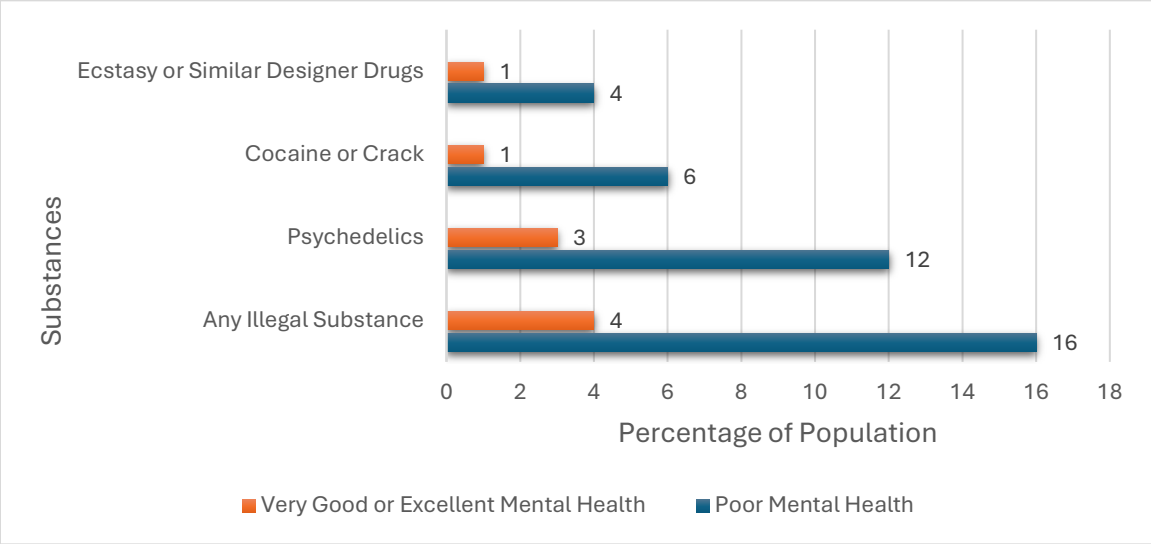
2.6.4 Mental Health and Substance Use

Substance use is strongly associated with mental health challenges (Bahji, 2024; Bukten et al., 2024; McCance-Katz, 2019) for a variety of reasons including genetic, familial, and psychosocial factors (Sullivan, 2022). Approximately 20% of individuals diagnosed with a mental illness also meet criteria for an SUD, and those with mental health conditions are twice as likely to develop an SUD compared to the general population (Canadian Institute for Health Information, 2021; Lang et al., 2018; Pearson et al., 2013). A national analysis of 134,600 respondents revealed that individuals with poor self-perceived mental health were significantly more likely to report substance use (see Figure 5), than those with excellent or very good mental health (Statistics Canada, 2023). Specifically, 27% of those with poor mental health reported increased alcohol consumption (versus 14% for those self-reporting good mental health), 34% reported

cannabis use (versus 13%), and 27% were current smokers (versus 15%). Those rating their mental health as poor or fair were four times more likely to have used illegal substances in the past year. This association is particularly acute among PWUD, who frequently experience co-occurring mental health issues and an SUD (Kosteniuk et al., 2022).

Figure 5

Past 12-Month Illegal Substance Use in Canada, by Self-rated Mental Health



Note. Data source: Canadian Substance Use Survey (CSUS), Summary of Results for 2023, Figure 8 (CSUS, 2023).

Research on stigma associated with PWUD remains comparatively underdeveloped compared to what is known regarding mental health diagnosis and stigma (Public Health Ontario, 2024; Papalamprakopoulou et al., 2024). Stigma, fragmented services, and limited coordination between mental health and addiction programs continue to impede equitable access to care (Todd et al., 2002; Wood, 2016) and may have significant negatives implications for PWUD accessing emergency health care services. The persistently high overdose and mortality rates among PWUD

highlights the significant barriers to accessing effective healthcare, with a substantial proportion either not seeking emergency services or not surviving despite receiving care (Boileau-Falardeau et al., 2023; Health Canada, 2024). Between January 2017 and June 2024, Emergency Medical Services (EMS) responded to 227,468 suspected opioid overdoses, 72% involving males and 35% involving individuals aged 30 to 39 years (Public Health Agency of Canada, 2022). Although PWUD access the emergency departments at rates seven to eight times higher than the general population, care remains fragmented, stigmatized, and often conditional upon abstinence (Chan Carusone et al., 2019; Kendall et al., 2017; Nambiar et al., 2017; Pauley et al., 2022). Emerging evidence suggests that stigma and provider perceptions of substance use can influence emergency care, shaping clinical judgment and introducing bias into triage, documentation, and treatment decisions for PWUD (Caso Vega & Figueroa Feliciano, 2026).

2.6.5 Pain and Substance Use

Pain is another critical risk factor influencing substance use and healthcare engagement among PWUD. Defined as a sensory and emotional experience associated with actual or potential tissue damage, pain serves as a protective mechanism by signaling harm and prompting corrective action (International Association for the Study of Pain, 2020; Haja et al., 2020). Pain may be acute or chronic, with chronic pain persisting beyond three months and often lacking a clear physiological cause (Raja et al., 2020).

Chronic non-cancer pain (CNCP) is particularly prevalent among PWUD, occurring at rates more than double those observed in the general population (Dassieu et

al., 2020; Voon et al., 2018). Unlike acute pain, which typically resolves with treatment, CNCP is ongoing and frequently associated with conditions such as fibromyalgia, neuropathic pain, musculoskeletal disorders, and mental health comorbidities (Voon et al., 2021). Pain management strategies include pharmacological interventions (e.g., analgesics) and non-pharmacological approaches such as physiotherapy, cognitive-behavioural therapy, and interventional procedures (Dowell et al., 2016). However, PWUD, and other low-income populations often face significant barriers to accessing these effective pain management strategies, particularly when opioid therapy is restricted due to concerns about diversion and misuse.

It remains unknown whether reducing risk factors such as homelessness, pain, or stigma increases the likelihood of PWUD accessing emergency healthcare services. What is clear, however, is that PWUD face significant harms resulting from intersecting vulnerabilities and life events (Perri et al., 2023; Piatkowski et al., 2024). The vulnerabilities of PWUD are often exacerbated by multiple risk factors resulting in serious harms which will be explored in the next section.

2.6.6 Harms Related to Substance Use

Harms represent tangible outcomes of unmitigated risk factors and have serious health implications, and are frequently manifested as acute health crises, hospitalizations, readmissions, LAMA, reduced quality of life, and premature mortality (Binswanger et al., 2008; Bonn et al., 2020; Eschliman et al., 2024).

2.6.7 Social Harms and Substance Use

There are profound social harms that permeate multiple dimensions of life for PWUD (McNeil et al., 2014). These harms include negative impacts on relationships, employment, education, and overall social functioning, often culminating in social isolation, involvement in criminalized activities, and incarceration (Canadian Institute for Health Information, 2021). The traumatic and often violent social and environmental contexts in which many PWUD live exert a persistent and harmful influence on both physical and mental health (Holdo & Bengtsson, 2020; Horwitz et al., 2022; Paquette et al., 2018). Substance use further compounds these vulnerabilities, creating cycles of disadvantage characterized by economic hardship, marginalization, and heightened exposure to chronic health conditions (Jackson et al., 2014; Ti & Ti, 2015). Intersecting social harms not only exacerbate health inequities but also reinforce structural barriers to care, perpetuating stigma and limiting opportunities for recovery and reintegration.

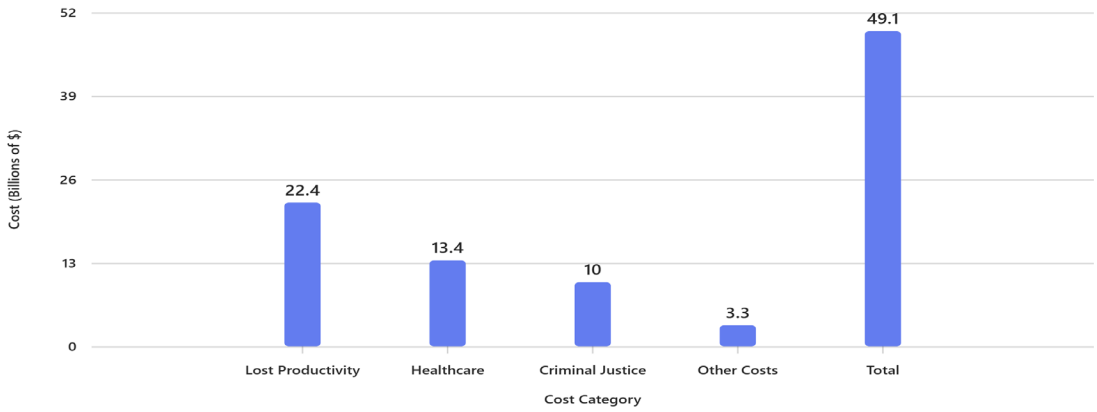
2.6.8 Economic Harms and Substance Use

Economic harms, often overlooked, affect PWUD at both systemic and interpersonal levels (Doucet & Porter, 2023). Systemic harms refer to the broad financial and operational burdens placed on societal institutions such as healthcare, criminal justice, and social services. These include increased healthcare expenditures for emergency visits and hospitalizations, costs associated with law enforcement and incarceration, and resource demands on housing and welfare programs. According to the Canadian Centre on Substance Use and Addiction (CCSA, 2023), the total economic cost of substance use in Canada was approximately $49.1 billion in 2020. Lost productivity

accounted for $22.4 billion, primarily due to work absences, disabilities, and premature deaths. Healthcare costs, including hospitalizations and emergency services, totaled $13.4 billion, while the criminal justice system incurred $10.0 billion in expenses related to policing, court proceedings, and correctional services. These figures are based on the most recent validated and published national data available for 2020; newer estimates are being compiled but were not finalized as of March 2025. Figure 6 illustrates the distribution of these costs by category, showing lost productivity as the largest contributor, followed by healthcare and criminal justice expenses.

Figure 6

Costs of substance use and harms in Canada, in billions of dollars



Note. Data source: Canadian Centre on Substance Use and Addiction (CCSA, 2023).

The economic burden of substance use in Canada, estimated in the billions of dollars, reflects not only financial costs but also significant health system strain and human suffering (Canadian Centre on Substance Use and Addiction, 2022).

2.6.9 Health-Related Harms and Substance Use

People who use drugs have unique risk factors that have serious health implications and ultimately can impact decisions regarding healthcare access, which result in increased health-related harms (Doucet & Porter, 2023; Piatkowski et al., 2024). Risk factors such as poverty, homelessness, withdrawal symptoms, or a history of negative interactions with healthcare providers refer to individual, environmental, and systemic conditions that can increase PWUD vulnerability to negative health outcomes (Felitti et al., 1998; Jackson et al., 2014; Saine et al., 2020; Simon et al., 2020). The interplay among risk factors, health implications, and harms is often cyclical and self-reinforcing (Fu et al., 2024). For instance, poverty or homelessness can contribute to untreated health conditions, which subsequently lead to additional harms such as hospitalization or premature discharge. These harms further perpetuate barriers to care and intensify the original risk factors. Recognizing these interconnections underscores the importance of addressing risk factors through trauma-informed healthcare interventions to mitigate harms and improve health outcomes for people who use drugs (PWUD) (Guta et al., 2022; Roberts et al., 2024). Understanding these interconnected harms highlights the need to examine both systemic and individual risk factors that motivate and influence PWUD to access emergency health care.

People who use drugs frequently experience complex and overlapping health needs resulting from chronic conditions, infections, pain, and substance use related complications (McNeil et al., 2022; Zolopa et al., 2021). Despite these pressing needs, many PWUD remain disconnected from formal healthcare services due to entrenched

structural and interpersonal barriers. Experiences of stigma, discrimination, and inadequate care, particularly within hospital and primary care environments, contribute to a deep distrust of the healthcare system (Fairbairn et al., 2012; Chan Carusone et al., 2019; Cheatle et al., 2015). These factors lead to avoidance or delayed care, resulting in late-stage disease presentations, lengthier hospitalizations, discharges against medical advice, and preventable mortality (Butt et al., 2017; Levitt et al., 2020; Eschliman et al., 2024).

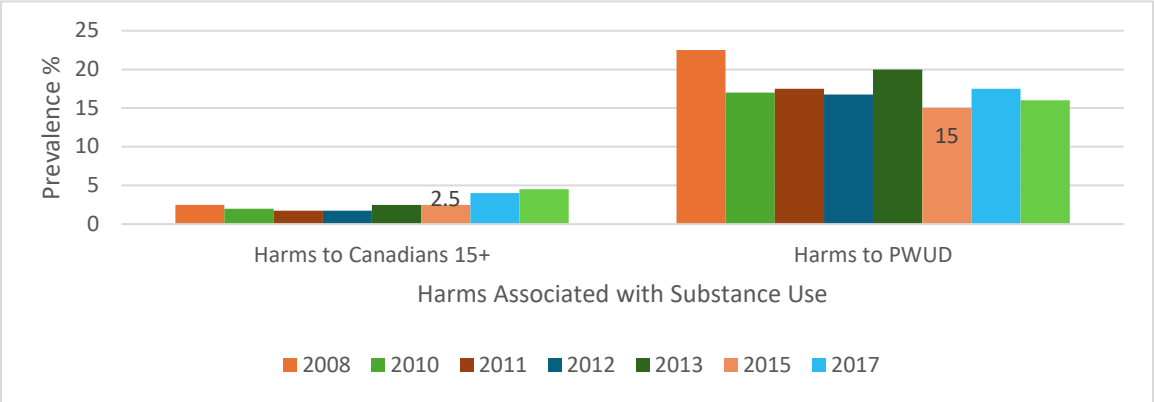
These health-related harms are further exacerbated by system level limitations in healthcare access, especially in primary care. Ideally, primary care serves as the foundation of the Canadian healthcare system, offering comprehensive, continuous, and coordinated services for individuals across the lifespan (Stanhope et al., 2021). However, a growing shortage of primary care providers, combined with regional disparities, and funding constraints, has made access increasingly difficult for many Canadians. According to the Canadian Institute for Health Information (2024), one in five Canadians does not have regular access to a primary care provider (PCP). In New Brunswick, the 2022 to 2023 Primary Care Survey revealed that 14.6 percent of residents, approximately 118,552 people, do not currently have a family doctor or nurse practitioner (New Brunswick Health Council, 2024). These gaps in care place additional pressure on emergency departments and create disproportionate barriers for marginalized groups such as PWUD, who already face systemic exclusion and limited access to nonjudgmental care (Motavalli et al., 2021; McNeil et al., 2017).

2.6.10 Cumulative Harms and Substance Use

Cumulative harm is the compounding impact of multiple, adverse risk factors that place PWUD at increased, significant, and negative outcomes (Frueh et al., 2023). These harms range from social isolation and marginalization to severe outcomes including overdose and death (Zolopa et al., 2021). According to the 2023 Canadian Substance Use Survey (CSUS), a substantial proportion of Canadians reported experiencing at least one harm related to substance use in the past year, with the highest rates among individuals aged 20 to 24 (Health Canada, 2024). The CSUS identified harms across multiple domains as illustrated in Figure 7, including physical and mental health, social relationships, financial stability, housing, legal issues, and educational or employment opportunities. Although detailed visual data from the CSUS have not yet been released, findings from the 2019 Canadian Alcohol and Drugs Survey (CADS) similarly reported that PWUD experience disproportionately higher rates of harm, particularly in relation to cannabis and illicit substances such as crystal methamphetamine, ecstasy, and heroin (Health Canada, 2022). Notably, prevalence data for 2009 were unavailable or not reported, creating discontinuity in longitudinal trends and highlighting gaps in national surveillance systems.

Figure 7

Prevalence of Harms Related to Drug Use, Canada 2008–2019



Note. Data source: CADUMS 2008–2012; CTADS 2013, 2015, 2017; CADS 2019; PHAC (Health Canada, 2022).

While existing research extensively documents the challenges faced by PWUD in the ED settings, including experiences of stigma, inadequate pain management, and frequent discharge or leaving against medical advice, there is a scarcity of studies specifically examining instances where PWUD access the ED as a strategy to avoid harm. The available literature focuses on the barriers to care and negative experiences within the ED, rather than exploring the initiative-taking decisions of PWUD to seek emergency care as a means of harm avoidance (Sud et al., 2022). The literature has emphasized barriers and adverse care experiences, while comparatively less work has examined the psychosocial conditions that make care-seeking possible or tolerable for people who often delay or avoid emergency care.

Harms described within the population of PWUD represent the tangible consequences of the risk factors and health implications, which encompass a broad spectrum of health, social, and economic issues (Binswanger et al., 2008; Bonn et al.,

2020; Eschliman et al., 2024). Health-related harms include an increased risk of infectious diseases (e.g., HIV/AIDS, HCV) due to needle sharing, acute and chronic health conditions, mental health disorders, overdose, and death (Canadian Nurses Association; 2017). Other physical health issues faced by PWUD, such as HIV/AIDS infections, hepatitis, skin and soft tissue infections, endocarditis, bacteremia, osteoarticular infections, and sepsis requiring emergency healthcare services, treatment, and often hospitalization (Bonn et al., 2020; Cruz et al., 2007; Kimmel et al., 2020). What is known is that PWUD will often not access or delay access to these services or leave without having the capacity to follow through on medical advice and direction (Collins et al., 2025; Kendall et al., 2017).

2.7 Healthcare Access and Substance Use

Healthcare systems often fail to address structural and relational dynamics that can result in fragmented care, avoidance of services, leaving against medical advice (LAMA) or repeat ED visits, and worsening health outcomes for PWUD.

2.7.1 Primary Healthcare and People Who Use Drugs

Primary care providers play an essential role in care for PWUD, functioning as the initial point of contact for most patients and offering integrated, person-centred care across the lifespan. Their responsibilities encompass preventive care, management of acute and chronic conditions, health promotion, and coordination with other health services to ensure continuity of care (New Brunswick Health Council, 2024).

Preventive services delivered by a PCP, such as routine screenings, vaccinations, and health education, are foundational to early detection and management of disease. These services not only improve individual health outcomes but also reduce the long-term burden on the healthcare system by minimizing the need for intensive interventions later in the disease trajectory (New Brunswick Health Council, 2024). For individuals without an SUD, access to a PCP often facilitates timely and routine healthcare engagement. These individuals are more likely to benefit from ongoing provider relationships, scheduled appointments, and referrals to specialists when necessary. However, even in this population, challenges such as long wait times, limited availability, and fragmentation of services may lead to the use of walk-in clinics or emergency services for non-urgent concerns (Motavelli et al., 2021). These challenges are further compounded by a persistent shortage of primary care providers in Canada, with approximately 5.7 million adults lacking access to a regular healthcare provider, limiting timely access to preventive and continuous care (Canadian Institute for Health Information [CIHI], 2025).

In contrast, PWUD face significantly more complex barriers to accessing primary care. These include systemic stigma, poverty, and discrimination, which are often compounded by urgent and multifaceted health needs (Biancarelli et al., 2019; Matsuzaki et al., 2018). In many cases, the nature of care required, such as treatment for injection-related infections, management of withdrawal, or access to opioid agonist therapies, is not readily available in primary care settings. Specialized care from addiction medicine, infectious disease, or wound care specialists is often necessary (Gerber et al., 2015).

As a result, PWUD frequently rely on informal and community-based services, including harm reduction programs, community volunteers, peer-led outreach, mobile health units, and nonprofit organizations. These venues offer accessible, nonjudgmental care and essential supplies such as sterile injection equipment, naloxone, pregnancy tests, and wound care materials (Canadian Centre on Substance Use and Addiction, 2022; Canadian Nurses Association, 2017; McNeil & Small, 2014). However, the capacity and availability of these programs can be limited by resource constraints and restrictive hours of operation.

Structural barriers such as limited primary care availability, compounded by the urgency of complex health needs, mean that PWUD are less likely to be attached to a PCP (DeCoux, 2005; Kendall et al., 2020). When health crises arise, an ED becomes the default option, offering 24/7 access and the ability to address multiple urgent concerns simultaneously, including diagnostic imaging, surgical intervention, and stabilization. For many PWUD, an ED is not only the most accessible entry point into the healthcare system but also the only viable one (McNeil et al., 2021).

2.7.2 Hospital Care Experiences

Hospitals serve as essential healthcare access points for PWUD, who, due to their lower likelihood of having a PCP, frequently rely on hospital-based services for managing both acute and chronic conditions (Kendall et al., 2017). However, interactions between hospitals and PWUD remains challenging, as hospitals have been identified as at-risk and unsafe environments where social and structural factors can exacerbate harm for PWUD (McNeil et al., 2014; Muncan et al., 2020). A pervasive mistrust characterizes

the relationship between healthcare providers and PWUD; providers often express concerns about deception and due to a lack of training for medical professionals they erect barriers to forming therapeutic relationships with their patients (Collins et al., 2025). Conversely, PWUD frequently report experiences of stigma, inconsistent care, and lack of pain management, reinforcing their wariness of the healthcare system (Lennox et al., 2021; McNeil et al., 2014).

This mutual mistrust deters PWUD from seeking timely care, leading to delayed treatment, disease progression, and missed opportunities for early intervention (Chan Carusone et al., 2019; Paquette et al., 2018). When PWUD decide to access hospital care, they have higher rates of unplanned, patient-initiated discharges (25-30%), often due to inadequate pain or withdrawal management, negative encounters with staff, or restrictive or punitive hospital policies (McNeil et al., 2014; Ti & Ti, 2015). These early discharges are typically associated with poorer health outcomes such as increased readmission rates and 30-day mortality rates. The most damaging aspect is the missed opportunities for healthcare providers to establish trust and deliver consistent, compassionate care for this complex high-risk population (Choi et al., 2011; Ti & Ti, 2015).

2.7.3 Leaving Against Medical Advice: Underlying Factors

When PWUD are admitted to the hospital, despite having legitimate health concerns, they are often labeled by healthcare providers as drug-seeking, confrontational, and noncompliant (Grewal et al., 2015; Smith et al., 2017). Discrimination and the requirement for abstinence-based drug policies force PWUD to either use their personal drug supplies which causes predictable conflict, or they decide to LAMA leading to

inevitable lower health outcomes and readmissions (McNeil et al., 2014; Mayer et al., 2023; Muncan et al., 2020).

The incidence rates of PWUD that LAMA in Canada and the US ranges from 25% to 41% (Ti & Ti, 2015). Individuals living with an SUD, HIV, mental illness or experiencing homelessness, have even higher readmission rates and repeated instances of leaving the hospital untreated (Choi et al., 2011; Gaetz et al., 2014). Interestingly, the relationship between PWUD and healthcare providers plays a critical role in LAMA decisions (Lewer et al., 2020). It has been demonstrated that PWUD are eight times more likely to overdose post-hospital discharge if they LAMA, however, when the relationship with healthcare providers is positive, they are more satisfied with their care and less likely to LAMA (Jetiah et al., 2019). Further, Mayer and colleagues (2023) noted through qualitative semi-structured interviews with PWUD speaking about their experiences and perceptions in hospital described that it was the stigmatizing, discriminating, and neglectful encounters with healthcare providers that directly impacted the quality of care they felt they received and bolstered attitudes of being unwilling to engage or access future healthcare services.

2.7.4 Emergency Healthcare Access and People Who Use Drugs

Emergency healthcare services refer to the treatment of individuals of all ages who have a severe and life-threatening medical condition that requires immediate attention. These conditions can be the result of an accident, trauma, injury, overdose, or a sudden onset illness. The ED is a medical treatment facility specializing in emergency and paramedicine (ambulance) care of patients without prior appointments (American

College of Emergency Physicians, n.d.). The main goal of emergency care is to stabilize the patient, address the immediate medical concern then transfer them to appropriate follow-up care (Ramrakha et al., 2020).

It is well-documented that for catastrophic injuries, crises related to addiction, acute mental health issues, or exacerbations of unmanageable chronic illnesses, PWUD will at times seek care in emergency or urgent care departments (Kerr et al., 2010). A systematic review by James et al., (2023), clearly outlined the high rates of ED presentations, admissions, LAMA, and readmissions associated with higher rates of morbidity and mortality for PWUD.

With higher incidence rates of trauma, injuries, and demand for addiction and mental health services there are a disproportionately higher number of PWUD accessing emergency healthcare services in the ED with unmet social needs (Canadian Institute for Health Information 2021a; Kimmel et al., 2020). For instance, Doran and colleagues (2018) examined a random sample of urban hospital EDs patients and demonstrated that individuals with an SUD to alcohol, heroin and/or prescription opioids had higher rates of homelessness and food insecurity (Norman & Reist, 2021). Multiple studies have confirmed the findings that PWUD who present in the ED often have multiple complex health, housing, and social care needs (Dorney-Smith et al., 2020; Gaetz, 2020; Smith & Kopec, 2023). These factors are further complicated with tenuous interpersonal dynamics and previous negative experiences with healthcare providers that have affected their sense of self worth, connection, and mattering.

2.8 Psychosocial Dimensions: Connection, Self-Worth, and Mattering

Effective interpersonal communication and meaningful connections between PWUD and their healthcare providers are essential components of healthcare engagement (Jetiah et al., 2019; McNeil et al., 2014). Emerging theory suggests that the combined influence of connection, self-worth, and mattering offers a valuable framework for understanding health-seeking behaviours among PWUD. The concept of mattering, the feeling that one is significant and valued by others, has been extensively explored in psychological and community health literature, emphasizing its role in promoting well-being and social inclusion (Elliott et al., 2005; Flett & Hewitt, 2014; Gordon, 2018; Prilleltensky & Prilleltensky, 2021). This integrated perspective may provide a stronger foundation to reinterpret and improve existing models that explain why PWUD decide to access healthcare services. The decision to leave against medical advice is often rooted in negative interactions and a lack of trust between PWUD and healthcare providers. These experiences underscore the critical importance of fostering meaningful connections, promoting self-worth, and ensuring that individuals feel they matter within healthcare settings, which are explored in the following three sections.

2.8.1 The Psychological Construct of Mattering

Understanding the construct of mattering is essential for comprehending the psychological and social factors that shape well-being, resilience, and health engagement across the lifespan. Mattering, defined as feeling valued and significant to others, has been associated with positive mental health outcomes, greater resilience, and increased participation in health-promoting behaviours (Elliott et al., 2004; Dixon & Tucker, 2007).

For PWUD, the extent to which they perceive themselves as valued and connected can play a crucial role in their willingness to seek emergency healthcare services. This sense of mattering may influence trust in healthcare providers and systems, potentially reducing barriers related to stigma and marginalization and improving healthcare engagement and outcomes.

The construct of mattering has emerged as a psychological concept for understanding how individuals interpret their significance and relational value. Broadly defined, mattering reflects the perception that one is important to others, is noticed, and is relied upon. It captures a fundamental human need to feel that one's existence is meaningful in the lives of others. Over the past four decades, mattering has developed from a concept centered on feeling valued by others into a broader framework that helps explain experiences across a variety of populations and contexts, including aging, caregiving, adolescence, marginalization, and health behaviors.

Growing attention to mattering reflects a broader recognition that psychological well-being is deeply embedded in relational experiences. Feelings of insignificance or invisibility are increasingly implicated in mental health challenges such as depression, loneliness, and suicidality. Conversely, experiences of being valued and needed are associated with resilience, coping, and improved health outcomes. This literature reviews the foundational development of mattering, the core dimensions, and the key studies that have shaped the field, with attention to its relevance for populations such as caregivers, older adults, adolescents, marginalized youth, and how this intersects with this study and PWUD.

2.8.2 Origins and Conceptual Foundations of Mattering

The construct of mattering was first formally introduced by Rosenberg and McCullough (1981), who defined it as the extent to which individuals feel noticed, cared about, depended upon, and emotionally important within relationships. Their seminal work positioned mattering as central to social integration and self-concept, emphasizing that individuals derive a sense of identity and worth through their perceived relevance in social relationships. This early conceptualization identified mattering as distinct from, yet related to, constructs such as self-esteem and belonging.

Rosenberg and McCullough (1981) proposed several indicators of mattering, including attention, importance, dependence, and appreciation. These indicators suggest that mattering is shaped not only by external interactions but also by internal interpretations of those interactions, a sense of personal worth and significance. Their survey-based research demonstrated that individuals with higher levels of perceived mattering reported stronger psychological well-being and lower levels of distress.

Schlossberg (1989) made a significant contribution to the development of mattering by situating it within her broader transition theory, emphasizing its importance during periods of change and instability. She conceptualized mattering as a critical component of how individuals navigate life transitions, particularly when they experience marginality or disconnection from established social roles and relationships. Schlossberg highlighted that individuals in transition often fluctuate between feelings of marginality and validation, with mattering serving as a key psychosocial resource that affirms their significance and place within their social environments. Expanding on earlier definitions, she underscored that feeling noticed, important, and relied upon is essential for

maintaining identity and psychological stability during times of change and disruption. This work extended mattering beyond simply perception to a more dynamic experience, reinforcing its role in coping, adaptation, and feelings of belonging. Schlossberg's contribution is particularly relevant for populations experiencing stigma, exclusion, or role transitions, as it underscores how disruptions in mattering can intensify vulnerability while its presence can foster resilience and connection (Schlossberg, 1989).

Subsequent scholarship expanded upon this foundation. Flett (2018) advanced mattering as a core psychological need, arguing that it functions as a protective factor against stress, alienation, and psychological vulnerability. According to Flett, mattering is not merely a pleasant experience but a fundamental requirement for mental health, particularly in contexts of adversity. This perspective positions mattering alongside other basic psychosocial needs such as autonomy and belonging.

Flett (2022) further refined the construct by identifying three core dimensions: awareness, importance, and reliance; awareness refers to the sense of being noticed and acknowledged by others, importance reflects the perception of being valued and cared for, and reliance captures the belief that others depend on or need the individual. Together, these dimensions provide a comprehensive framework for understanding how mattering is experienced and operationalized across different contexts. Prilleltensky (2020) contributed and conceptualized mattering as both feeling valued and adding value. This dual framework emphasizes reciprocity and agency, suggesting that mattering involves not only receiving recognition but also contributing meaningfully to others and to society at large. This perspective has significant implications for community psychology and the design of interventions, as it highlights the importance of fostering

environments in which individuals can both experience and provide opportunities for mattering.

2.8.3 Mattering and Caregiving: Loss of Mattering

One of the most significant extensions of the mattering construct emerged from the work of Pearlin and LeBlanc (2001), who introduced the concept of "loss of mattering" in the context of caregiving and bereavement. Their research focused on caregivers of individuals with Alzheimer's disease, a population characterized by profound relational changes and emotional strain. Through longitudinal analysis, Pearlin and LeBlanc (2001) demonstrated that caregivers often experience a decline in perceived mattering as the cognitive and relational capacities of their loved ones deteriorate. As the individual with Alzheimer's disease becomes less able to recognize or respond to the caregiver, the caregiver's sense of being needed and valued diminishes. This erosion of mattering disrupts the caregiver's identity and sense of purpose.

The study found that loss of mattering was significantly associated with increased incidence of depression, loneliness and chronic stress. These findings highlighted the importance of feeling valued in maintaining caregiver well-being and underscored the unique psychological burden associated with caregiving roles that involve progressive loss. This work represents a critical contribution to the literature by illustrating that mattering is not static but can fluctuate over time in response to changes in social relationships. It also introduced the notion that the absence of mattering can be as impactful as its presence, particularly in contexts where individuals have derived identity and purpose from caregiving roles.

2.8.4 Mattering in Older Adulthood

Research on mattering among older adults has emphasized its role in promoting resilience and psychological well-being during later life stages. Dixon (2007) examined how perceptions of mattering influence aging experiences, particularly in the context of retirement, social transitions, and potential isolation. Dixon (2007) found that older adults who reported higher levels of mattering experienced greater life satisfaction, a stronger sense of purpose, and lower levels of loneliness and depression. These individuals were more likely to maintain social connections and engage in meaningful activities, which contributed to sustained psychological health. The study highlighted that aging could pose risks to mattering due to factors such as reduced social roles, loss of employment, and decreased visibility within society. However, maintaining opportunities for contribution and recognition can mitigate these risks. For example, involvement in community activities, volunteer work, and intergenerational relationships can reinforce a sense of being needed and valued.

This body of work underscores the importance of designing age-inclusive environments that promote social engagement and affirm the continued relevance of older adults. It also reinforces the broader principle that mattering is integral to psychological resilience and wellness across the lifespan.

2.8.5 Adolescent Mattering and Mental Health

The role of mattering in adolescent mental health has been extensively explored, particularly in relation to suicidal ideation and emotional well-being. Elliott, Colangelo, and Gelles (2005) examined the relationship between mattering and suicidal thoughts

among adolescents, finding that those who perceived themselves as valued by family, peers, and teachers were significantly less likely to experience suicidal ideation. Their findings suggest that mattering serves as a protective factor during a developmental period characterized by identity formation and perceptions on how they are viewed by others in different social situations. Adolescents who feel visible and important within their social networks are better equipped to navigate emotional challenges and are less likely to internalize feelings of worthlessness.

Taylor and Turner (2001) extended this understanding by applying the concept of mattering to school counseling practices. They argued that fostering a sense of significance among students can reduce depressive symptoms, enhance emotional well-being, and improve academic outcomes. Their work emphasized the role of educators and institutional environments in shaping students' perceptions of mattering. Together, these studies demonstrate that mattering is not only an individual perception but also a socially constructed experience influenced by the people and environments in which they live. Schools, families, and peer networks play critical roles in either reinforcing or undermining adolescents' sense of significance. These findings with adolescent populations may hold relevance for health-seeking behaviours amongst PWUD.

2.8.6 Mattering, Marginalization, and Violence

Recent research has expanded the application of mattering to contexts of marginalization and social exclusion. Billingham and Irwin-Rogers (2021) examined the relationship between perceived insignificance and violent behavior among young people.

Their findings suggest that a lack of mattering can create profound psychological distress, described as a "terrifying abyss" of insignificance (p. 1227). According to Billingham and Irwin-Rogers (2021), individuals who feel invisible, undervalued, and excluded may seek alternative means of asserting significance, including engagement in violence. Research indicates that feelings of not mattering are highly prevalent among young people. Drawing on large-scale studies in North America, Flett (2018) reports that up to half of adolescents do not feel they matter to their communities, and approximately one-third do not feel they matter to others. These findings suggest that experiences of insignificance are widespread and may contribute to the increasing rates of mental health challenges observed among youth. Behaviours such as engagement in violence or other forms of risk-taking, can be understood as attempts to create visibility and a sense of self-worth in the absence of positive validation from family, teachers, and peers.

This perspective aligns with broader theories of social identity and recognition, that state that individuals have a fundamental need to be acknowledged and respected within their communities and social circles. When this need is unmet, it can lead to maladaptive coping strategies, including aggression, violence, and self-harm. Scarpa et al. (2021) further explored the relationship between mattering and fairness in marginalized populations, highlighting the role of systemic inequities in shaping perceptions of significance. Their work found that experiences of unfair treatment and social exclusion undermine mattering, particularly in educational and community settings. Conversely, environments that promote fairness, inclusion, and respect can enhance individuals' sense of being valued.

These findings underscore the importance of addressing structural determinants of mattering, including discrimination, stigma, and inequality. Interventions aimed at promoting mattering must therefore extend beyond individual-level strategies to include systemic and institutional changes (i.e. food insecurity, homelessness).

2.8.7 Mattering as a Protective Psychological Resource

Flett (2018) conceptualized mattering as a psychological shield that protects individuals from the negative impacts of stress, trauma, and mistreatment. This protective function is particularly important in environments of adversity, where individuals who maintain a sense of mattering are better able to cope and recover.

During the COVID-19 pandemic, researchers highlighted the importance of mattering acts as a buffer against social isolation and uncertainty. Casales and Flett (2020) and Flett and Zangeneh (2020) emphasized that maintaining connections and friendships were critical for sustaining mental health during periods of uncertainty and disruption. These studies demonstrated that even in the absence of physical proximity, perceived mattering could be preserved through meaningful communication and support. Elliott (2009) also contributed to this literature by examining mattering in relation to stress and coping, finding that individuals who felt valued were more likely to engage in positive coping strategies and less likely to experience psychological distress and destructive behaviours.

2.8.8 Mattering as Self-Worth and Connection

Mattering was first defined by Rosenberg and McCullough (1981) as the perception that one is noticed, important, and relied upon by others. In this dissertation, mattering is more explicitly understood as both self-worth and connection. This means

that individuals not only see themselves as having value but also experience that value through their interactions with others. Rosenberg and McCullough (1981) identified four key elements of mattering: attention, importance, dependence, and appreciation. Attention refers to being noticed, importance reflects being valued, dependence relates to being needed, and appreciation reflects recognition. These elements together describe how individuals interpret their role and significance in relationships.

Later work has emphasized the importance of mattering for mental health. Flett (2018) described mattering as a core psychological need and demonstrated that it is linked to lower levels of loneliness, depression, and distress. Prilleltensky (2020) further expanded the concept by suggesting that mattering involves both feeling valued and having opportunities to contribute, highlighting the active and relational nature of the construct. For PWUD, mattering is especially relevant. Individuals often have contact with healthcare providers, social services, and peer groups. However, these interactions do not always communicate value. For example, attending appointments may provide connection, but if individuals feel dismissed or not listened to, they may not experience mattering. In contrast, when individuals are treated with respect, listened to, and recognized as persons, both self-worth and connection are supported. These experiences strengthen the perception that one matters.

Mattering is therefore distinct because it captures the experience of value within relationships. It is not only about being connected to others, and it is not only about feeling good about oneself. It is the combination of both.

2.8.9 Distinguishing Mattering from Self-Esteem

Self-esteem refers to an individual's overall evaluation of their own worth (Rosenberg, 1965). It is an internal process that reflects how individuals judge themselves based on their beliefs, experiences, and personal standards. Self-esteem answers the question, "How do I see myself?" Although self-esteem can be influenced by interactions with others, it remains an internal judgment. Individuals interpret their experiences and develop their own view of their value. Self-esteem can increase or decrease depending on life circumstances, but it reflects personal evaluation rather than relational experience. The distinction between self-esteem and mattering is clear. Self-esteem is internal evaluation, whereas mattering is self-worth and connection. A person can have positive self-esteem and still feel that they do not matter to others. For example, a PWUD may feel confident in their abilities or identity but may feel ignored or dismissed within healthcare settings. In this case, their internal sense of self remains intact, yet their relational experiences do not communicate value. This reflects low mattering, not necessarily low self-esteem.

Research supports this distinction. Flett (2018) found that mattering explains unique aspects of mental health, including depression and loneliness, even when self-esteem is considered. This suggests that feeling unimportant to others is a distinct experience that cannot be fully understood through self-evaluation alone. Self-esteem reflects how individuals value themselves. Mattering reflects whether they feel valued by others. While these constructs are related, they are not interchangeable.

2.8.10 Distinguishing Mattering from Belonging

Belonging refers to the sense of being accepted and included within a group (Baumeister & Leary, 1995). It reflects whether individuals feel that they have a place within a social context. Belonging answers the question, “Am I included?” Belonging focuses on inclusion and group membership. Individuals who feel they belong experience acceptance and connection with others. This can occur in families, peer groups, community organizations, and service settings. For PWUD, belonging may be found in peer networks or supportive environments were shared experiences foster acceptance. However, belonging does not necessarily mean that individuals feel valued. A person can be included in a group but still feel that their presence is not important. Belonging is about inclusion, whereas mattering is about self-worth and connection. For example, a PWUD may feel accepted within a peer group but may believe that their contribution is not important or that others do not rely on them. In this situation, belonging is present, but mattering is low. The individual has a place but does not feel that they make a meaningful difference. Mattering extends beyond belonging by focusing on relational significance. It reflects whether individuals feel valued within their relationships, not just included in them. This distinction helps explain why inclusion alone is not sufficient for well-being.

2.8.11 Relationships and Overlap Among Constructs

Mattering, self-esteem, and belonging are related constructs that often interact, but they represent different aspects of experience. Self-esteem reflects internal evaluation. Belonging reflects inclusion within a group. Mattering reflects whether

individuals feel valued through self-worth and connection. Each construct contributes to well-being in a different way, however, these constructs can influence one another. For example, belonging can provide the social environment where mattering may develop. Positive experiences of mattering can support self-esteem by reinforcing a sense of value. However, the presence of one does not guarantee the presence of the others. An individual can belong without mattering and can have self-esteem without mattering. This highlights the unique role of mattering in understanding relational experiences.

Scholars have emphasized that mattering adds a relational dimension that is not captured by self-esteem or belonging alone (Flett, 2018; Prilleltensky, 2020). It reflects how individuals experience recognition, importance, and value within their relationships.

2.9 Mattering and Healthcare Engagement

In contemporary healthcare discourse, human caring and connection occupy central positions in providing care (Brown, 2019; Hoskins, 2003). Human caring is often conceptualized within nursing theories such as Jean Watson's Theory of Human Caring, which emphasizes authentic and compassionate interactions between healthcare providers and patients (Watson, 2008). This perspective underscores the need for care providers to attend not only to physical needs but also to social, psychological, and spiritual dimensions of health. Establishing meaningful relationships between individuals and their healthcare practitioners, as well as interdisciplinary team members, is essential for addressing the complex needs of PWUD (Pauly et al., 2018; Perri et al., 2023). Such connections can foster trust, reduce stigma, and enhance engagement with health services.

2.9.1 Mattering and PWUD: Implications for Health Behaviors

The construct of mattering offers a valuable framework for understanding health-seeking behaviors among PWUD. Emerging findings suggest that perceptions of personal value and social connection are key motivators influencing service engagement. Within this population, and based upon the findings, experiences of stigma, marginalization, and social exclusion can potentially erode mattering, which could lead to avoidance of healthcare services. Conversely, as evidenced by the narratives, when PWUD perceive that they are treated with dignity, respect, and recognition, they are more likely to seek care and engage in behaviours that support their health. Viewing these dynamics through the lens of mattering allows for a deeper understanding of how relationship experiences shape decisions to access care. It highlights the importance of creating healthcare environments that affirm the worth and humanity of PWUD, fostering both feelings of being valued and opportunities to contribute, that they matter.

This perspective aligns with Prilleltensky (2020) dual framework, emphasizing that interventions should not only provide care but also empower individuals to participate meaningfully in their own health decisions. It also reinforces the broader literature demonstrating that mattering is central to resilience, positive coping strategies, engagement, and well-being across diverse populations throughout the lifespan.

2.9.2 Implications for People Who Use Drugs

The distinction between mattering, self-esteem, and belonging is particularly important in understanding the experiences of PWUD. Individuals in this population often face stigma, discrimination, and exclusion, which can affect how they experience

both connection and value. PWUD may experience belonging through peer networks or service environments and may work to maintain self-esteem. However, these experiences do not ensure that individuals feel that they matter. Interactions that are dismissive, rushed, or lacking respect can weaken perceptions of value, even when connection and inclusion are present.

Considering the construct of mattering highlights the importance of relational quality. When individuals are listened to, treated with dignity, and recognized as persons, both self-worth and connection are supported. These interactions strengthen mattering and may influence engagement with services and health behaviors. This perspective aligns with broader mattering research, which identifies the construct as a protective factor that supports resilience and well-being (Flett, 2018). It also aligns with the emphasis on contribution and meaningful participation described by Prilleltensky (2020).

2.10 Conclusion Chapter 2

Comparatively little work has examined early-stage motivations of a cohort of PWUD, who consistently avoid or refuse to access emergency care. While much research has examined barriers to healthcare, little is known about the underlying factors driving this avoidance among this subset, leaving an important dimension of healthcare engagement unexplored. This chapter provided an in-depth analysis of published literature on factors influencing the health and well-being of PWUD, with particular emphasis on barriers to accessing emergency healthcare. The review examined the complex interplay of social, structural, and individual determinants that shape healthcare engagement in this population and contribute to the harms associated with Canada's

ongoing overdose crisis. Key issues include the widespread presence of potent synthetic opioids such as fentanyl, alongside systemic challenges such as poverty, stigma, and homelessness, which exacerbate inequities in healthcare access. Importantly, despite extensive research on barriers to care, comparatively less work has examined the motivations and facilitators that prompt PWUD to seek ED services. Addressing these gaps is critical for designing responsive, trauma-informed, and equitable interventions. The next chapter introduces the mixed-methods approach employed in this dissertation, integrating quantitative and qualitative strategies to examine this gap. This comprehensive research design aims to generate deeper insights into the multi-layered nature of emergency healthcare engagement for PWUD.

Chapter 3: Research Design

This chapter provides an overview of the research design that guided the study and explains the methodological choices in relation to the research purpose. The study employs an explanatory sequential mixed methods approach, in which quantitative data are collected and analyzed first, followed by qualitative data used to explain and expand upon the initial findings, to examine factors that influence and motivate PWUD to access emergency healthcare services. Mixed methods research is well suited to addressing complex health-related questions because it combines the strengths of quantitative analysis with the depth of qualitative interpretation, enabling a comprehensive understanding of both structural patterns and experiential meanings (Creswell & Plano Clark, 2018).

The design reflects the complexity of the research question by integrating SNA and ID. In Phase I, SNA was used to identify the structural characteristics of participants' social networks and to examine how relationships and their social capital resources shape access to emergency healthcare services. The second phase employed ID to explore lived experiences and contextual factors influencing healthcare access (Thorne, 2016b, 2025).

The overarching research question guiding this study was, *"What motivates and influences PWUD to access emergency healthcare services?"*

To address this question, the study objectives were as follows:

1. Identify structural patterns within the social networks of PWUD and examine how these relationships and resources relate to emergency healthcare access.

2. Explore the experiences, perceptions, and contextual influences that contribute to PWUD avoiding, refusing, or accessing emergency healthcare services.

3. Integrate quantitative and qualitative findings to develop a comprehensive understanding of the mechanisms shaping the engagement of PWUD with emergency healthcare services.

This chapter begins by presenting the researcher's positionality and reflexive stance, followed by a discussion of the philosophical assumptions and theoretical foundations that informed the study. It then provides the rationale for employing a mixed methods approach and describes the explanatory sequential design, including strategies for integrating quantitative and qualitative components. The informed consent process, sampling strategies, study setting, data collection procedures, and ethical considerations are outlined to demonstrate the rigor and appropriateness of the design. The chapter concludes with a discussion of the strengths and limitations inherent in the design and together, these elements provide a transparent account of the research process and establish the foundation for interpreting the findings presented in Chapters 4 and 5.

3.1 Positionality and Reflexive Practice

Articulating the researcher's positionality and reflexivity was essential for ensuring transparency, credibility, and ethical integrity in qualitative, quantitative, and mixed-methods research (Jamieson et al., 2023). Researchers inevitably bring their own values, assumptions, and worldviews to the research process, which can influence the design, data collection, analysis, and interpretation of findings (Holmes, 2020).

Acknowledging and critically examining these influences strengthened methodological rigor and enhanced contextual relevance.

In this study, the researcher's positionality was shaped by disciplinary training, institutional affiliations, and professional experience as a community health nurse. These elements informed the development of the research question, the focus of inquiry, methodological choices, and theoretical orientation. As noted in the Land Acknowledgement at the beginning of this dissertation, the researcher's longstanding commitment to addressing healthcare inequities for PWUD and sustained engagement with this population influenced both the formulation of research questions and the interpretation of findings. This standpoint aligned with the principles of ID, which values professional expertise in generating practice-relevant knowledge (Thorne, 2008).

Positionality also encompassed the researcher's subjective perspectives, including personal beliefs, social location, and lived experiences, all of which shaped interactions with participants and engagement with data (Creswell & Creswell, 2018). The researcher's advocacy for equitable healthcare, informed by years of frontline nursing practice with structurally marginalized populations, contributed to a nuanced understanding of the barriers and motivations experienced by PWUD when seeking emergency care. This orientation, while subjective, was embraced as a strength within the ID framework, enhancing the relevance and depth of the inquiry.

Although reflexivity was not traditionally associated with quantitative approaches such as SNA, it played a critical role in this mixed-methods design. Reflexivity involved a deliberate and ongoing examination of how the researcher's assumptions, experiences,

and decision-making influenced all phases of the research process (Olmos-Vega et al., 2023). In this study, reflexivity primarily informed the qualitative component but also guided the interpretation of network structures by ensuring that analytical decisions were transparent and ethically grounded. Reflexive strategies included daily journaling, consultation with a clinical counselor, and regular engagement with dissertation committee members. At times, interviews were emotionally challenging and participants' stories difficult to process; therefore, these practices supported critical self-awareness, helped manage emotional strain, while upholding ethical responsibilities throughout the study.

The integration of positionality and reflexivity into the research process enhanced the integrity, depth, and relevance of the findings. By explicitly acknowledging and thoughtfully addressing the influence of the researcher's professional and personal standpoint, this study demonstrated a commitment to methodological transparency, ethical engagement, and the production of meaningful, evidence-informed knowledge. Building on this discussion, the next section outlines the philosophical assumptions that underpinned the research design and informed the interpretation of findings.

3.2 Underlying Philosophical Assumptions

Philosophical assumptions were foundational to the research process, influencing every aspect from design to interpretation. Explicitly identifying these assumptions strengthened the study by ensuring that it was logical, ethically sound, and theoretically grounded, thereby enhancing its overall rigor and relevance (Creswell & Creswell, 2018;

Denzin & Lincoln, 2018). This research was shaped by four primary philosophical assumptions: ontology, epistemology, axiology, and methodology.

Ontology is concerned with the nature of reality and existence (Creswell & Poth, 2008). In this study, the researcher viewed the realities of PWUD as both objectively and subjectively constructed. These realities were influenced by the physiological aspects of substance use and shaped by everyday life and social interactions, reflecting a complex interplay between individual experiences and societal contexts.

Epistemology is focused on the nature of knowledge and how it is acquired (Lincoln & Guba, 1985). The researcher adopted a constructivist stance, emphasizing that knowledge was co-created through collaborative interactions and the lived experiences shared by participants. This perspective was central to the study design, with participant interviews serving as a critical method for capturing and understanding these shared realities.

Axiology examines the influence of the researcher's personal values on the study. The researcher explicitly acknowledged her positionality as a Caucasian woman of privilege with a professional education in nursing, and her values that were rooted in honesty, compassion, social justice, and health equity. Drawing on Holmes (2020), the researcher recognized that positionality was inseparable from the research process and findings.

Methodology that was adopted for this study was a constructivist stance, emphasizing the co-construction of meaning through qualitative inquiry. At the same time, the inclusion of SNA introduced a quantitative component grounded in a positivist orientation. Rather than viewing these paradigmatic differences as contradictory, the integration reflected a pragmatic strategy to address the complexity of healthcare access

among PWUD. Mixed methods research often draws on methodological pluralism to capture both experiential and structural dimensions of a phenomenon (Creswell & Creswell, 2018; Thorne, 2008).

The study employed a mixed methods design that combined ID and SNA. The SNA offered a structural perspective on the relational dynamics shaping healthcare utilization, while ID provided a qualitative lens to explore the nuanced experiences and motivations of PWUD. Together, these approaches enabled a comprehensive understanding of individual and systemic factors influencing emergency care access. This methodological integration aligned with the study's aim to generate actionable insights that were contextually grounded and practically relevant for improving care delivery (Thorne, 2008; Thorne, 2016a; Thorne, 2025).

The integration of reflexivity with four philosophical assumptions fostered awareness of potential biases and deepened the researcher's understanding of the population under study. Reflexivity, combined with a commitment to co-creating knowledge with participants, supported rigor, integrity, and relevance throughout the research process (Holmes, 2020). By emphasizing practical applicability and ethical engagement, the study contributed meaningful insights to clinical practice and to the broader understanding of the everyday lives of PWUD and the factors that motivated them to access emergency healthcare services (Creswell & Creswell, 2018).

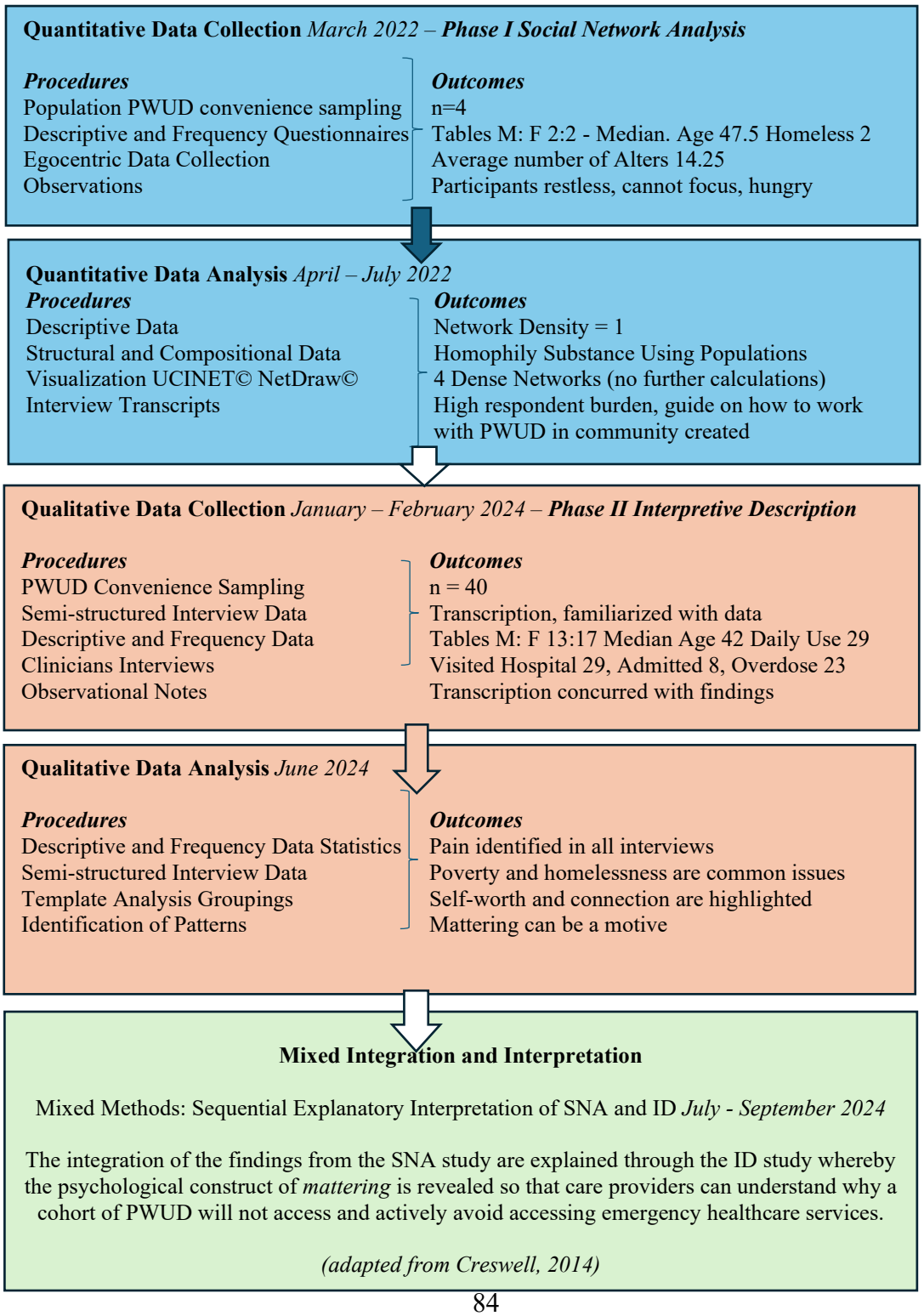
3.3 Overall Methodological Design

The study employed a mixed methods sequential explanatory design (see Figure 8) to investigate the social and relational factors that influence emergency healthcare

access among PWUD. This design, as defined in their field handbook by Ivankova, Creswell, and Stick (2006). The study involved two consecutive phases, quantitative followed by qualitative, with the latter phase providing context and providing depth to the statistical findings obtained in the SNA analysis. The central premise of this design is that quantitative methods yield generalizable patterns, while qualitative methods offer contextual and experiential explanations that deepen our understanding of those patterns (Creswell & Plano Clark, 2018).

Figure 8

Study Design: An explanatory sequential mixed methods research design using Social Network Analysis and Interpretive Description to identify the factors that motivate and influence PWUD to access emergency healthcare services.



Priority was initially given to the quantitative phase of egocentric network analysis, consistent with the explanatory sequential model's assumption that qualitative data are used to support, expand, or explain quantitative trends (Ivankova et al., 2006). The quantitative component consisted of SNA, specifically egocentric network mapping, to explore the structural attributes of participants' social networks. This phase generated data on network density, relational ties (alters), and the perceived influence of social connections on health-related decisions. The findings revealed the presence of completely dense, emotionally cohesive networks within the substance using populations, yet they did not sufficiently explain the subjective meaning of these connections or their influence on participants' behaviour related to healthcare access.

Guided by the explanatory model, the study then transitioned into a qualitative phase employing ID, as the methodological approach. The qualitative interviews were designed to build directly upon the quantitative findings, with a specific focus on how participants experienced and interpreted their network structures in the context of motivating access to emergency healthcare services. In accordance with Ivankova et al. (2006) recommendations for integration, the qualitative sample was drawn purposefully from the original SNA participants, ensuring linkage between the two phases and enabling deeper insight into the quantitative trends. Unfortunately, three of the four Phase I participants had expired prior to the start of the second ID Phase of the study. The Phase II ID interviews took place, and patterns emerged such as the influences of pain, self-worth, and connection as central to understanding how participants were influenced to seek, avoid or refuse emergency care within their social contexts.

The implementation of this design adhered closely to Ivankova et al. (2006) emphasis on connected data collection and integration during interpretation. Integration occurred at multiple levels. The study employed purposeful convenience sampling and sequential data collection to ensure that each phase informed the next. Analytically, the quantitative findings, particularly the social network configurations, were used to frame and refine the qualitative interview questions, ensuring relevance and alignment with emerging patterns. Interpretively, the structural data from the egocentric network analysis were woven together with the insights from the ID phase to develop a cohesive, nuanced narrative about what influenced PWUD to access emergency healthcare services. This layered integration advanced both explanatory power and interpretive depth, in alignment with best practices for mixed methods research.

The rationale for selecting this design stems from its ability to combine the numerical breadth of quantitative analysis with the narrative depth of qualitative exploration. Social Network Analysis provided a structural overview of participants' social environments and tight, dense networks, while ID clarified the emotional meanings, behavioural drivers, and sociocultural influences embedded within those structures. This layered understanding enabled the study to move beyond description to interpretation illuminating both what patterns exist and why they are important.

Although traditional addiction discourse often represents PWUD as socially isolated or situated within fragmented and high-risk networks (Bourgois & Schonberg, 2009; Latkin et al., 2001; Valente, 2010), contemporary evidence shows that their social worlds are more complex and frequently structured by place based, relationally

meaningful ties. The mixed methods explanatory design used here was effective for addressing unexpected findings, including that all participants described densely connected networks alongside two very sparse networks. These findings challenge prevailing assumptions in the literature. As noted by Ivankova et al. (2006), explanatory designs allow qualitative follow up to contextualize quantitative anomalies. The interpretive description phase illustrated how dense networks may be both supportive and constraining depending on connection, trust, knowledge, emotional reciprocity, significance, and shared values regarding accessing emergency healthcare.

While the strengths of this approach include methodological rigor, theoretical depth, and participant-centred integration, it is not without limitations. The extended duration required for sequential phases, and the challenges associated with conducting interviews with a population experiencing extreme marginalization, many of whom face unstable housing, health crises, and criminalization, necessitated considerable time, resources and a flexible, trauma-informed research approach.

In summary, the use of a mixed methods sequential explanatory design, guided by Ivankova et al. (2006), enabled the study to construct a nuanced understanding of healthcare access in substance using populations that would not have been attainable through a single-method design. The integration of quantitative network data with qualitative interpretations provided a robust framework for analyzing both the structural and experiential dimensions of the influencing and motivating factors of PWUD to access emergency healthcare access.

3.4 Rationale for Social Network Analysis

To determine the most appropriate quantitative methodology, a comprehensive literature review was undertaken. Studies involving highly marginalized, substance-using populations have frequently utilized SNA and in particular egocentric network analysis, a subtype of SNA, that offers valuable insights into social capital, interpersonal connections, and contextual factors that influence personal behaviour by mapping and measuring relationships through visual and statistical metrics (Borgatti et al., 2018; Latkin et al., 1995; Valente, 2010). Egocentric network analysis focuses on an individual participant's immediate social environment, their egocentric network, by mapping the direct relationships or ties surrounding them and illustrating the variations in strength, support, and influence across relationships. These features illuminate how social resources are embedded within, and accessed through, personal networks. Egocentric network analysis also enables the identification of patterns in how information and resources circulate within personal networks and how these patterns shape health-related behaviours (McCarty, 2007; Smith & Christakis, 2008).This approach was deemed particularly well-suited for Phase I of the research, which aimed to explore factors influencing motivations to access emergency healthcare services.

3.4.1 Rationale for Interpretive Description

For Phase II, the qualitative component of the research, methodologies from social sciences such as anthropology, psychology, and sociology were examined. Ethnography, phenomenology, grounded theory, in addition to ID, were considered, each offering unique structures and associated strengths and limitations. Interpretive Description, developed by Thorne et al. (1997), was selected because it is specifically

designed for applied and practice disciplines. Its purpose is to generate insights that inform clinical decision-making and system improvements rather than to develop formal theory, while drawing methodological techniques from traditional qualitative approaches without adopting their theoretical constraints (Thorne, 2008). Interpretive Description builds on the quantitative findings by offering a deep, context-rich exploration of participants' perspectives, motivations, and lived experiences. Through in-depth qualitative inquiry, ID contextualizes and captures individuals' subjective experiences and perspectives, uncovering the underlying relational and emotional factors that influence their behaviours and decisions.

Together, SNA and ID provide a comprehensive view that integrates both structural and interpretive elements to enhance the explanatory capacity of the design and generate insights that are both empirically grounded and contextually informed that has not been found in the previous published research literature. The two phases of this study required separate research ethics approvals, study protocols, recruitment strategies, data collection tools and data analysis: Phase I SNA, the egocentric network analysis was conducted in 2022 followed in 2024 by the Phase II ID study.

3.5 Ethical Principles and Considerations

As a population experiencing extreme and complex vulnerabilities, ethical considerations were at the forefront during each step of the research process of this mixed methods study. The protocol and all procedures were approved by the Research Ethics Board at the University of New Brunswick (UNB) REB #050-2021. The protocol aligned with the Canadian Tri-Council Policy (TCP) Guidelines and UNB research policies (Canadian Institutes of Health Research, Natural Sciences and Engineering Research

Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2018, p. 5-67).

First, is the importance of understanding the risks associated with a study. According to the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2), minimal risk refers to the probability and magnitude of harm or discomfort anticipated in the research being no greater than those encountered in daily life or during routine physical or psychological tests (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2018). In the context of this study, involving PWUD, minimal risk would imply that the research procedures would not exceed the usual risks associated with their daily lives or standard interactions. This includes ensuring that any potential harm from participation, such as psychological distress or privacy concerns, would be mitigated through appropriate safeguards. For instance, when conducting interviews or surveys with individuals who use drugs, the researcher ensured confidentiality, obtained informed consent, provided support resources and was aware of and minimized respondent burden (TCPS, 2018).

Maintaining boundaries is another essential element of ethical research with PWUD, and to ensure that this was demonstrated, the parameters and purpose of the study were clearly outlined with each participant at the beginning of every interview. The participants were aware of their role, the researcher's role, and the obligation of the researcher to notify authorities should the participant disclose criminal acts that harmed others or if the participant disclosed activities of self-harm or suicide.

There is significant discourse in the literature concerning the cognitive ability of PWUD to provide informed consent. Paternalism, overprotection, and exclusion from studies minimizes the knowledge and insight of PWUD, and the value they bring to the research. It is unethical to assume that PWUD are incapable of providing informed consent due to substance use (McCall et al., 2020). The solution is to protect vulnerable individuals from harm while ensuring their rights are also protected so that they have an opportunity for self-determination (McCall et al., 2020; Steenkamp et al., 2010; TCP, 2018). As an experienced community health nurse, the researcher was sensitive to and aware of the potential for PWUD to have had previous negative experiences with professionals and feel suspicious and distrustful. For this reason, participants were reassured of the voluntary nature of the study before and after signing the consent. A more detailed discussion of this phenomenon is provided in a practical guide for working with this population in Appendix A.

Finally, as with any study, individuals were assessed for their level of intoxication, cognition, and capacity to understand the aims of the study, their role, and that of the researcher. As an experienced clinician working with PWUD, the researcher could assess intoxication through observation and verbal feedback from participants, ensuring their participation was voluntary.

3.6 Informed Consent Process

Written informed consent was obtained from each participant and performed in accordance with the Tri-Council Guidelines and the University of New Brunswick Research Ethics Board policies and is attached as Appendix B. The participants received a $30 gift card as compensation for their time, effort, and involvement in the study.

An Interview Guide, seen in Appendix C, was developed to support the researcher in providing the participants with consistent wording and questions (Verdejo-Garcia et al., 2018). Participants in this study were reassured prior to the interview that, they could pause or end the interview at any given time should they become upset during the interview and if they were to end the interview, they would still receive remuneration for their time. They were also encouraged that if they were to become upset, they could reach out to a friend of family member for support as an option to access any type of formal healthcare. All four participants declined to keep copies of the consent form as they felt they did not have any place to keep the document. All participants were able to read and write English and there was not any perception by the researcher of any language barriers during the interviews.

The interview questions were delivered in the same manner for consistency to each participant to mitigate bias and reduce errors or misunderstanding. Two journals were kept for the interview process. One journal was kept for notes and direct quotations from the participants for accuracy. This journal was used during the interview process. The second journal was created as a personal journal for the researcher. This allowed for the researcher to be reflexive with respect to their conversations with the participants,

which at times were emotionally difficult. Boundaries were maintained during each interview, and participants were aware of the researcher's role. The participants were aware prior to the interview of the researcher's obligation to notify authorities should they disclose criminal acts that harmed others, self-harm, or contemplated suicide.

3.7 Data Collection Procedures

This study explored the healthcare experiences of PWUD using two complementary research methods, SNA and ID, each requiring distinct eligibility criteria based on their methodological purposes. While both phases focused on individuals affected by substance use, the SNA phase required participants to be current, regular users, whereas the ID phase included individuals who had used substances regularly in either the past or present. Specific data collection procedures are provided in the methodology chapters.

3.7.1 Study Setting

The study took place in New Brunswick (NB), one of Canada's three east coast Maritime provinces, which has experienced consistent population growth in recent years. As of July 1, 2023, the provincial population was estimated at 834,691, reflecting a 3.1% increase from the previous year (Statistics Canada, 2024). The province's demographic landscape is predominantly rural, with urban populations concentrated in three major centres: Moncton, Fredericton, and Saint John and collectively account for approximately 27.5% of New Brunswick's total population as of 2023, highlighting their demographic significance within the province (Statistics Canada, 2023). (Human Development Council, 2024).

The study was conducted in Saint John, New Brunswick, a historic port city and Canada's oldest incorporated municipality. According to the 2021 Census, Saint John had a population of 69,895 (Statistics Canada, 2022). Over the course of the four-year study period, the city experienced sustained population growth. By July 1, 2024, the population reached an estimated 78,165, the highest level recorded since the early 1980s (City of Saint John, 2024). This growth reflects broader demographic trends in the Greater Saint John region, which welcomed approximately 2,861 people new residents in 2021, bringing the regional population to 135,622 by 2022 (City of Saint John, 2022).

Despite recent economic growth, socioeconomic inequities in Saint John remain substantial. The Saint John Human Development Council (2022) reported that more than 25 percent of children in the city live in poverty, and the overall poverty rate exceeds 29 percent. These levels far surpass national averages, which indicate a 16.1 percent child poverty rate and a 9.9 percent overall poverty rate (Government of Canada, 2024). Homelessness data further illustrate the depth of local disadvantage. In November 2023, 237 individuals were identified as experiencing homelessness in Saint John, with 77 percent categorized as chronically homeless (Human Development Council, 2024; Homeless Hub, 2023). Given a city population of 78,165, this represents a per capita homelessness rate of approximately 0.30 percent, closely aligning with rates observed in larger urban centres such as Vancouver, where the estimated 2023 rate was 0.33 percent (Homeless Services Association of BC, 2023). These intersecting structural vulnerabilities, including poverty, housing instability, and constrained access to healthcare, contribute significantly to the elevated risk of overdose and substance-related harm among PWUD.

In response to the opioid crisis, New Brunswick has significantly increased the distribution of take-home naloxone kits, aiming to ensure PWUD, their families, and first responders with tools to intervene during opioid overdose situations (New Brunswick Department of Health, 2024). Naloxone, a rescue medication temporarily reverses the respiratory depression caused by opioids (Canadian Centre on Substance Use and Addiction, 2022; World Health Organization, 2022). However, the efficacy of naloxone can be compromised by the potency of certain opioids, such as fentanyl analogs and does not address barbiturate, alcohol, or stimulant overdoses (Mayer et al., 2023; WHO, 2021). Despite increased access to naloxone, official records of drug overdose events in New Brunswick remains limited. Current data primarily reflects cases where paramedics administer naloxone, omitting information from an ED healthcare providers, law enforcement and fire fighter personnel, friends, family members, and non-profit agencies (New Brunswick Pharmacists' Association, 2025).

In addition, the mortality rates of individuals with an SUD, or those who are living unhoused, is not specifically recorded, nor is there clear documentation of deaths from other treatable or preventable medical conditions within the population of PWUD, and who are experiencing homelessness. The inability to access this important data may lead to a significant underestimation of all cause-specific mortality rates among PWUD in the community (Y. Legere, personal communication, October 15, 2024).

To address these gaps, New Brunswick's Chief Coroner's Office would like to meet with the researcher to discuss an enhanced data collection process to systematically track and report deaths among individuals experiencing homelessness, aiming to begin to

inform targeted interventions (Donkin, 2024). Similarly, other Atlantic provinces have implemented measures to address mortality rates and substance-related harms. For instance, Nova Scotia now publishes statistics on the living situations of individuals who die from drug toxicity (Government of Canada, 2022a), Prince Edward Island is exploring an electronic case management system to capture data on housing status and occupation (Government of Canada, 2022b), and Newfoundland and Labrador is in discussions with the Public Health Agency of Canada to also establish standardized data collection methods (Government of Canada, 2022a). These varied approaches underscore the need for standardized data collection methods to accurately assess the intersection of homelessness, health inequities, and substance use across Canada. Addressing the intertwined issues of homelessness, poverty, and opioid overdose in New Brunswick necessitates a comprehensive approach by all sectors in the community.

Phase I of the current study recruited PWUD who were actively using substances and had accessed emergency health care services at least once in the past twelve months. Phase II was designed to include a broader cohort of individuals who were both active and had a history of severe substance use disorder, with the intention of capturing a continuum of healthcare engagement, from consistent users of services to those who intermittently or entirely avoided services (Lewer et al., 2020; Pauly et al., 2015). This approach was informed by the researcher's clinical experience as a community health nurse and is supported by extant literature emphasizing the complexity of healthcare engagement among PWUD (Pauly et al., 2018).

3.7.2 Eligibility Criteria for Phase I and Phase II

For the purposes of this research, PWUD were defined as individuals 18 years of age or older living with an SUD who ingest, inhale, or inject unregulated and potentially contaminated substances, or who misuse prescription medications not prescribed to them or used in a manner inconsistent with medical guidance. Substance use included past or present use of illicit drugs such as cocaine, crack, ecstasy, crystal methamphetamine, or heroin, as well as prescription medications such as narcotics, sedatives, or stimulants when used outside the prescriber's intent. Participants were required to believe that their substance use had caused harm or negatively impacted their quality of life. Individuals who used only prescription medications as prescribed or whose substance use was limited to legal, regulated substances such as alcohol, tobacco, or cannabis were excluded.

Eligibility distinctions between phases reflected methodological objectives. Phase I required participants to be actively using substances to accurately map real-time social networks. Phase II included individuals with either past or present substance use to capture a broader range of healthcare experiences. This approach enriched the qualitative data and allowed for reflection on both current and historical encounters with emergency healthcare services.

3.7.3 Sampling and Recruitment Process

Recruitment strategies prioritized participant safety and accessibility. For Phase I, participants were recruited through purposive convenience sampling in person at Avenue B Harm Reduction Inc., a nonprofit organization recognized as a safe space for PWUD. Recruitment was facilitated by a peer support worker working at the front desk who was

aware of the eligibility criteria for Phase I and would direct clients to consider the study. The researcher was located in an adjacent room waiting for clients to approach and ask questions about the purpose and process of the study. Clients were then screened regrading their substance use by the researcher. Four participants met eligibility criteria were enrolled, consistent with sample size recommendations for SNA studies (Borgatti et al., 2018).

Phase II ID recruitment occurred in January and February 2024. Although the Research Ethics Board approved additional sites, safety concerns including increased violence, fires at homeless encampments, and fatalities necessitated limiting recruitment to Avenue B Harm Reduction Inc. This site provided a secure environment and immediate engagement opportunities, which participants preferred. The initial target was fifteen participants, consistent with ID guidelines (Thorne, 2008). To address attrition and enhance diversity, over-enrollment was employed, resulting in forty participants. This strategy reflects methodological flexibility and responsiveness when working with marginalized populations. Sampling combined purposive and convenience approaches to ensure representation and feasibility (Creswell, 2014).

3.7.4 Participants Enrolled in both Phase I and Phase II

A subset of participants engaged in both phases of the study, providing continuity between quantitative and qualitative components. However, there was a two-year gap from Phase I in 2022 when participants were recruited for the SNA and when the Interpretive Description Phase II in 2024 was conducted. This gap in time was a volatile period that intersected with the pandemic response, the overdose crisis, local housing

instability, service access, and drug supply period. These individuals contributed to the integration of findings by offering insights into both their social network structures and their lived experiences with emergency healthcare access. Their dual participation strengthened the explanatory power of the mixed methods design.

3.8 Approach to Data Analysis and Interpretation

Data analysis followed an explanatory sequential mixed methods approach. Phase I SNA data were examined using network metrics to identify structural patterns and relational dynamics influencing access to emergency healthcare services. Phase II qualitative data were analyzed using ID, employing iterative coding and thematic development to uncover experiential and contextual influences. Integration occurred through a comparative process that explored how network structures intersected with lived experiences, generating a comprehensive understanding of the mechanisms shaping emergency healthcare engagement among PWUD.

The explanatory sequential mixed methods design offers notable strengths, particularly its ability to integrate quantitative and qualitative approaches to capture both structural and experiential dimensions of healthcare access. SNA provides systematic insights into the configuration and influence of social relationships, enabling identification of patterns that shape healthcare behaviours (Borgatti et al., 2018). Interpretive Description complements this by uncovering contextual meanings and lived experiences, producing practice-relevant knowledge that informs clinical decision-making and policy development (Thorne, 2016a). This combination enhances the comprehensiveness and applicability of findings (Creswell & Plano Clark, 2018).

However, limitations include the complexity of integrating two distinct methodological traditions and challenges in sequencing phases, such as delays between data collection stages or difficulties maintaining participant engagement (Creswell & Plano Clark, 2018; Thorne, 2016b). Additional constraints involved time and financial resources required for two phases, as well as physical, social, and emotional burdens experienced by PWUD during participation. Despite these challenges, the design was well suited to the study's purpose, enabling a nuanced understanding of the interplay between social structures and individual experiences in shaping their decision to access healthcare.

3.9 Conclusion Chapter 3

This chapter outlined the philosophical assumptions, theoretical frameworks, and methodological design guiding the study. It described ethical considerations, informed consent procedures, and detailed data collection strategies, including instruments, eligibility criteria, sampling, and recruitment. Finally, it introduced the analytic approach and integration strategies that connect the quantitative and qualitative phases through the reflexive positioning of the researcher in understanding the importance of mattering for PWUD to access emergency healthcare services. These elements establish coherence between the research purpose and methodological choices, providing the foundation for the detailed presentation of SNA and ID methodologies and findings in Chapters 4 and 5.

Chapter 4: Social Network Analysis and Phase I Results

This chapter presents the application of SNA as the first phase of a mixed methods sequential explanatory design to examine factors influencing PWUD in accessing emergency healthcare services; focusing on individuals who are reticent to access ED services, are unhoused, transient, experiencing mental illness and living with one or more substance use disorders. SNA provides a structural perspective for understanding how relational dynamics shape decisions and behaviours (Borgatti et al., 2018; Crossley et al., 2015).

The discussion begins with the historical context of SNA, followed by methodological foundations, terminology, visualization, and key theoretical concepts. The study design and purpose are then described, along with data collection procedures, recruitment strategies, tools, and ethical considerations. The chapter concludes with methodological rigor, participant characteristics, network composition and structure, and unexpected findings that informed the qualitative phase.

4.1 Historical Context of Social Network Analysis

Social Network Analysis originated in the early twentieth century as an interdisciplinary approach grounded in sociology, anthropology, and psychology, with its roots in efforts to understand relational structures rather than isolated individual attributes. Early developments included Jacob Moreno (1889–1974), whose sociometry in the 1930s introduced systematic mapping of interpersonal ties. Anthropologists such as John Barnes (1918–2010) and Elizabeth Bott (1924–2016) later applied network concepts to kinship and community structures. By the 1970s, Harrison White (1930–2024)

advanced SNA into a formalized structural framework, and subsequent works by Stanley Wasserman and Katherine Faust provided comprehensive analytical tools for its application (Borgatti et al., 2018).

Although SNA is sometimes described as a single method for analyzing relationships, it is best understood as a methodological approach encompassing multiple theories, concepts and techniques for collecting, analyzing, and interpreting relational data across diverse contexts (Crossley et al., 2015).

4.2 Methodological Foundations

Social Network Analysis is a methodological approach that examines patterns of relationships among individuals or entities within a network. Two primary forms exist: sociometric, which analyzes entire networks (e.g. social platforms, community organizations, schools, and classrooms), and egocentric, which focuses on one individual, the ego, and their immediate social connections, or alters, including the relationships among those alters.

This study employs egocentric SNA to explore the personal networks of PWUD and their influence on health-related decisions (Borgatti et al., 2018; Crossley et al., 2015). For the purposes of this dissertation, SNA will refer exclusively to egocentric SNA. Structural attributes of SNA networks include size, density, and composition, along with relational qualities such as trust, emotional support, and frequency of interaction (McCarty, 2002).

Access to healthcare for PWUD is conceptualized as a socially embedded process shaped by relational dependencies and contextual factors (Valente, 2010). SNA addresses

gaps in existing research by mapping and quantifying the flow of social capital, resources, and support within personal networks, offering insight into mechanisms that both enable and constrain healthcare engagement (Latkin & Knowlton, 2015).

4.3 Terminology and Visualization

Personal network data were collected through semi-structured interviews (Campbell & Lee, 1991) and analyzed using network analysis software (UCINET and NetDraw) (Borgatti, 2002). Participants identified individuals (alters) within their personal networks based on study criteria, described key attributes of each alter, and indicated whether alters knew one another. In line with standard practice, the ego is removed from network visualizations, as all alters are assumed to be connected to the ego (Borgatti et al., 2013). This approach facilitates examination of structural characteristics such as network size, density, and composition (see Table 2).

Table 2

Social Network Analysis Terminology

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1. Ego – The individual upon whom the network is based.
2. Alter – Person named by the ego as being known to them.
3. Node – An individual in the network, visually represented by a point or dot.
4. Tie – Interaction or relation between two nodes, visually represented by a line.
5. Size – The number of alters named by the ego.
6. Density – Overall connectedness in the network measured by the number of ties in the network as a proportion of all possible ties.
7. Degree centrality – Number of ties an individual sends to or receives from other nodes in the network.

8. Betweenness centrality – The degree to which an individual lies on the shortest paths connecting other individuals in the network.

9. Attribute - Refers to a characteristic or property of the node or alter in an egocentric network. Attributes can be used to analyze how personal traits influence network structure and relationships. (Freeman, 1979).

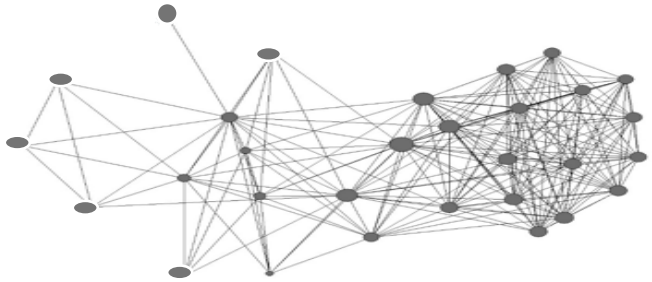
10. Homophily - Refers to the tendency for individuals to form social ties with others who are similar to themselves in characteristics such as demographics, attitudes, or behaviours. In other words, contact between similar people occurs at a higher rate than among dissimilar people (McPherson et al., 2001).

11. Isolate – A node that is not connected to any other node.

Figure 9 illustrates an egocentric network visualization. The ego is excluded from the figure because they are assumed to be connected to all identified alters; the visualization instead depicts the relationships among alters and how they are connected to one another. In some instances, densely connected networks may provide cohesive support during a health crisis, whereas sparse, loosely connected networks may have limited capacity to offer coordinated assistance (Borgatti et al., 2018). Mapping these network structures helps identify influential individuals and relational ties that may facilitate or constrain access to resources and care (Valente, 2010).

Figure 9

Visual Representation of an Egocentric Network



Note. This figure, created, and with permission, by C. Hamilton (2019), represents a visualization of an egocentric network. It depicts the ties or lines (connections) between the alters or nodes/dots (persons) identified by the ego. The ego is not shown, as it is understood to be connected to all alters.

4.4 Foundational Theories and Key Concepts

Social Network Analysis is a mathematical approach and based upon sociological theories. Graph theory provides the structural basis by conceptualizing networks as nodes (individuals) and ties (relationships), enabling analysis of properties such as centrality and density (Borgatti et al., 2018). Empirical theories and concepts explain social dynamics within networks**:**

Social Capital Theory views networks as sources of trust and resources that facilitate cooperation (Coleman, 1988; Putnam, 2000).

Exchange Theory emphasizes reciprocity and resource exchange as drivers of tie formation (Blau, 1964).

Strength of Weak Ties highlights the role of weak ties in bridging networks and providing access to novel information (Granovetter, 1973).

Homophily is a concept that refers to the tendency for individuals to associate with others who are similar, shaping network composition and influence (McPherson et al., 2001). Together, these theories and concepts explain how network structures and relational dynamics influence PWUD to access emergency healthcare services.

4.5 Mixed Methods Sequential Explanatory Research Design

Phase I employed SNA to generate quantitative insights into the structure and composition of PWUD networks. These findings were expected toinform Phase II, which was planned to explore the mechanisms underlying observed patterns through qualitative interviews. The design was planned so that quantitative results would guide the development of qualitative questions, enhancing explanatory depth and methodological rigor. The study utilized a mixed methods sequential explanatory design to investigate social and relational factors influencing emergency healthcare access among PWUD. This design consists of two phases: an initial quantitative phase followed by a qualitative phase, where the second phase typically builds upon and elaborates the findings of the first (Ivankova et al., 2006). In this study, Phase I involved egocentric SNA, and Phase II planned interpretive description (ID) to provide contextual understanding to the results of Phase I.

The underlying premise is that quantitative data would offer insight into network structures and supports for PWUD, while the qualitative data would provide deeper understanding of participants' perspectives and lived experiences (Creswell & Poth, 2018; Tashakkori & Teddlie, 2010). This integration would normally strengthen the explanatory power of the research by combining structural analysis with narrative

interpretation, ensuring that the complexity of social and relational influences on PWUD healthcare access would be fully explored.

4.6 Purpose of Social Network Analysis Phase I

This phase of the study employed SNA to achieve three primary objectives:

1. Identify and understand the social networks of the participants.

2. Explore the factors that motivated or influenced PWUD to access emergency healthcare services.

3. Understand feasible and practical approaches for engaging with PWUD.

Having established the purpose of Phase I, the next section outlines the procedures used to collect, analyze, and visualize personal network data through SNA.

4.7 Data Collection Tools

Semi-structured, one-on-one interviews captured sociodemographic and egocentric network data using four tools:

1. **Ego Demographics** – Collected individual-level information such as age, gender, substance use patterns, and health behaviours (Appendix D).

2. **Alter Name Generator and Attributes** – Identified significant individuals in the participant's network and gathered attributes such as relationship type, frequency of interaction, and perceived influence on healthcare decisions (Appendix E).

3. **Alter Attributes Summary** – Consolidated alter data, including age, substance use, communication patterns, and willingness to assist with health concerns (Appendix F).

4. **Alter-Alter Ties** – Explored relationships among alters to understand internal network dynamics and influence on healthcare access (Appendices G–H).

These tools enabled a comprehensive assessment of each ego's relationships and social environments and attempted to examine the impact on emergency healthcare utilization (Borgatti et al., 2018; Valente, 2010). Once tools were administered sitting side by side with participants, interviews were conducted in a manner that prioritized participant comfort and ethical integrity.

4.7.1 SNA Phase I Participant Questionnaire Completion

The questionnaires were completed at a local needle exchange as this was considered by participants to be a safe environment. Comfort measures were provided and completing questionnaires lasted approximately 60 minutes (see Appendices D, E, F G, H, J). Questionnaire questions were read aloud by the researcher to participants to accommodate their inability to read, focus, and/or respond. The answers to the questionnaires were not audio-recorded due to participant preferences. The answers to the questionnaires were documented through handwritten notes. The researcher maintained two journals: one for notes on questionnaire answers and direct quotes, and another journal was maintained for the researcher's personal reflections. Ethical boundaries were communicated clearly, and participants were informed that disclosures of self harm, harm to others or criminal activity had to be reported. Each participant received a $30 Tim

Horton's gift card and were reassured of the voluntary nature of their study participation. A master list of participant codes is provided in Appendix I. Given the complexity of the responses to the network questionnaire a, respondent burden, i.e., memories of people they had known but have since passed away, was monitored and addressed throughout the process. After four participants had completed the questionnaire, the researcher deemed the respondent burden was too high for this vulnerable population to ethically continue data collection after identical results, i.e., fully dense networks, were noted (Borgatti et al., 2018).

4.7.2 Recognizing the Importance of Respondent Burden

Respondent burden, defined by McCarty, as the effort and stress experienced during network surveys was a central consideration (2002). Strategies to minimize burden included:

- Providing reassurance and informal support
- Offering refreshments and a private setting
- Using visual aids to support engagement (Appendix J)
- Simplifying language and questions for clarity

Despite these measures, some participants experienced emotional distress due to unstable living conditions and trauma histories. Formal support services were offered but declined; participants preferred informal debriefing with friends and peers. Ethical considerations were therefore critical to maintaining participant safety and trust.

4.7.3 Ethical Considerations with Vulnerable Participants

Ethical approval was obtained from the University of New Brunswick Research Ethics Board (REB File #050-2021). Informed consent was secured prior to data collection. A harm reduction and trauma-informed approach guided all interactions to ensure confidentiality, safety, and voluntary participation. Following ethical clearance, network mapping and analysis were conducted through supportive specialized software.

4.7.4 Network Mapping and Software

UCINET 6 © was used for computational analysis and NetDraw© for visualization. Metrics such as network density and alter-alter ties were calculated, and sociograms were generated to illustrate network structures according to the data provided. To ensure methodological rigor, standardized procedures were applied consistently across all analyses.

4.8 Methodological Rigor and Data Analysis

Social Network Analysis employed a structured name generator approach (see Appendix E), through which participants identified up to twenty alters who provided emotional, informational, or material support, and indicated whether these alters knew one another. These data were used to calculate network density (Valente, 2010) and to generate sociograms Rigor was maintained through:

- Clear operationalization of constructs
- Standardized interview guide across participants
- Consistent use of UCINET© and NetDraw© for all analyses

Transparent documentation and systematic procedures supported validity, reliability, and replicability. The next section presents participant network characteristics, offering a descriptive overview of how social support structures may shape, facilitate, or constrain healthcare engagement.

4.8.1 Social Network Analysis Participant Characteristics

Four participants (two male, two female) with a median age of 47.5 years were enrolled in the study (see Table 3). All participants described challenges related to poverty, particularly food insecurity and difficulty securing safe housing. Two participants lived in unstable housing, while two were unhoused. Daily substance use was reported by all participants, including methamphetamine, crack cocaine, heroin, marijuana, and alcohol. Three participants were enrolled in methadone maintenance therapy. Each participant reported living with chronic pain and multiple health issues.

Table 3

Participant Demographics and Substance Use Characteristics (n=4)

Age	
Median	47.5
Range	29-57
Gender	
Male	2
Female	2
Other	-
Housing Status	
Apartment	2
Shelter/tent/homeless	2

Substances Used	
Crystal Methamphetamine	2
Heroin	1
Crack	2
Cocaine	0
Fentanyl	1
Dilaudid ©	0
Marijuana	4
Benzodiazepine	0
Alcohol	3
Nicotine	4
Other: methadone	3
Frequency of Substance Use	
Daily	4
Q3-4 days / Weekly / Monthly	-
Frequency of Hospital Visits	
3+ times per year	1
6+ times per year	3
Health Concern	
MD Community Clinic	2
Nonprofit Agency	1
Friend	1
When Feeling Really Sick	
Emergency Department	1
Nonprofit Agency	1
Ambulance	1
Refuse Care	1
Long Term Health Conditions	
Heart Disease	1
Kidney Disease	1
Liver Failure	1
Chronic Pain	4
Use Drugs with Someone	
Always with someone	2
Sometimes / Often / Rarely	-
Always alone	2

Note. This table summarizes demographic and substance use data for the study participants (n = 4). Data collected during Phase I interviews.

All participants were living with chronic pain, serious long-term health conditions, and one participant was a palliative care patient. Participants reported varying levels of engagement with healthcare services in the previous 12 months with three individuals reporting more than six visits to healthcare services and one participant stating they had engaged services fewer than six visits. When asked who they would approach with health concerns one participant stated a medical doctor, another preferred a community health clinic, another would go to a non-profit agency, and another said they would approach a friend. When asked if they were very sick who would they go to for help, again there was high variability in their responses. One participant stated they would go to an ED, another would go to a nonprofit agency, another would call an ambulance, and one participant stated they would refuse care. All of these responses were numerically coded, and data was entered into the UCINET-6 © software program. Analysis revealed a density of 1.0, and this precluded any other meaningful results from being calculated due to the lack of variation (Borgatti et al., 2018)

4.9 Network Composition

Participants used pseudonyms and had varying numbers of alters: Cohen 17 (n=6), Levi (n=20), Wendy (n=11), and Monkey (n=20). Social networks varied in gender composition; two women and one man had female-dominated networks, while the second man had more male alters. Communication occurred primarily in person between themselves and the alters (71%). Across all four participants, 57 alters were identified, with a median age of 48 years and an average relationship length of 8.5 years. There was a range of alters for participants from six to twenty; with one participant citing six alters,

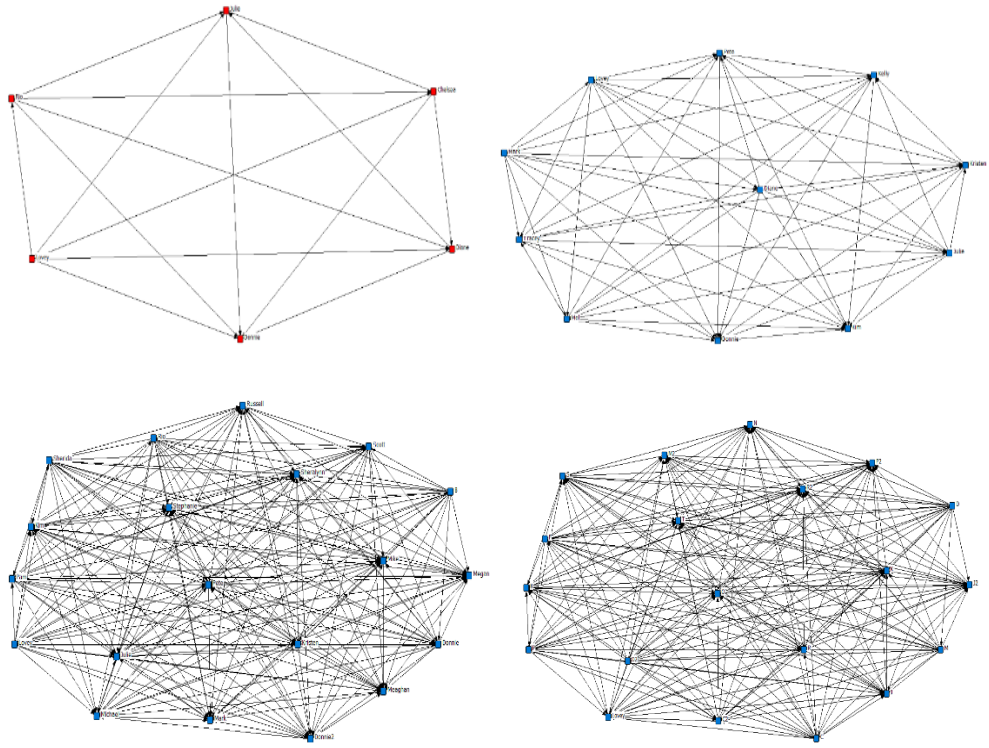
one participant had 11 and the remaining two participants had 20 alters. During the interview and completion of the SNA questionnaire, participants were aware they were allowed to state if they were unsure if the alters knew one another, or if the alters attributes, i.e., age, were unknown. No tie codes were stated as unknown. These descriptive characteristics provide context for understanding the structural features of the networks analyzed in the next section.

4.9.1 Network Structure

All participants (n=4) knew one another prior to the study. All four networks demonstrated a density score of 1.0 (see Figure 10), meaning each alter in the individual networks knew every other alter. Therefore, centrality analyses could not be calculated due to the lack of variation in the collected data. High-density networks indicate cohesive social systems but also limits exposure to new resources or ideas (Valente, 2010; McCarty, 2002). The following figure illustrates the complete interconnectedness observed across the four networks.

Figure 10

Visualization of Ego Network Density



Note. Data source: UCINET© data from participants in the SNA Phase I study. Cohen 17 and Wendy have sparse networks.

4.10 Results: Unexpected Network Density

The discovery of completely dense networks was unexpected as this is an empirically rare occurrence (Borgatti et al., 2018), meaning in each network, all of the alters knew one another. This finding of fully dense networks was found in both sparse and maximized networks. The sparse networks, i.e., Cohen 17 and Wendy (n=6 and n=

11 respectively) as well as the more complicated networks for Monkey and Levi also had a density of 1.0. Therefore, analysis of cliques, isolates, brokerage, and bridging could not be conducted which were essential for addressing the SNA study objective focused on identifying factors that motivate or influence PWUD decisions to access emergency healthcare services.

Completely dense networks provide strong emotional support for PWUD but limit their access to diverse or external social capital (Borgatti et al., 2018; Granovetter, 1983; Voon et al., 2014). In this study, alters and egos shared lived experiences, including poverty, substance use, and housing instability. While network density revealed interesting and important patterns indicating that PWUD are strongly interconnected to one another and not to anyone outside of their immediate social circle, however, due to the fully dense networks analyses could not be completed to help explain participants' motivations or experiences. In addition, the questionnaires were difficult for the respondents to complete as they recalled a time with friends, and family members prior to the challenges living with an SUD. To interpret the SNA quantitative findings more fully, the study progressed to the qualitative phase using ID, which explored the significance of these insulated relational patterns from participants' lived experiences and perspectives.

4.11 Conclusion Chapter 4

Phase I applied SNA to examine the structure and composition of personal networks among PWUD. Using egocentric network data, the analysis revealed that all networks had a density of 1.0, meaning every alter was connected to every other alter. This finding was unexpected, as complete density and homogeneity are rarely reported in SNA literature. While completely dense networks can provide strong emotional support,

they often restrict access to diverse or external social capital, which may limit opportunities for healthcare engagement (Borgatti et al., 2018; Granovetter, 1983; Voon et al., 2014).

A density score of one also precluded the calculation of other important structural measures, including degree centrality, which reflects the number of ties an individual sends or receives, and betweenness centrality, which indicates the extent to which an individual lies on the shortest path in connecting to others in the network. These limitations underscore the need for additional inquiry beyond structural metrics.

The networks in this study were characterized by shared lived experiences among alters and egos, including poverty, substance use, and housing instability. Although density provided insight into structural cohesion, it could not explain the motivations, meanings, or decision-making processes underlying these patterns. To address these gaps, Chapter 5 introduces the qualitative phase of the study, which employs ID to explain how participants perceive their social networks and how these interpretations influence decisions to access emergency healthcare services.

Chapter 5: Interpretive Description and Phase II Study Results

Interpretive Description, developed by Sally Thorne in 1997 as a non-categorical applied qualitative research methodology that moves beyond traditional descriptive approaches by offering an interpretive lens to explore the complexities and subtle contextual differences in human experiences. Interpretive Description is particularly distinct in its ability to bridge theory and practice, making it well-suited for research aimed at informing applied healthcare interventions (Thorne, 2016a). The decision to employ this methodology was guided by its capacity to address the complexity of the research questions, capture the intricate dynamics of vulnerable patient health experiences, and generate insights that were meaningful, pragmatic, and applicable to the researcher's clinical nursing practice.

Interpretive Description is both a form of disciplinary knowledge and a methodological approach to qualitative research. It is particularly well-suited for explanatory studies, as it aligns with a constructivist and naturalistic orientation that values the interpretation and co-construction of human experiences (Thorne, 2008, 2016). This perspective holds that individuals construct meaning through their interactions and experiences within natural, real-world contexts, without external interference (Denzin & Lincoln, 2018; Lincoln & Guba, 1985). Interpretive Description emphasizes understanding complex phenomena by interpreting subjective experiences in context, making it especially relevant for the cohort of PWUD who actively refuse or avoid emergency healthcare services. The discovery of these motivating factors informs the development of patient-centred interventions aimed at improving healthcare access and responsiveness for a marginalized population.

5.1 Methodological Foundations of Interpretive Description

Methodologies represent systematic and theoretical frameworks that guide research design, the 'blueprints' that rationalize the use of specific approaches. Each methodology carries its own assumptions, rules, and strategies for addressing research questions (Sandelowski, 2000; Creswell, 2014). Often in clinical research, attempts to apply traditional theory-driven qualitative social science methodologies have resulted in "methodological slurring," where clinical researchers struggle to fit practice-based questions into rigid frameworks (Morse & Field, 1995; Sandelowski, 1989). To address designed for applied disciplines such as nursing, where the goal is to generate clinically relevant insights rather than abstract theory (Thompson Burdine et al., 2021).

This study employed a mixed methods sequential explanatory design, integrating SNA with ID to explore what factors motivate PWUD to access emergency healthcare services. While SNA provided structural insights into social connections and social capital influencing healthcare decisions, ID offered a flexible interpretive lens to examine the nuanced, context-dependent experiences underlying these patterns. This combination ensured that quantitative findings were complemented by rich qualitative interpretations grounded in nursing practice.

5.1.1 Theoretical Foundations of Interpretive Description

Interpretive Description, as conceptualized by Thorne, is rooted in constructivist and naturalistic traditions that value the co-construction of meaning within real-world contexts (Thorne, 2008, Thorne, 2016a). It prioritizes understanding health-related phenomena in ways that are dynamic, contextually relevant, and directly applicable to

clinical practice. Unlike traditional qualitative methodologies that emphasize theory generation or philosophical essence, ID bridges theory and practice, producing actionable insights for applied health disciplines.

As a nurse and researcher, ID was particularly resonant because it aligned with the research question and the complexity of participants' lives. PWUD often experience intersecting vulnerabilities, including homelessness, an SUD, and mental illness. Interpretive Description's flexibility allowed the researcher to capture these multidimensional realities without imposing rigid theoretical constraints. Central to ID is the integration of "wholes" and "parts." The wholes represent the broader context of a patient's life, social, emotional, and cultural dimensions, while the parts refer to clinical specifics such as symptoms, treatments, and physiological processes. Nursing practice depends on synthesizing these perspectives to deliver care that is both individualized and comprehensive (Thorne, 2016a).

This framework moves beyond reductionist thinking, emphasizing that PWUD are not defined solely by symptoms such as pain or withdrawal. For example, a 25-year-old woman living with an SUD may also be a single parent and an artist. These identities are integral to her being and must inform care planning. By considering both wholes and parts, ID supports context-sensitive interventions that reflect the complexity of real lives (Thorne, 2008). This adaptability was essential for the study, enabling a departure from excellent, yet rigid social science theories, toward a methodology that mirrored the dynamic and often chaotic nature of participants' experiences.

5.1.2 Epistemological Hardwiring and Reflection

A defining feature of ID is its acknowledgment of "epistemological hardwiring" the deeply embedded assumptions and professional lens that researchers bring to the inquiry process (Thorne, 2008). For nurses, this hardwiring stems from clinical training and decades of experiential knowledge, shaping perceptions of legitimate evidence and influencing methodological choices. In this study, the researcher's 40 years of nursing experience informed the framing of questions, participant interactions, and interpretive processes.

Recognizing and managing this hardwiring was critical to maintaining methodological integrity. Reflexivity served as the primary strategy for mitigating bias and ensuring openness to emergent insights. This involved continuous self-examination through journaling, consultation with committee members, engagement with scholarly literature, and professional counselling. These practices allowed the researcher to interrogate assumptions and remain responsive to participants' sometimes violent and tragic narratives. While hardwiring is inevitable, ID positions it as a resource rather than a liability, leveraging clinical expertise while demanding critical reflection to prevent distortion of findings (Thorne, 2016a; Thorne, 2025).

5.1.3 Comparison with other Qualitative Methodologies

Phenomenology, grounded theory, and ethnography were considered but ultimately deemed less appropriate for this study's aims. Phenomenology, as described by Giorgi (2009), seeks to uncover the essence of lived experience through rigorous description and bracketing of researcher assumptions. Phenomenology is excellent for

understanding the deep, subjective meaning of experiences, but because it is rooted in philosophy and focuses on describing the essence of those experiences rather than applying them to real-world practice, it does not easily produce findings that can be directly used to guide clinical decisions or interventions.

Grounded theory, articulated by Glaser and Strauss (1967), emphasizes systematic coding and constant comparison to develop explanatory models. Although robust for theory generation, it was misaligned with this study's purpose, which prioritized interpretive insights over formal theory construction.

Ethnography, traditionally rooted in anthropology, focuses on cultural immersion and prolonged observation to understand social norms and behaviours within a community (Hammersley & Atkinson, 2019). While ethnography offers rich cultural insights, its emphasis on extended fieldwork and cultural interpretation was not feasible given the study's often transient and paranoid population, the time limit, design, and objectives. Furthermore, ethnography often prioritizes cultural description over clinical applicability, making it less suited for generating actionable findings for nursing practice.

Interpretive Description occupies a pragmatic middle ground, offering methodological rigor while producing clinically relevant knowledge. Its flexibility and applied orientation made it the most suitable choice for integrating qualitative interpretation with quantitative SNA findings, ensuring that the study outcomes inform nursing interventions and health policy for marginalized populations (Thorne, 2016a). Building on the theoretical foundations and methodological rationale outlined above, the following section describes Phase II of the study, which employed ID to deepen an understanding of the factors influencing PWUD to use emergency healthcare services.

5.2 Purpose of Phase II Study

The use of ID in Phase II of the study served two interconnected purposes. First, it sought to identify and explain the factors that shape and motivate PWUD to access emergency healthcare services. Second, it aimed to delineate the research skills necessary to establish empathic and meaningful engagement with PWUD, fostering trust and facilitating authentic knowledge generation. By moving beyond description, ID generated practice-relevant insights that complemented the quantitative findings from SNA, resulting in a more comprehensive understanding of healthcare access among this population.

5.3 Data Collection Procedures

Transitioning from purpose to process, data collection in Phase II was guided by the flexible and pragmatic orientation of ID. Methods are the tools used to investigate research phenomena (Creswell & Poth, 2008), and in ID, they are incorporated as needed to address the complexity of the research question (Thorne, 2008). This adaptability allows ID to draw on techniques from other qualitative traditions, such as constant comparative analysis from grounded theory, field notes from ethnography, and semi-structured interviews from phenomenology (Glaser & Strauss, 1967; Giorgi, 2009; Hammersley & Atkinson, 2019; Savage, 2000; Thorne, 2025).

Evolving from nursing practice, ID remains firmly grounded in addressing everyday issues within applied disciplines (Thorne, 2008). It encourages researchers to ask questions such as: *"What is happening here?" "What am I learning about this?"*, and *"What variations exist?",* questions that uncover connections and patterns within

complex human experiences (Thorne et al., 1997; Thorne, 2025). These guiding principles informed the design and execution of data collection in the study.

5.3.1 Interpretive Process

Following informed consent (Appendix K), participants completed a demographic questionnaire (Appendix L). Open-ended, semi-structured interviews were conducted at the needle exchange site, providing a safe and familiar environment for participants. The purpose was to elicit perspectives on what precipitated or influenced their decisions to access emergency healthcare services.

With ID, interviewing goes beyond formal questioning to "explore the contradictions and convolutions of human experience," with the researcher taking an active, engaged role (Thorne, 2008, p. 124). This was achieved through prompts and a conversational style that encouraged openness. Examples of prompting questions included:

- "Can you tell me about your health?"
- "Have you ever had to go to the hospital?"
- "Can you tell me why you went or why you didn't go to the hospital?"
- "Was there another time you felt you needed to go to the hospital?"
- "What was going on before you went to the hospital?"

- "What kind of day were you having on the day you went to the hospital?" (See Appendix M for full guide.)

To ensure high-quality data, the researcher-maintained attentiveness, eye contact and neutrality, fostering rapport and respect throughout the process. Interviews were iterative, supported by note-taking, journaling, and memo writing to enhance credibility and document decision-making. Handwritten notes were immediately transcribed and elaborated upon within one hour of completing the interview. Descriptions of the interview was also described in detail, i.e., weather, during transcription similar to the transcription/description process conducted in Phase I. Regular meetings with the supervisory committee provided opportunities for discussion and clarification regarding data collection and analysis. Having outlined the interview process and strategies for ensuring data quality, the next section addresses respondent burden and the measures taken to minimize its impact on participants.

5.3.2 Recognizing and Managing Respondent Burden

During the interview process, participants were required to focus and provide details about their health, experiences, and decisions related to accessing emergency healthcare services. Discussing these personal situations was often difficult for PWUD, as they recounted the pain of their health conditions and the stigma and discrimination they experienced from healthcare providers.

In Phase I, the egocentric SNA study revealed similar challenges. Participants reported that completing interviews was cognitively and physically demanding. They struggled to concentrate and often experienced withdrawal symptoms during the sessions.

Recalling past experiences was particularly difficult, as it required revisiting periods before their addiction and remembering friends and family lost due to addiction-related behaviours. Long-term substance use, combined with a history of overdoses and chronic health conditions, further impaired memory, and concentration (Kendall et al., 2020).

Participants in Phase I provided several recommendations for future research with PWUD, which are listed in Appendix N. These recommendations were intentionally incorporated into the design, recruitment strategies, and interviews for Phase II to minimize respondent burden.

To reduce burden, and based on both published literature (McCarty, 2002) and verbal feedback from Phase I participants, the following strategies were implemented:

1. Care and comfort were prioritized by creating a safe space with snacks and refreshments.

2. A respected community member provided visible support for the study, signaling trust and encouraging participation.

3. Interviews were conducted in a quiet, uninterrupted location.

4. Scheduling was flexible and avoided high-stress days, such as social assistance cheque distribution dates.

5. Most interviews were held before noon, allowing participants on substitution therapy to receive medications beforehand and feel more relaxed. (Methadone is a long-acting opioid agonist and form of substitution therapy that stabilizes brain

opioid receptors, preventing withdrawal symptoms and reducing cravings, which allows individuals with SUD to feel more focused, calm, and physiologically balanced).

6. Awareness of neighborhood stressors, such as police activity or overdoses, informed scheduling to avoid disruptions.

7. Participants were reassured that they would receive an honorarium regardless of whether the interview was completed.

8. Participation was emphasized as voluntary, with no pressure to continue.

9. Support from friends and peers was permitted without question, as outlined in the consent process.

In summary, interviews were open-ended, semi-structured, and conducted in a mutually acceptable, safe location. Participants were reminded that the study was voluntary and that questions were welcomed.

Sensitivity to participant concerns was critical. In Phase I, participants requested that interviews not be audio-recorded due to negative past experiences with law enforcement, social services, and child welfare. This preference was respected in Phase II, where eight of the 40 participants opted out of recording, and handwritten notes were taken instead. Confidentiality was maintained throughout the study. All personal information was de-identified, and participants selected unique code names. Consent forms, journals, and master lists of participant identifiers were stored separately from transcripts in locked cabinets in secure university offices. Participants were informed that

all data would be destroyed after three years. Having addressed respondent burden and ethical considerations, the following section outlines the analytic strategies used to interpret the qualitative data collected during Phase II.

5.4 Interpretive Description Data Analysis

According to Thorne (2008), data analysis is "unquestionably the most painfully difficult and yet the most essential element in what constitutes a credible interpretative description study" (p. 141). In ID, data collection and analysis occur concurrently to maintain scientific rigor, ensuring that interpretation is based on what is learned rather than any previous biases or knowledge of the researcher (Thorne, 2008). While description in ID is straightforward, interpretation is a slow, methodical process that requires time and patience as the data is interrogated for similarities, differences, and patterns.

Traditionally, coding is undertaken as an initial step to develop data into patterns and eventually arrive at a basic understanding of social processes (Cresswell & Cresswell, 2018). Thorne identifies that there is a risk of losing the voice of the subjects when conducting a rigidly structured analysis of the data; therefore, the key to coding in ID is to keep the codes very broad, focusing less on counting "words and expressions" and paying closer attention to ideas and patterns (Thorne, 2008, p. 145). Data analysis in ID involves finding patterns among pieces of data and interpreting them in a manner that is considerate of both the research question and the disciplinary standpoint (Thorne, 2010).

In this study, by repeatedly comparing pieces of interview data across participants and examining commonalities and differences, patterns of human experience were uncovered (Thorne, 2008). Guided by techniques of template analysis (Appendix O) and a constant comparative approach, every piece of data was compared, and connections and similarities were highlighted (Thorne, 2016a). Data was grouped and rearranged in multiple ways, by age, gender, education, and housing situations, then reorganized to examine substances used, with or without alcohol and cannabis, whether use occurred alone or with others, and overdose history (Winniker et al., 2020). At this point, the data transformed into patterns, and by reflecting on these patterns, the researcher was able to consider meanings both individually and collectively, contributing to knowledge that was not visible prior to the study (Thorne, 2016a).

In the template analysis process, patterns such as substance use, homelessness, and poverty were created as a starting point. Initially, five transcripts were reviewed, and using the template, these patterns were developed, and new ones were written in. It was an iterative process, working slowly from the transcripts to broader patterns, inductively adding more to the participant interviews (Braun & Clarke).

Understanding street terminology was absolutely essential while working with PWUD and reviewing the transcripts (Appendix P). The data analysis was done by hand as encouraged by Thorne (2016) rather than by data management software programs. The patterns took shape as participants expressed complex ideas and beliefs about their health and health experiences, supported by transcripts throughout the analysis process.

Thorne (2016) does not explicitly prohibit the use of qualitative data analysis software; however, she consistently cautions against excessive dependence on these tools. One of her central concerns is the risk of mechanization, as software can shift the analytic process toward a technical exercise in coding and sorting rather than supporting the reflexive and iterative engagement with data that ID requires. A second limitation is the fragmentation of meaning since programs often divide data into small, coded segments, which can obscure the contextual richness and whole narratives essential to interpretive work. Thorne (2008) also highlights the illusion of rigor that software may create, as outputs such as code frequency counts and visual maps can give a misleading sense of objectivity or scientific legitimacy. Thorne (2016) warns that "the analytic logic of such programs too easily drives the thinking of the researcher" (p. 180), reflecting the risk of fitting data into software structures rather than allowing interpretive insights to emerge organically. Finally, Thorne underscores that the credibility of ID rests on the researcher's skill, particularly their reflexivity, clinical judgment, and capacity to generate practice-relevant insights, rather than on the use of analytic tools. While she acknowledges that qualitative software can be helpful for managing and retrieving large data sets, she reminds researchers that such tools should serve only as supports and that analytic reasoning and interpretation must remain firmly in the hands of the researcher (Thorne, 2016b; Thorne, 2025).

Following the iterative process of template analysis, the researcher systematically identified and organized emerging patterns within the data of the forty participants. Subsequent analytic attention was directed toward ensuring methodological rigor through the application of established qualitative research standards. These analytic strategies

provided a robust foundation for the development of the study's findings, and the next section addresses the strategies employed to ensure methodological rigor and trustworthiness in Phase II of the study.

5.4.1 Ensuring Methodological Rigor

Data analysis incorporated criteria to enhance rigor and trustworthiness as outlined by Lincoln and Guba (1985), including credibility, dependability, transferability, and confirmability (p. 290).

5.4.2 Credibility

Credibility, or internal validity, refers to confidence in the truth of the data (Creswell & Poth, 2008). In this study, credibility was supported through strict adherence to ID methodology, with continuous review and comparison of data sets to identify patterns and ideas that accurately reflected participants' words. Multiple data collection techniques, such as interviews, questionnaires, and note-taking, added depth and strengthened credibility.

Although member checking is often recommended in qualitative research, it was not feasible in this context. This process would have required transcription and follow-up interviews, which posed significant challenges because participants frequently went off grid. Attempts to locate them for a second visit could have been perceived as suspicious, a concern confirmed during conversations with Phase I egocentric SNA participants.

In ID, the perspective of a "thoughtful clinician" strengthens the power of the data and analysis (Thorne, 2008, p. 84). Thorne explains that "triangulating what the best of

them may have observed, with what patients tell you they experience, can make for a fairly powerful set of findings" (Thorne, 2008, p. 85). To achieve this, the researcher interviewed three key clinicians: (1) an individual with over 30 years of experience in a nonprofit agency serving PWUD, (2) a mental health and addiction nurse active in street outreach, and (3) an infectious diseases physician specializing in care for complex and vulnerable populations. Their perspectives, detailed in the results section, informed and validated the data, enhancing accuracy and supporting both collection and analysis (Thorne, 2000).

5.4.3 Dependability

Dependability was demonstrated through consistent and reliable methods of data collection, transcription, and analysis. Maintaining a journal, memos, and methodological field notes provided a chronological record of thoughts and decisions, offering justification for findings (Thorne, 2008). As an iterative process, questions were reframed or removed as needed, resulting in substantial note-taking. Emerging descriptions, perspectives, and patterns were reviewed continuously to prevent loss of information. Additionally, consultation with colleagues, committee members, and peers added value and supported methodological consistency.

5.4.4 Transferability

Transferability was supported by methodological rigor and detailed demographic data collected through questionnaires. This information enables findings to be considered in similar contexts (Lincoln & Guba, 1985). Thorne et al. (2004) emphasize that ID

researchers have a pragmatic obligation to produce research relevant to their practice discipline, a principle reflected in this study.

5.4.5 Confirmability

Confirmability requires neutrality and a high degree of reflexivity. Interpretive Description provides a framework for designing studies that engage deeply with phenomena from an applied science perspective. Reflexivity was consistently practiced throughout the study and documented through journaling and committee consultations. A transparent description of research design, sampling, recruitment, data collection, and analytic decisions further supports confirmability.

Having established methodological rigor, the following section presents the results of the ID phase, which extend the quantitative insights from Phase I and deepen understanding of the factors influencing the decisions of PWUD to access emergency healthcare services.

5.5 Key Findings from Phase II Interpretive Description Study

The egocentric SNA study focused on individuals who used substances daily to capture real-time social network dynamics, whereas the ID phase included participants with current or past substance use to allow for retrospective and reflective insights. Daily use represents an ongoing and embedded social context in which relationships, support systems, and barriers to healthcare access are most visible and can be mathematically measured, providing a snapshot of interactions influencing healthcare decision-making, trust, and risk behaviours. In contrast, the broader inclusion in ID enabled participants living a sober life to articulate how their perceptions, motivations, and feelings of

mattering or connectedness evolved before, during, and after periods of active use. This diversity enriched the interpretive analysis, offering a deeper understanding of meaning and motivation across different stages of substance use.

A challenge in interpreting findings is the lack of a consistent definition of PWUD in the literature, with variations in age, substance types, and frequency of use across studies. For the Phase II study, PWUD were defined as "individuals who, at any point in the past or present, have used licit or illicit substances in a manner that has significantly and negatively impacted their quality of life." Participants were excluded if they solely used legalized substances such as alcohol, tobacco, or cannabis. The differentiation between daily users in Phase I and individuals with past or present substance use in Phase II was driven by the distinct aims of each phase. Although beyond the scope of this study, future research should examine the varied interpretations of PWUD across the literature.

The following section presents results from the demographic questionnaire completed by all 40 participants in Phase II. These data provided context for understanding adverse experiences, current substance use, overdose history, ED and hospital visits, and chronic health conditions.

5.5.1 Impact of Adverse Childhood Experiences

The concept of ACEs was first introduced by Felitti et al. (1998) through the landmark CDC-Kaiser Permanente ACEs study, which identified a strong, graded relationship between cumulative childhood adversity and a wide range of negative health outcomes across the lifespan, including substance use and addiction into adulthood.

Although ACEs questionnaires and scores were not formally administered in this study, many participants disclosed traumatic experiences consistent with high ACEs exposure, such as abuse, neglect, and household dysfunction. These narratives reflected the enduring impact of early adversity on health and coping across the lifespan.

Structural and social determinants such as poverty and homelessness, recognized risk factors for both the development and perpetuation of substance use, also emerged as salient patterns in participants' accounts. These factors can be conceptualized as both consequences and perpetuating harms associated with substance use. The next section examines the substances used by participants in greater detail.

5.5.2 Substance Use Patterns

Among the 40 participants in the ID study, as illustrated in Figure 11, ten individuals (25 percent) reported living a sober life with or without legal substances such as alcohol, nicotine, or marijuana. Of these ten, eight participants (20 percent) were on substitution therapy. The remaining 30 participants were actively using at least one illegal or illicit substance, with 24 participants (80 percent) using daily.

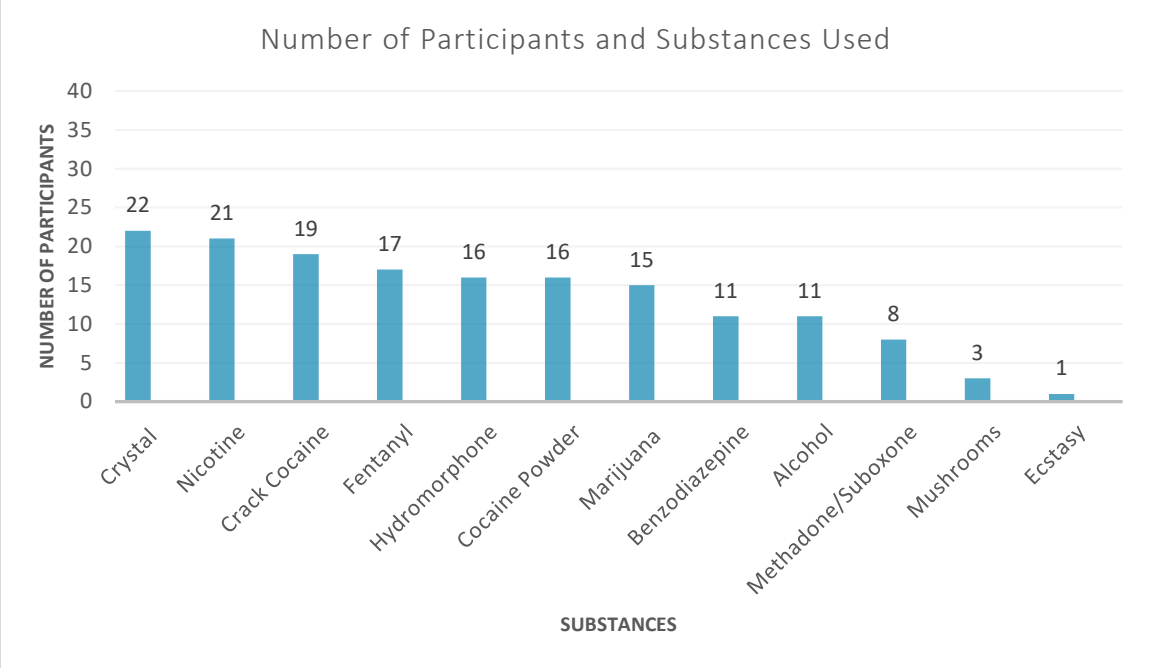
The substances most frequently reported in the broader group of 40 participants were crystal methamphetamine 22 participants (55 percent), nicotine 21 participants (52.5 percent), crack cocaine 19 participants (47.5 percent), fentanyl 17 participants (42.5 percent), hydromorphone or Dilaudid® 16 participants (40 percent), cocaine powder 16 participants (40 percent), marijuana 15 participants (37.5 percent), benzodiazepines 11 participants (27.5 percent), alcohol, 11 participants (27.5 percent), methadone,

buprenorphine, or iOAT eight participants (20 percent), mushrooms three participants (7.5 percent), and ecstasy one participant (2.5 percent).

All 40 participants were asked about their history of substance use, including whether they used drugs with others or alone, in the past or present. Twenty participants (50 percent) reported always using alone, while 11 individuals (27.5 percent) reported never using alone. The remaining nine participants (22.5 percent) indicated that they sometimes, often, or rarely used alone. The average number of substances used per participant was 5.2, with a range of one to ten substances per person.

Figure 11

Prevalence of Substances Used by Participants (n = 40)



Note. Data source: Data taken from participant interviews on types of substances used.

The 10 participants who identified as living a sober life demonstrated diverse approaches to recovery, with some utilizing medication-assisted treatments such as methadone or buprenorphine, while others reported abstaining without pharmacological support. These varied recovery trajectories reflect the complex and individualized nature of substance use and stabilization. However, regardless of the path taken, ongoing substance use, particularly in the context of polysubstance use and solitary consumption, positions many individuals at heightened risk of drug poisoning and overdose, a concern explored in the following section. All participant demographics and characteristics are outlined in Table 4. Having outlined patterns of substance use and recovery trajectories, the next section examines participants' overdose histories to understand the scope and severity of drug-related harms within this population

5.5.3 Participant Overdose Histories

When asked about overdose history, 23 of all the 40 participants (57.5 percent) reported experiencing at least one overdose in their lifetime (Table 4). The median age of those who overdosed was 42 years. For the 23 participants the combined total number of overdoses was 145, with an average of 6.3 overdoses per person. One participant, who had the highest level of education, reported 22 overdoses. All overdoses were treated with naloxone regardless of the substances involved. Of the 145 overdoses, 64 incidents (44 percent) resulted in an ED visit, while 81 incidents (56 percent) were managed by friends or community agency staff. Notably, five individuals accounted for 78 overdoses, indicating a significant clustering of risk within this subgroup. Following the discussion

of overdose experiences, attention now turns to the broader health profile of participants, highlighting chronic conditions and comorbidities that shape their healthcare needs.

5.5.4 Health Status of Participants

Thirty-five participants (87.5 percent) self-identified as living with at least one long-term health condition, including chronic pain, arthritis, chronic obstructive pulmonary disease, asthma, bronchitis, lung cancer, diabetes, kidney disease, hypertension, heart disease, hepatitis, HIV, and end-stage liver disease (Breivik et al., 2006; Neilsen, 2011). The median age of participants with chronic health conditions was 42.5 years, compared to 33 years of age for those without such conditions. Eighteen participants (51.4 percent) reported living with four or more chronic conditions. Additionally, three male participants aged 34, 41, and 58 years (8.6 percent) disclosed diagnoses of terminal illnesses. Building on the analysis of health status, the next section explores participants' interactions with healthcare systems, including ED visits and hospital admissions, to identify patterns of access and perceived quality of care.

5.5.5 Healthcare Service Utilization

Of the 40 participants, 35 (87.5%) reported having visited a hospital for care at some point in their lives. Twenty-eight participants (70%) had visited the ED within the past 12 months, accounting for 121 total visits. Among these, 21 (75%) felt their health concerns were not adequately addressed. One participant reported 20 ED visits in a single year, noting that investigations were not conducted, they only saw a physician, and they

were never admitted. Of the eight participants admitted to hospital, one (12.5%) left against medical advice.

Table 4

Demographic and Participant Characteristics (n=40)

Median Age	42
Range	23-63
Gender	
Male	13
Female	27
Other	
Housing	
Apartment	15
Friend / Family	3
Shelter	14
Tent/Homeless	1/7
Substance Use	
Crystal Methamphetamine	22
Nicotine	21
Crack Cocaine	19
Fentanyl	17
Cocaine Powder	16
Hydromorphone Dilaudid ©	16
Marijuana	15
Benzodiazepine	11
Alcohol	11
Methadone/Buprenorphine/iOAT	8
Other: mushrooms / Ecstasy (MDMA)	5/1
	27
Frequency of Use	
Q3-4 days/Weekly	1 weekly
Monthly	2
Use Patterns	
Always Alone	11
Sometimes / Often / Rarely	5 / 0 / 4
Never Alone	20
Chronic Health Condition	
Yes / No	32 / 5
Terminal	3

Education	
< Grade 12	8
Grade 12 / GED	26
College / University	5 /1
Overdose	
Yes	23
No	17
Treated in ED	19
Did not go to ED	4
Hospitalized	
Yes	35
No	5
To ED in past 12 months	
Yes	28
No	12
Health Issue Addressed in ED	
Yes	7
No	21
Admitted in the past 12 months	
Yes	8
No	20
Leave Against Medical Advice	
Yes	1
No	7

5.6 Interpretive Description and the Interview Data

The interviews were designed to address the research question: What influences and motivates PWUD to access emergency healthcare services (Appendix M). While participants described significant barriers to accessing care and shared experiences within the ED, these narratives did not directly answer the research question. To explore these experiences more deeply and identify underlying motivations, prompting questions, i.e., Tell me about the day and what you were going through at that time, were introduced

during interview. Notes taken during the interview were immediately transcribed and elaborated within one hour of the interview. Handwritten notes were then typed up within one week of the interview. Manual coding of the typed transcripts began once the first five interviews were completed. A coding template was generated after the first five interviews were examined (Appendix O). The initial coding template contained five patterns 1) trauma, 2) poverty, 3) substance use, 4) pain, 5) value and connection with multiple factors noted for each pattern. For instance, the pattern "trauma" contained individual factors that were noted by interviewees such as raped, beaten, shot. As the coding of transcripts continued the five patterns remained unchanged, however, a variety of new factors were added to each pattern section. This process of interviews, notetaking, generation of transcripts, and coding continued for eight to ten weeks. Upon completion of this initial coding, all transcripts were reviewed multiple times, i.e., approximately ten to twelve times per participant in a variety of groupings, over a period of six months. For instance, all interviews from women were examined together, or all people living a sober life, or groupings based on drugs of choice to see if new patterns emerged or established patterns faded. When there was no movement in patterns the analysis was exhausted. In an attempt to consolidate the patterns noted in the data several xx were engaged. An informal scoping review of the related literature on factors contained within the patterns, such as self esteem, self worth, and belonging noted in value and connection pattern. As well as reading, reviewing, and remaining focused on the research question the major finding of the study emerged.

Pain emerged as a predominant concern, articulated through multiple dimensions such as trauma, injury, substance use, retribution, poverty, homelessness, grief, and loss (Palepu et al., 2013).

5.6.1 Pain Experienced by People Who Use Drugs

In the initial minutes of most interviews, participants frequently began by discussing pain. This immediate focus suggested an urgent need to legitimize their substance use and contextualize their lived experiences. The researcher observed that many participants leaned forward, maintained direct eye contact, and raised the tone of their voice and an overall urgency to share their pain narratives. Understanding PWUD through these accounts provided a critical framework for interpreting their lives and healthcare interactions.

Although intractable pain and overdose were often cited as reasons for ED visits, these explanations did not fully address what motivated or influenced participants to seek ED care. Therefore, a deeper interpretive analysis was required to connect these narratives to concepts of connection, self-worth, and mattering, as important components influencing PWUD and their engagement with healthcare services.

5.6.2 Physical Pain

Extensive research with PWUD (Chan Carusone et al., 2019; Fairbairn et al., 2012; Kerr et al., 2010) corroborates the prominence of pain in this study's interviews. Candy illustrated the pervasive nature of pain and fear:

> You're always in pain, and afraid and scared. You're afraid of dyin,' afraid of feelin,' afraid of being sick and comin' down, afraid of bein' robbed, afraid of the police, scared of your dealer and your boyfriend, afraid of going to the hospital and scared to be alone.

This statement reinforces that pain and fear are normalized aspects of daily life for PWUD, a theme consistently repeated across interviews. To organize these narratives, pain was categorized into six domains:

1. Pain of substance use and withdrawal
2. Pain of poverty, food insecurity, and homelessness
3. Pain of grief and loss
4. Pain of hopelessness, violence, injury, and retribution
5. Pain of stigma, fear, and discrimination
6. Pain associated with chronic health conditions

These categories provide a conceptual structure for understanding pain as a multidimensional phenomenon influencing ED access.

5.6.3 Pain of Substance Use and Withdrawal

Pain represents a significant challenge in the context of substance use and withdrawal, with implications for treatment outcomes and long-term recovery (Baxter et al., 2019; Körkel, 2021). Although trauma and addiction were not the primary focus of this study, they emerged as salient features of participant narratives. Shell explained, "I take the drugs to stop the pain … pain in my body and pain in my mind … an if you don't know how that feels … how can you really help me?"

Several participants described moments of profound hopelessness, where pain led to suicidal ideation or attempts. Sidewinder shared, “I put a gun in my mouth … I just wanted the pain to stop.” Five participants disclosed previous suicide attempts, underscoring the severity of untreated pain and the perceived lack of healthcare options. Yung reflected, “I’m all fucked up, you know, I drank Drano © so I wouldn’t have to think about it anymore ... I kinda gotta a death wish.” TG echoed this sentiment, “You want out, out of the lifestyle, but you just can’t do it, so sometimes there ain’t any no other way to get out.”

Participants emphasized that drug use was no longer about achieving euphoria but about avoiding withdrawal. Leigh described withdrawal vividly, “It hurts, you’re crawlin’ out of your skin, you’re pukin’ and sick and cryin’ like a baby, it’s the worst, and I wouldn’t wish it on anybody.” Another participant shared “I went cold turkey, and I was so pill sick, I was pukin’ and shakin’ so after about two days I called an ambulance, and they said ‘we ain’t no cab service.’ So, I said fuck it, who cares anyway, and I went back on and I’m doing way more drugs now.” Another participant expressed similar sentiments when talking about independently managing overdose stating, “I just narc myself, ya know, I don’t bother nobody.”.

Beyond the physical and emotional pain associated with substance use and withdrawal, participants’ narratives revealed another profound source of suffering the pain rooted in poverty, food insecurity, and homelessness, which compounded their vulnerability and shaped their interactions with emergency healthcare services.

5.6.4 Pain of Poverty, Food Insecurity, and Homelessness

Poverty is also a painful experience “I got no home…I’m palliative, you know …and I just don’t wanna die in the shelter. I just want a little place… It’s all I ask for before I die … be in my place with my girlfriend and the nurses can come there…that’s it …that’s all I want.”. Similar to other studies, participants in the current research expressed anger toward their circumstances and felt that the formal systems intended to help them had failed, thereby worsening their poverty (Mago et al., 2018; Quiton et al., 2020). They conveyed despair and often did not see a way out of poverty. One participant, Bubby, expressed his fears in this way, “I’m scared of the cops, I’m hungry, I’m poor and tired, I got no friends, no family, no one and nothin’ but the cold and the dark to look forward to.” Another interviewee stated ““I never know where I’ll sleep from one night ta the next, so really, why am I gonna worry about goin’ to a hospital? I just don’t give a fuck about those people, I needa finda place to sleep.”. Participants stated that, initially, using substances made living a life of poverty more tolerable. Some explained that when they were high, all their problems seemed to disappear, and they felt calm and relaxed.

With poverty comes a lack of resources to meet basic needs, particularly food and shelter. Hunger was mentioned repeatedly during interviews. Angie stated, “What are you supposed to do when you don’t have a doctor, no drive, no money, no phone, and you’re always hungry, you tell me … what are you supposed to do?” For individuals living a sober life, food resources were more accessible because they were better able to organize and gather information. Cathy reflected, “When you’re not usin’ you can get your shit

together and be a little smarter about stuff." She further explained that when people are actively using substances, "They don't eat for days, they just kinda forget and don't feel hungry, and the weight just falls off of them."

Many participants appeared thin and had visibly poor dentition, which they attributed to substance use. This observation aligns with literature linking poor oral health to poverty, malnutrition, and crystal methamphetamine use (Hammoud et al., 2018; Pabst et al., 2017). Sidewinder noted, "I used to have decent teeth at one time, but now with the meth, they've fallen out."

Homelessness is defined as "the situation of an individual, family or community without stable, safe, permanent, appropriate housing, or the immediate prospect, means, and ability to acquire it" (Gaetz et al., 2014; Pauly et al., 2013). The intersection of systemic and societal barriers, lack of affordable housing, inadequate income, mental or physical health issues, and discrimination can make safe housing unattainable for PWUD (Krisberg et al., 2016; Mejia-Lancheros et al., 2021). Most people do not choose homelessness; it is an unhealthy, unsafe, and stressful circumstance. For participants, homelessness was pervasive and a constant concern. Bubby explained his fears in this way:

> When I was throwin' up blood, like the exorcist, just everywhere, while I was at the shelter, I passed out and the ambulance took me to the hospital. Once I come to, I didn't wanna stay at the hospital 'cause I was afraid I'd lose my bed at the shelter, and I don't like sleepin' outside.

All 40 participants spoke about their current living situations. Fifteen individuals lived in apartments, typically women with children, individuals living a sober life, or those with a partner who paid for housing. Fourteen individuals were living in one of two emergency shelters in the city. Participants felt shelters were unsafe and expressed fear of assault, violence, theft, and exploitation. Police presence in shelters created additional fear and anxiety.

Eight participants, all identifying as women, were living outside and unsheltered. One participant felt fortunate to find an abandoned shed and lived there through the winter. Women were particularly vulnerable to homelessness when in precarious relationships, as Britt explained:

> I was with my ex-boyfriend the first time I overdosed, and when I went unconscious, he waited ten minutes before he called an ambulance, because he was busy robbin' me. They said they almost lost me and had to Narcan © me seven times, then he kicked me out.

Leigh also described a violent relationship, "He was always throwin' me around, he liked to grab me by the throat and up against the wall, telling me that no one was every goin' to love me and I'd be better off tranquilized." Jennifer also spoke about her life of trauma, addiction, and homelessness, "I grew up on the streets, I was sexually abused at 11, unmanageable by 12, and kicked out and on the streets usin' by the time I was 13, and I never had a home since."

Three participants were couch surfing and anticipated moving to a shelter or tent encampment. Several recalled times when they were securely housed, often childhood memories or pre-addiction periods when they owned homes. These recollections were

emotionally difficult. Angie stated, “When you’re an addict, it's always hard to remember the good times.”

Poverty, food insecurity, and homelessness overshadowed participant conversations, with many individuals speaking openly about engaging in high-risk behaviours to purchase substances and meet basic needs. These discussions were emotionally challenging, yet participants insisted on sharing their stories despite reassurances that they could stop at any time. TG summarized this sentiment, “I just want people to know, we’re not bad people…we just got some serious shit goin’ on in our lives, you know?”

The pain associated with poverty, based on participant interviews, was linked to a lack of safe and affordable housing, food security, and the ability to meet basic needs. Collectively, participants voiced anger and frustration when attempting to address these issues with government agencies and formal systems. In addition to the pain of poverty, food insecurity, and homelessness, participants’ narratives revealed profound emotional suffering rooted in loss, grief, and hopelessness, experiences that further shaped their health-seeking behaviours and overall well-being.

5.6.5 Pain of Loss, Grief, and Hopelessness

During the interviews, participants spoke about loss and grief in diverse ways, such as: (1) losing friends and family members, (2) losing their children to social services, (3) grieving the deaths of friends and adult children due to overdose, suicide, or substance use, (4) losing their health, and (5) losing security and self-worth (Kristensen et al., 2012).

Grief is a natural process that enables individuals to adapt to loss; however, complicated grief is associated with increased risks of mental and physical morbidity, as well as suicide (Drabwell et al., 2020). When the loss involves younger individuals or is related to violence (e.g., homicide), accidental death (e.g., overdose), or suicide, those grieving face an increased risk of suicide within the first six months following the death.

In the interviews, participants exhibited a flat affect and minimal expression when recounting stories of loss or grief. They spoke of anger about what had occurred but rarely expressed sadness. It was often during these moments that they also mentioned their own thoughts of suicide and previous attempts, due to despair. Jennifer spoke of the loss of her children to foster care, "I had six kids, and the system screwed me over and took them all, they never let me keep even one of them."

Yung also explained his sense of hopelessness in this way, "I wish I was dead lots of times… a lot of my friends are dead, and my life is kind of fucked up … sometimes I just want it to end."

For City Momma, she stated how discrimination against her sons who were struggling with an SUD led to their deaths:

> If you're gonna call yourself a doctor or a nurse, then you gotta care, see beyond the addiction. My son was more than an addict, he was a brother, an uncle, a dad himself and he was my baby boy…. he didn't want to die; he wanted to live.

The emotional restraint observed during interviews, particularly in narratives of loss, grief, and despair, underscores the pervasive and often unspoken pain that permeates

participants' lives. This pain is frequently rooted in experiences of violence, injury, and systemic retribution, as explored in the following section.

5.6.6 Pain of Violence, Injury, and Retribution

A scoping review of the literature by Almquist and Walker (2022) identified that a disproportionate number of youths experiencing homelessness have contact with law enforcement compared to youth living in stable housing. Living precariously, often unhoused, and engaging in high-risk behaviours is associated with crime and sex trade, placing participants in situations where they were exposed to and experienced violence. For instance, one participant stated, "My boyfriend got pissed off, so he broke both my legs, he jumped on me on the stairs, I thought I was gonna die, I was screamin' and when I was in emerg, two of the nurses laughed at me….they fuckin' laughed…I'm tellin' ya Kim, its not healthcare its deathcare, an I fuckin' hate hospitals. Others spoke of enduring long-standing pain, such as Cohen, who shared, "I got hit by a car a few years back and my knees are real bad, but no one cares, they just say ya gotta live with it. I sleep outside or in the shelter, an I hurt so bad I can hardly walk." Participants in the current study discussed reciprocity and violence in a matter-of-fact tone, explaining, "this is just how it is." Street justice and retribution were considered normal and expected aspects of everyday life. Many participants described past and current injuries, including physical beatings, rape, domestic violence, and stabbings. "Oh yeah, I got raped at 10 and two years later I was out on the street, and I never looked back." one participant stated. Others spoke of being fearful, coerced, or obligated in some way due to their substance use. Chazz, however, felt her life improved significantly when supported through a

medication substitution therapy program for substance use. She stated, “I don’t have to run the streets, I don’t need to shoplift or suck dick anymore, you know what I mean? I gotta a life now.”

Violence and retribution were described as everyday realities for PWUD. Following an assault and stabbing, Sidewinder stated that once his assailant was released, he would retaliate:

> I’m gonna beat his ass and he deserves it, I’m gonna show him. I’m not someone he can rob and just come up and stab. I’ll tell him every time he sees me, he better cross the street, or else.

Female participants described particularly brutal violence, including assaults with weapons (e.g., knives, sledgehammers) and sexual assaults (e.g., rape). Chelly, an articulate young woman with a university degree who uses fentanyl daily, stated:

> There is so much violence out on the streets lately, this year I had both my legs broken, I overdosed 11 times and have been to the hospital 20 times, but not because I overdosed. I had pulmonary edema, jaundice, liver failure, infections, and I tried to kill myself a few times. It's dangerous out there and the drugs are just dirty poisons.

Participants spoke nonchalantly about street justice and emphasized that “Nobody calls the police. We look after it ourselves.”

In addition to the physical dangers and psychological trauma associated with life on the street, participants described persistent experiences of stigma, fear, and

discrimination, factors that compounded their suffering and further marginalized them from essential services and support networks. While much of this discrimination was rooted in systemic encounters with healthcare, justice, and social service systems, participants also reflected on internalized hierarchies and interpersonal judgments within their own substance-using communities. These experiences of violence and systemic retribution were compounded by stigma, fear, and discrimination, which participants described as pervasive and deeply harmful, as discussed in the following section.

5.6.7 Pain of Stigma, Fear, and Discrimination

Participants described discrimination at both systemic and interpersonal levels. Systemic discrimination occurred within justice, health, and social service systems, while interpersonal discrimination emerged within substance-using communities. Boo explained, “If you’re a crack whore, you’re at the bottom of the pile, you got no value, you know?” She continued, “The ones that use cocaine, those guys are on top.”

Discrimination manifested in multiple forms, including words, looks, gestures, public shaming, shouting, withdrawal of services, removal of children, and incarceration. Power dynamics were a dominant undercurrent, and participants described healthcare interactions with statements such as, “I was invisible to them.” “They wouldn’t listen.” “They did not believe me.” “They pretended they couldn’t hear me.” “They shut the door to my room, so they didn’t have to look at me.” Chazz observed, “You know when someone is taking care of you because they care ... and other times they just don’t care, and their body says it all…. it's not always the words that hurt.”

Discrimination and inequitable access to healthcare for PWUD are well documented in the literature (McNeil et al., 2021; McNeil et al., 2017; Pauly et al., 2015; van Boekel et al., 2013). Participants often stated they were labeled as "drug seeking." However, their primary drugs of choice, crystal methamphetamine and crack cocaine, are not available in hospitals. Felix explained, "Why would I sit in the ER for 12 hours waiting for drugs that I don't even want, for fuck sakes, I have my own drugs, exactly what I want, and I don't need their crap." Another interviewee, Karen, echoed this sentiment stating " I'd rather be dead than to the hospital.".

Participants were often dismissed by healthcare providers and told their health concerns were not legitimate. One participant attempted suicide by ingesting a bottle of clonazepam, which he vomited on route to the hospital. As TG recounted, "I felt terrible, how was I goin' to be okay, I just tried to kill myself, and I was left standing there on the sidewalk, feeling totally worthless."

Another participant visited the ER 15 times in the previous twelve months. The 23-year-old female participant was homeless, sleeping on the streets during the day to stay safe, and using substances daily and alone. She reported having no primary healthcare provider and receiving no medical tests or treatments during her ER visits. She denied having a chronic condition but did not disclose why she went to the ER. During the interview, she appeared unkempt, with broken nails, missing teeth, swollen hands, and facial cuts and bruises. She was hungry and spoke in a monotone voice, avoiding eye contact. She stated that in the ER her vital signs were taken, and then she was discharged. Without a home, she slept outside.

Participants repeatedly expressed negative feelings about hospitals, describing them as unsafe. Kat stated, “I might go if I think I’m gonna die … and even then, I might not go…. not always.” Yung elaborated on his feelings of hopelessness by explaining “I don’t usually decide to go to the hospital myself, it’s what I do to myself that decides … walkin’ in the snow for hours in my bare feet and gettin’ frostbite.” Captain added, “I’d only go if I was hurt bad ... like unconscious or knocked out or somthin’ and then it wouldn’t even be my decision to make then, would it?” Eight participants were adamant they would rather die than go to the hospital while six participants stated they would not hesitate to go, and the remainder were ambivalent. Sahlena reflected by stating, “You know, I don’t care, not really, but in the end, it doesn’t matter that much what they think, as long as you get fixed up.” Beyond the emotional and social pain of stigma, fear, and discrimination, participants also described the persistent physical suffering associated with chronic health conditions, an additional layer of vulnerability that shaped their experiences with emergency healthcare.

5.6.8 Pain Associated with Chronic Health Conditions

All participants were asked whether they had a long-term health (LTH) condition. In this study, 35 participants (88%) reported living with an LTH condition, which included diabetes, mental health disorders, heart disease, hypertension, HIV and hepatitis, muscular and joint diseases, skin infections, and long-term pain from previous accidents and injuries.

The average number of chronic health conditions per participant was 3 and six participants were living with six or more chronic health conditions. The average age of

participants living with a chronic health condition was 44 years. In addition, three participants stated they had been diagnosed with a terminal illness, which included lung and liver cancers and end-stage kidney disease, and all were under sixty years of age. These findings underscore the complexity of pain as a multidimensional experience, deeply intertwined with chronic illness, substance use, and social determinants of health, a theme further explored in the summary of Phase II.

5.6.9 Summary of Pain Experiences

Pain emerged as a common denominator across all interviews, often attributed to substance use, poverty, homelessness, and overall health status, a finding supported by existing literature (Kosteniuk, 2020). The relationship between chronic pain and an SUD is well documented. Research indicates that individuals with chronic pain conditions, such as arthritis, fibromyalgia, and lower back pain, are at elevated risk of developing an SUD (Schaffer et al., 2023). This risk is frequently linked to the use of substances such as opioids for pain management, which can lead to dependence or addiction (Volkow, 2014). The misuse of pain medications, particularly opioids, is a significant contributor to the initiation and progression of an SUD (Kosteniuk, 2020).

Individuals with an SUD often experience heightened pain sensitivity and altered pain processing. Chronic substance use can affect the brain's reward and pain systems, complicating pain management and exacerbating existing pain conditions (Volkow et al., 2017). This altered pain perception among PWUD results in increased pain experiences and difficulties in managing chronic pain effectively, highlighting the complex interplay between substance use and pain.

Understanding the complexity and multidimensional nature of pain experiences is essential to critically reflect on how pain influences PWUD to seek services. Although participants frequently identified pain as a concern, further exploration revealed that pain was not the underlying reason motivating them to seek emergency healthcare services. Following participants' accounts of pain rooted in violence, stigma, and discrimination, it became evident that these experiences were not only sources of physical and emotional suffering but also disrupted fundamental relational bonds. Amid this adversity, the presence or absence of human connection emerged as a critical factor in shaping participants' decisions to access emergency healthcare services. The following section offers a more detailed explanation of participants' perceptions and experiences regarding connection and self-worth as an influencing factor when considering accessing healthcare services.

5.7 Connection to Someone or Something

Amid the pervasive pain described in previous sections, participants emphasized that human connection, whether with friends, family, or others, played a critical role in shaping decisions to seek emergency healthcare services.

Connection to other humans was identified as an important and significant motivating factor influencing whether participants sought emergency healthcare services. In this study, participants described human connection in various ways; however, the primary descriptor was often expressed numerically (e.g., "I have x number of friends"), which is an interesting way to convey the perceived value of friends and relatives. Nat

spoke about her friendships and the support she received following an injury, “I have three friends, they saved my life.”

Another participant, Iggy, relayed a story about an accidental overdose in this way:

> I went to the playground with my sister and her kids, but I didn’t feel good. On the way home, I was laying in the parking lot on the ground and my friend happened to go by on his bike and he asked if I was okay, he’d call 911, and as I was layin’ there I was thinking, God, all I got in this world is my sister and my two best friends, they’re all I got, you know?

Connection was a recurring theme, as participants often referred to their overdose experiences as “dying.” Chelsea stated, “I died twice this weekend” followed by “and my friend saved me,” in reference to being resuscitated with naloxone. Similarly, another participant who lived unhoused and arrived for the interview with several facial lacerations and contusions stated, “I don’t have any friends, I don’t ever remember having friends, not even growing up, only people I know.”

5.7.1 Connection to Pets

While many participants identified human relationships as central to their sense of belonging and motivation, others described their most meaningful connection as being with their pets, companions that provided emotional support and a sense of purpose. For some participants, a pet represented their most important connection and relationship. Two participants were accompanied by their pet dogs during the interviews. One

participant, Sidewinder, had been the victim of a vicious physical assault, and when asked about going to the hospital, he summarized his feelings in this way:

> All I wanted was my cat … Sassy … she's like my kid, you know … she's 16 years old and I just love her … she's the only thing that keeps me going … I dunno … I just love her to death… we've been through a lot…she really, really needs me…we look out for each other …her and I have been through a lot together, so I guess I'd even go to the hospital for her, if I really had to, for her.

For some participants, like Sidewinder, the most meaningful source of connection was found not in human relationships but in the companionship and unconditional presence of their pets, which offered emotional support, routine, and a sense of purpose (Kerr-Little, 2018). These deeply valued bonds often served as critical motivators for engaging with the healthcare system. For example, one participant stated they wouldn't come to the interview without their pet. They are considered family members and not to be left behind, even if it means not accessing a shelter for the night. They are the most meaningful relationship in their lives. Citing that their dog "has their back" and holds more trust in that animal than any human person. While connections with animals were significant for some, others identified it was their mothers who were the most enduring and influential relationship in their lives, a theme explored in the following section.

5.7.2 Maternal Connections

Beyond friendships and pets, participants frequently highlighted maternal relationships, either as mothers themselves or through their own mothers, as powerful

motivators influencing health-related decisions. For instance, one participant shared “All I wanted was my mom. I was crying like a baby inside, but I was like frozen on the outside. Then I kind of died, they had to Narc’ me three times.” Captain stated, “It’s all about my mom, she is the light at the end of the tunnel for me, otherwise it’s just a dark hole, with no one and nothin’.” Another interviewee said “It was always mom who helped me. If my mother said, ‘You’re going to the hospital,’ I just went. Sometimes she could fix me up herself, she’d glue me up or stitch me up or whatever. She always took care of me.” Another interviewee also shared “If I die, it all ends, it doesn’t hurt me, but my family will be hurtin, in their hearts, and I just’ can’t do that to them.” reflecting the importance of feeling valued and connected to their family of origin.

Participants who were mothers expressed a strong attachment to their children and emphasized the importance of staying well to support them, even when their children were being cared for by family members or in foster care. Sahlena, who is currently homeless and whose mother cares for her children, explained, “There are days I don’t wanna even get outta bed, but Jeez, I got kids, they need me… even if it means going to the hospital, which I hate…It’s my kids that take me out the ‘dark holes,’ like when I am really bad, they are the driving force that keeps me going..

For Iggy, the motivation was similar, “I grew up on the streets, but I have kids now and it’s only ‘cause a them that I go to the hospital, the only reason.” Another participant Shy spoke of her love and commitment to her children, “I’ll do anything for my two girls, anything, even if it means I gotta go to the hospital.” For City Momma she described her role in protecting and supporting her children:

> I have four kids, all use, or used, and two of them are dead, so I gotta take care of myself, even if I need to go to the hospital, I have to if I wanna take care of my two girls, they are all I got left…right?

Participants who had connections to their own mothers' spoke of their influence and how this motivated them to access emergency healthcare services. Pete explained, "My mom has glued me up and helped me out so many times, so when she says I gotta go to the hospital, I go, no questions asked." For TA spoke about his health and his mother in a similar way:

> I'm goin' die, it's that simple. I been really sick, and I'm at that point, even though I want to live ya' know, but you can only put so many drugs into your body. Lately, I have fallen a lot … I am like right out of it … but I don't want my mom comin' to my funeral … it's not supposed to be that way ... she's like a light at the end of the tunnel for me ... I wanna live and I wanna a life … and I don't want mom to come to my funeral.

It was noted that not a single participant mentioned their fathers, only the individuals they identified as their mothers. These observations about connection to family, children and mothers transitions into another critical section which is the role of perceived self-worth in shaping health-seeking behaviours among PWUD.

5.8 Participants Express Perceptions of Self-Worth

Self-esteem and self-worth are both core components of the self-concept, yet they represent distinct aspects of how individuals perceive themselves. Self-esteem refers to an individual's internal evaluation of their value, typically based on personal

achievements, abilities, and perceived success (Elliott et al., 2005). It is shaped primarily by individual experiences and self-reflection. In contrast, self-worth is a relational construct that depends on how individuals perceive their value in the eyes of others. For instance, an interviewee with the pseudonym Sidewinder explained "I feel so bad sometimes, I go play in the traffic…I'd even let Mike Tyson have a go at me, I just don't care, ya know…the hardest thing to do in this world is to ask for help, you feel weak, you're not thinking straight, it's degrading, you feel like dirt." It is influenced by social interactions, such as feeling acknowledged, respected, and supported by others, particularly in vulnerable or marginalized contexts (Flett, 2021). "Everyone treats me like shit…being treated like shit is nothing new. It happens in the hospital, in the stores, in the street…that's just the way it is…no one ever gives a fuck about me." was shared by an interviewee reflecting the importance of social interactions. Self-worth is therefore closely tied to social recognition and the quality of interpersonal relationships.

In the context of this study, participants consistently highlighted the crucial role that self-worth and feeling valued played in their decisions to seek emergency healthcare services. Relationships characterized by empathy, non-judgmental attitudes, and genuine concern were identified as critical factors in encouraging participants to engage with healthcare systems. When healthcare providers demonstrated these affirming behaviours, participants reported feeling more inclined to seek care. However, participants also frequently described feeling diminished, invisible, or silenced within healthcare environments, particularly when confronted with stigmatizing attitudes or dismissive behaviours from healthcare providers.

As one participant, Sidewinder, shared, “Ya know Kim, not you per se, but other people, they act like they don’t even see ya, like they see right through ya, even though yer standin’ right there in front of them…It’s bad enough they take you to Emerg in shackles, but then everyone ignores you, like they see right through you, like you ain’t even there, that’s the worst. This quote illustrates how feelings of invisibility and devaluation diminish self-worth, making PWUD less likely to seek care. Another participant, Chazz, recounted a distressing experience:

> I’m in the hospital, I ring my bell ‘cause my IV wasn’t workin’ and my arm was swellin’ up and stuff, and they walked down the hall and just slammed the door shut. They didn’t even ask me what was wrong! It was like I was just a fuckin’ bother, not even worth their time.

Such experiences of devaluation contributed not only to emotional distress but also to physical harm, highlighting the detrimental effects of a lack of recognition and respect on self-worth.

In conclusion, while self-esteem pertains to personal evaluations of one’s abilities and achievements, self-worth is rooted in the value placed on an individual by others, particularly within social contexts. For PWUD, self-worth plays a significant role not only in healthcare engagement but also in how they perceive acceptance and recognition within their social circles, families, and friendships. When participants felt valued and respected by healthcare providers and by people in their immediate social networks, they were more likely to seek emergency healthcare services. Conversely, when interactions with providers or peers undermined their sense of worth, participants were less likely to engage with healthcare services. This underscores the critical relationship between self-

worth, social belonging, and health-seeking behaviours (Elliott et al., 2005; Flett et al., 2022). Building on the pattern of self-worth and its influence on health-seeking behaviours, the next step in the interpretive description process involved validating these findings with clinicians to ensure accuracy and contextual relevance.

5.9 Validation Interviews with Clinicians

The use of clinician validation interviews is useful and a necessary part of the ID process however they are not equivalent to participant validation and cannot substitute for participant member reflection, especially when the central construct concerns participants' internal sense of value and relational meaning. (Thorne, 2008). To assess the clinical resonance, plausibility, and practice implication of the findings of the current study three clinicians with extensive expertise in the local population of PWUD were invited to review the findings. These clinicians included a specialist in Infectious Diseases, a nurse manager with expertise in Mental Health and Addictions, and an Executive Director for a nonprofit organization with over three decades of experience.

Despite their familiarity with the population, all three clinicians expressed surprise regarding participants' drug preferences, the number of substances used, frequency of overdoses, and the high prevalence of chronic illnesses among PWUD. Although they initially questioned the extent of their contribution to the study's findings, they raised several pragmatic concerns. For instance, one clinician inquired whether participants were sober during the interviews and about the safety of the researcher and others on site. They also questioned whether ED visits were attributed to acute events or cumulative health issues, reflecting concern for the nature of health-seeking behaviours. These

discussions underscored the clinicians' attention to participant complexity and researcher safety. Ultimately, a consensus emerged among all three clinicians regarding the importance of this research and its potential to advance an understanding of mattering and shed light on morbidity and mortality issues affecting PWUD. This leads to an exploration of mattering as a central construct that surfaced through the interpretive analysis.

5.10 Mattering: A Psychological Construct

The use of an ID methodology supported the psychological construct of mattering to emerge organically through immersion, reflection, and iterative analysis. The researcher engaged deeply with participants' narratives by repeatedly reading and re-reading transcripts, journaling, and attending closely to tone, word choice, body language and emotional expression.

Patterns of connection and self-worth were directly articulated in participants' accounts; however, pain, both physical and emotional, was the most pervasive and complex thread woven throughout their narratives, shaping the everyday realities of PWUD. Understanding how pain was expressed, managed, or endured required sustained interpretive attention and sensitivity to its layered manifestations.

Through this iterative analytic process, the researcher identified specific factors that interrupted the prevailing sense of despair and illuminated what fostered hope or moments of openness to care. These were described as glimmers, brief affective cues that emerged within suffering and revealed possibilities for connection, dignity, and healing.

5.11 Conclusion Chapter 5

Engaging with the full scope of the interview material, the researcher attended not only to the explicit content of participants' words but also to subtle moments of relational recognition and meaning making embedded within their stories. It was within this context of profound suffering, pain, and quiet resilience that mattering surfaced as a central construct. It was not imposed by the researcher but rather identified through the depth and texture of participant narratives, reflecting the expressed need to feel seen, valued, and significant, even within lives shaped by stigma, trauma, and systemic marginalization.

As Thorne (2025) argues, the purpose of qualitative inquiry is to illuminate human experience in a way that honors its complexity and offers insights into actionable understanding. In this study, mattering offered an affectively grounded and conceptually rich lens through which to understand not only the weight of suffering but also the conditions under which individuals might be motivated to seek emergency healthcare services.

The findings of the centrality of mattering in the lives of participants will be further examined in Chapter 6 with recommendations for education, clinical practice, public policy, and directions for future research with this population.

Chapter 6: Discussion, Recommendations, and Conclusion

This chapter begins with Section 6.1 which discusses the characteristic and experience of this population and justifies why changing the approach to providing care is so important; Section 6.2 elucidates further on the factors that motivate this population to seek or avoid and the role of connection, self worth, and mattering; Section 6.3 discusses the theoretical implications of these findings on mattering and Section 6.4 lays out a series of recommendations on these findings for both research and practice with this population.

The study employed a sequential explanatory mixed-methods design, consisting of two distinct phases: a quantitative egocentric SNA followed by a qualitative ID study. As noted by Creswell (2014) and Morse (1995), this design enabled qualitative data to clarify and contextualize the quantitative findings.

Phase I, the egocentric SNA, revealed that participants had highly dense and tightly knit social networks, a finding that was both unexpected and highly relevant. It was unexpected because this is rarely found in any population (Borgatti et al., 2018) as typically participants do not have a completely dense network where all the alters, i.e., people they know, all know each other. Hence, PWUD in Saint John, New Brunswick present as having unique cohesive networks which are not reported in the published literature. Secondly, the researcher gained valuable insight and understanding in Phase I of this project on the vulnerability of the population and the complexity of the environments in which they survive (Appendix A). The shortened data collection in Phase I reflects the high respondent burden that was discovered and the limited feasibility of conducting SNA with this local population. Finally, due to the density of the social

networks the necessity of Phase II for gaining insight into factors that motivate or influence PWUD to access emergency healthcare services was recognized as being essential. Therefore, by integrating these results from the egocentric SNA with the narrative depth of Phase II ID interviews, the study achieved a comprehensive understanding of participants' shared perspectives, social capital, and the experiences that shaped and motivated their decisions to access healthcare services.

This approach demonstrated that network dynamics involving connection and perceived self-worth fostered a sense of mattering, which emerged as an important but not necessary condition for PWUD to access ED services. The following section compares the demographic profile of participants in this study with national data to situate the sample within a broader context.

6.1 Participant Profile and Context

Thorne (2008) asserted that small ID studies may set an "arbitrary sample size" (p. 98) and that there "will always be more to study" (p. 98). Consistent with this perspective, the current study included participants who provided a rich diversity of experiences and viewpoints. Thorne (2016) also emphasized that no single participant can represent all perspectives, and that recruiting a non-homogeneous sample enhances the construction of interpretations that resonate with applied disciplines. This principle was evident in the present study. Participants were both similar to and distinct from the Canadian PWUD described in the Canadian Substance Use Survey (CSUS, 2024) across several demographic dimensions, which are discussed below.

6.1.1 Age and Gender

The Canadian Substance Use Survey (CSUS) categorizes participants by age and gender to report national trends in substance use. The 2024 CSUS identifies two primary age groups: youth aged 15 to 24 years and adults aged 25 years and older (Health Canada, 2024). In contrast, participants in this study were primarily older adults, although a small number were in their early twenties, with ages ranging from 29 to 57 years (median = 47.5, SD = 12.9) in the egocentric SNA phase and 23 to 63 years (median = 42, SD = 11.4) in the ID phase. This represents an older cohort compared to those typically emphasized in national prevalence surveys. This age difference is important because the CSUS reports higher rates of substance use initiation among youth and young adults, whereas participants in this study had prolonged and often more complex substance use histories. The older age range was associated with a higher burden of chronic health conditions and cumulative exposure to social and structural vulnerabilities, including poverty, stigma, and unstable housing, factors that are less frequently captured in national surveys (Canadian Centre on Substance Use and Addiction, 2022; Voon et al., 2015).

These findings highlight the influence of pain, self-worth, connection, and mattering on healthcare-seeking behaviours among PWUD, particularly within an older cohort facing chronic illness and structural disadvantage. Participants' experiences of physical and emotional pain were compounded by marginalization. However, moments of relational affirmation within dense networks, with pets, or in healthcare settings fostered a sense of mattering that mitigated systemic devaluation. This perception of being seen, heard, and respected, emerged as an important though not necessary

condition for accessing emergency care. These dynamics illustrate the interplay between relational factors and structural barriers in shaping health-related decisions.

In terms of gender distribution, the CSUS reported that 50 percent of respondents identified as men, 49 percent as women, and 1 percent as non-binary (Health Canada, 2024). In comparison, the egocentric SNA phase included two men and two women, while the ID phase consisted of 30 individuals not living a sober life of which 13 identified as men and 17 identified as women, indicating a modest overrepresentation of women in the qualitative component. This provided an opportunity to explore gendered dimensions of substance use and healthcare access, particularly women's experiences of trauma, homelessness, and stigma, factors often underexplored or aggregated in national datasets (Boyd et al., 2018).

The overrepresentation of women in the ID phase yielded important insights into gendered health trajectories. Both the youngest and oldest participants were women, underscoring the salience of women's experiences across the life course. This pattern may reflect broader structural and social factors shaping women's engagement with health systems, including disproportionate exposure to trauma, gender-based violence, economic marginalization, and caregiving responsibilities. For many female participants, substance use was intertwined with relationships and chronic pain, both physical and emotional, which eroded self-worth and agency. Participants often described seeking healthcare not solely for personal well-being but in relation to caregiving roles, reflecting a complex interplay between relational identity and health-seeking behaviour. These caregiving efforts were often met with systemic stigma and dismissal, contributing to a profound sense of invisibility. Such experiences underscore the importance of mattering,

the perception of being significant to others, as a critical yet underexplored determinant of women's health trajectories (Elliott et al., 2005; Flett, 2018). Within this context, the desire to feel valued and connected emerged as a powerful motivator for accessing care, whereas the absence of mattering contributed to disengagement or avoidance of health services.

This divergence in gender representation may reflect localized patterns of substance use or differences in willingness to participate in research among women, particularly in qualitative interviews. It also reinforces the need to disaggregate data by gender in future studies to better understand the unique social and structural challenges faced by women who use drugs. Overall, while the CSUS provides valuable epidemiological insights into national trends (Health Canada, 2024), it does not fully capture the lived experiences of older and more marginalized populations. The current study addresses this gap by offering an in-depth exploration of individuals with long-term substance use histories, many of whom face intersecting chronic health and social challenges that are often underrepresented in large-scale surveys. Although this distinction limits generalizability, it emphasizes the unique contribution of qualitative inquiry in uncovering nuanced, context-specific dimensions of substance use. Central to these narratives were interwoven threads of pain, diminished self-worth, disrupted connection, and the search for significance, elements that collectively highlight the relevance of mattering as both a psychological and relational construct (Elliott et al., 2005; Flett, 2018). A lack of perceived mattering appeared to contribute to disengagement from care, whereas moments of being seen and valued served as motivators for re-engagement and healing.

These findings underscore the need for research and service models that move beyond uniform approaches and instead address the complex, localized realities of PWUD, accounting for their diverse social identities, health needs, and relational contexts. The following subsections examine key health-related challenges identified in the study, situating them within national trends and highlighting implications for care delivery.

6.1.2 Mental Health Challenges for People Who Use Drugs

Mental health challenges represent a significant concern among individuals who use substances. According to the Canadian Substance Use Survey (CSUS, 2024), individuals reporting moderate to severe symptoms of depression are up to 3.2 times more likely to engage in problematic alcohol or cannabis use (Health Canada, 2024). In contrast, participants in the egocentric SNA and ID phases were not directly asked about a specific mental health diagnosis or service utilization. Although formal mental health data were not collected, anecdotal references to psychological distress were frequent in all four of the SNA interviews and often mentioned in the ID interviews. Participants described experiencing poor mental health and encountering multiple barriers to accessing mental health services.

These qualitative findings align with national trends but were not systematically measured in this study, which limits the ability to draw definitive conclusions about the relationship between substance use and mental health within this population. Nevertheless, the narratives underscore the intertwined nature of substance use and mental health, echoing national evidence on the heightened risk of concurrent disorders

among individuals with substance use challenges. Future research should include explicit assessments of mental health status and service utilization to better understand these needs and their influence on healthcare access among older adults with chronic substance use histories. In this study, participants' narratives revealed significant psychological distress that often coexisted with severe physical health conditions. This overlap underscores the importance of examining morbidity and mortality among PWUD, as these factors compound vulnerabilities and shape patterns of healthcare utilization.

6.2 Morbidity and Mortality

Morbidity and mortality among individuals with an SUD are critical factors influencing healthcare utilization patterns. National data indicate that individuals with an SUD face elevated risks for chronic health conditions, including mental health disorders, liver disease, communicable infections, cardiovascular disease, and other long-term illnesses (Health Canada, 2024). The CSUS also reports that problematic alcohol or cannabis use is associated with higher rates of depression and anxiety, which can exacerbate physical health issues and complicate treatment.

Consistent with these trends, the egocentric SNA and ID analyses revealed a substantial burden of chronic health conditions among participants. Thirty-two individuals reported at least one chronic condition, including three cases of terminal illness in the Phase II ID Study. Chronic pain emerged as a dominant and persistent issue, illustrating the intersection of substance use and physical health challenges. While national surveys provide broad prevalence estimates, they do not capture the detailed morbidity profiles observed in this study. Participants reported conditions such as heart disease, liver failure, and chronic pain, often exacerbated by substance use and

contributing to poor health outcomes. These findings highlight the need for integrated care models that address both physical and mental health simultaneously, particularly for individuals with complex health and social needs (Boyd et al., 2018). Taken together, these results emphasize the urgency of developing healthcare strategies that move beyond siloed approaches and instead provide comprehensive, person-centred care for PWUD. One concrete step in this direction would involve addressing the lack of standardized data collection and reporting systems among formal, publicly funded entities (e.g., first responders, hospitals) and community organizations (e.g., non-profit groups) that was apparent during this study, and would improve associated health outcomes for PWUD (Wood, 2016). The next section examines hospitalization and ED visits, situating these patterns within the broader context of morbidity and mortality.

6.2.1 Hospitalization and Emergency Department Visits

Hospitalizations and ED visits serve as indicators of healthcare access and the severity of underlying health conditions. National data suggest that approximately 8% of Canadians accessed ED services at least once in the past year (Health Canada, 2024). By comparison, individuals with an SUD exhibit significantly higher rates of ED utilization, with estimates ranging from 18% to 66% for substance-related concerns. These visits often involve multiple annual encounters and increased hospitalization rates (Canadian Institute for Health Information, 2021).

Findings from the current study mirror these national patterns and provide additional context. Of the 40 participants in the ID study, 28 participants (70 percent) reported visiting an ED within the past year, and eight of these individuals (20 percent)

were hospitalized. These utilization patterns likely reflect the acute and chronic health consequences of substance use but also point to systemic gaps in primary care access. Many participants described limited or nonexistent access to family physicians, mobile health units, or walk-in clinics, particularly within the urban context of this study. Consequently, the ED often functioned as the only consistently available point of care. These findings underscore the need for structural reforms that prioritize low-barrier, community-based services tailored to the needs of PWUD.

In addition to hospital-based care, participants reported reliance on nontraditional healthcare services, such as nonprofit agencies and community clinics, reflecting persistent barriers to conventional care. Avoidance, deflection and refusal of hospital-based services was common and was often attributed to stigma, discrimination, and mistrust of healthcare providers (Bonn et al., 2020; Voon et al., 2014). One participant expressed this sentiment starkly: “I’d rather be dead than go to the hospital.” It was frequently observed in this study and aligns with the literature that PWUD delay or avoid care due to perceived stigma and prior negative experiences (CSUS, 2024; Pauly et al., 2015; Voon et al., 2014).

The consequences of these barriers were profound. As of October 2025, all four participants in the egocentric SNA Phase I had died (D. Kerns, personal communication, October 15, 2025). Even when PWUD accessed ED services, premature departures and refusal of medical recommendations were common, often driven by intersecting social, structural, and financial barriers (Kendall et al., 2017; Mayer et al., 2023). Taken together, these findings illustrate the complexity of healthcare utilization among PWUD

and highlight the urgent need for interventions that reduce stigma and improve continuity of care. Building on these patterns of healthcare utilization, the following section addresses overdose, a critical public health crisis and a leading cause of morbidity and mortality among PWUD in Canada.

6.2.2 Overdose as a Public Health Crisis

Overdose remains a major public health concern among PWUD, representing one of the leading causes of preventable death in Canada. Nationally, between January and September 2023, there were 5,360 apparent opioid toxicity deaths, with 82% involving fentanyl and 75% involving multiple substances (Health Canada, 2024; CSUS, 2024). These statistics reflect an alarming upward trend in overdose frequency and severity.

In reviewing these national trends, the findings from the current study provide critical insight into overdose experiences among PWUD in Saint John. In the second ID phase of the study of the total number of 40 individuals, 23 participants (57.5%) reported experiencing at least one overdose in their lifetime, for a cumulative total of 145 overdoses. Particularly concerning were five individuals (21.7%) from this group who accounted for 78 overdoses collectively. This concentration of risk underscores the presence of high-risk subgroups within PWUD whose circumstances warrant targeted intervention and further research.

Despite the severity of these overdose events, only 64 cases (44%) resulted in ED visits. Four participants reported managing overdoses without seeking any medical assistance, that is consistent with national data indicating that many PWUD delay or avoid healthcare due to prior experiences of stigma, dismissal, or discrimination (Boyd et

al., 2018; Mayer et al., 2023). One participant explained, “I just narc myself, ya know, I don’t bother nobody,” illustrating the tendency to manage overdoses independently and outside formal healthcare systems.

The underutilization of healthcare services in overdose situations highlights not only structural barriers but also deeper psychosocial dimensions, including disrupted trust, diminished self-worth, and a lack of perceived connection to care providers. This reluctance to seek help may reflect a broader sense of invisibility and marginalization, wherein participants do not feel that their lives or well-being are valued by the healthcare system. Such experiences align with the concept of mattering, the perception that one is significant and valued by others, which has been identified as a protective factor in mental health and help-seeking behaviour (Elliott et al., 2005; Flett, 2018). When PWUD feel that they do not matter, they may internalize stigma, withdraw from services, and rely on informal or solitary strategies for survival, it at all.

Taken together, these findings underscore the importance of fostering relationally attuned, nonjudgmental care environments that affirm the worth and humanity of PWUD, particularly in the context of overdose response and harm reduction. In conclusion, the national CSUS data and the findings from the egocentric SNA and ID phases, although based on a small sample, reveal striking differences in healthcare utilization, health conditions, and overdose experiences of the broader Canadian population. These results highlight the ongoing need for local targeted interventions and integrated care models that provide comprehensive, accessible, and nonjudgmental services for individuals with an SUD. Beyond clinical interventions, structural determinants such as housing insecurity

emerged as critical factors shaping healthcare access and overall well-being among PWUD.

6.3 Homelessness

Homelessness is a significant social determinant of health with profound implications for healthcare access, mental health, and overall well-being. The Canadian Substance Use Survey (CSUS, 2024) reports that homelessness rates in Canada have been rising, particularly among individuals experiencing an SUD. Nationally, approximately 3% of Canadians experience some form of homelessness, including absolute, hidden, or relative homelessness (Echenberg & Munn-Rivard, 2020). Absolute homelessness refers to living without physical shelter, such as sleeping outdoors or in places not intended for habitation. Hidden homelessness includes temporary stays, couch surfing, or living with others without secure housing, while relative homelessness refers to living in substandard, overcrowded, or unsafe housing that does not meet basic health and safety standards (Gaetz et al., 2014).

In contrast, participants in the egocentric SNA and ID phases exhibited exceptionally high rates of homelessness, particularly absolute homelessness. In the SNA Phase II Study, two participants reported living in shelters or tents. In the ID Phase II Study, seven participants, all women, were experiencing absolute homelessness, while fourteen reported residing in shelters. An additional two participants were experiencing hidden homelessness, relying on informal accommodations with friends, and fifteen reported living in apartment housing. Together, these findings reflect significant housing instability and heightened vulnerability among PWUD, far exceeding national estimates reported by CSUS (2024).

Participants frequently described how unstable housing directly impacted their ability to access healthcare services. One participant remarked, “I never know where I’ll sleep from one night ta the next, so really, why am I gonna worry about goin’ to a hospital? I just don’t give a fuck about those people, I needa finda place to sleep.” For Bubby, who has a terminal illness, his request was simply stated, For Bubby, who has a terminal illness, his request was simply stated,

“I got no home…I’m palliative, you know …and I just don’t wanna die in the shelter. I just want a little place… It’s all I ask for before I die … be in my place with my girlfriend and the nurses can come there…that’s it …that’s all I want.”

These quotes illustrate the profound impact of homelessness on healthcare access, where unstable living conditions create barriers to consistent and reliable services. As Baxter et al. (2019) emphasize, homelessness disrupts continuity of care, making it difficult for individuals to manage chronic health conditions or engage in preventive health behaviours. This is further compounded by stigma and discrimination in healthcare settings, which can discourage PWUD from seeking care. The CSUS (2024) highlights that homeless individual, particularly those with an SUD, face significant health inequity, including higher rates of mental illness, chronic diseases, and injuries, as well as greater difficulty accessing healthcare services (World Health Organization, 2022). These patterns align closely with the findings in the current study.

Targeting homelessness at its structural roots and ensuring access to stable, supportive housing for PWUD is essential to addressing health inequities, particularly in the local context where visible homelessness and housing insecurity have become

increasingly prevalent. As Baxter et al. (2019) and the WHO (2022) emphasize, housing is not merely a basic human need but a core social determinant of health that directly influences an individual's capacity to access healthcare, engage in treatment, and participate in the broader social fabric. Findings from both the egocentric SNA and ID phases revealed high levels of housing instability, highlighting the pressing need for coordinated, equity-oriented strategies that integrate housing and healthcare services tailored specifically to the realities of PWUD.

Beyond mitigating exposure to environmental hazards, safety, and physical insecurity, stable housing plays a critical role in supporting psychological well-being. It contributes to a sense of autonomy, safety, and control, conditions that are foundational to cultivating self-worth. Furthermore, stable housing fosters connection to place and community, enabling individuals to establish, maintain, and sustain social relationships, access resources, and engage in meaningful activities. These psychosocial dimensions are tightly linked to the concept of mattering, which refers to the extent to which individuals feel valued, seen, and significant to others and to society at large (Elliott et al., 2005; Flett, 2018). Chronic homelessness, particularly in a small urban centre such as Saint John, can compound feelings of social exclusion and reinforce narratives of worthlessness and invisibility. When individuals are denied housing or repeatedly displaced, it communicates a societal judgment that their lives do not matter. In contrast, access to safe, permanent housing can act as a powerful affirmation of one's inherent dignity and worth, laying the groundwork for recovery, relational trust, and re-engagement with care.

Addressing homelessness among PWUD must therefore be understood not only as a clinical or policy concern but as a moral imperative rooted in relational justice and the promotion of mattering. Housing insecurity does not occur in isolation; it is deeply intertwined with economic deprivation. The following section examines poverty as a structural determinant that further constrains access to healthcare and amplifies the challenges faced by PWUD.

6.4 Poverty in Canada

Poverty in Canada is commonly defined as the condition in which individuals are deprived of resources essential to meet basic living standards, such as food, shelter, and clothing, which are necessary for active participation and integration within society (Economic and Social Development Canada, 2020). The Low-Income Measure After Tax (LIM AT) is often used to measure poverty, with the Canadian income threshold for a single person in 2023 set at $24,000 (Statistics Canada, 2023).

In New Brunswick, the provincial income assistance rate in 2024 was approximately $683 per month for a single individual without a disability, resulting in an annual income of $8196.00 (Government of New Brunswick, 2024). This amount fell well below the LIM AT threshold, contributing to fear, stress, and financial insecurity for individuals reliant on these benefits. As one participant, Sidewinder, stated, “It’s a struggle, every day, every hour man, yer always just hanging on.” This financial hardship severely restricted access to basic needs such as food, shelter, and safety, in addition to essential healthcare services, further exacerbating health disparities.

In Saint John, poverty was notably prevalent, with 28% of residents living below the poverty line, which is significantly higher than the national average of 9.9% (Campaign 2000, 2024; United Way Saint John, n.d.). This economic strain directly affected the ability of individuals to meet basic needs, reinforcing the cyclical nature of poverty and intergenerational disadvantage. The situation was further aggravated for PWUD, as they encountered additional barriers to care due to fear, violence, injuries, unstable housing, and stigmatization in healthcare settings.

These intersecting hardships compromised physical health and eroded psychosocial well-being. Chronic poverty, especially when coupled with substance use and social exclusion, led to diminished self-worth, disconnection from community resources, and an internalized sense of marginalization. Such conditions directly undermined mattering, the feeling of being important, recognized, and valued by others (Elliott et al., 2005; Flett, 2018). In environments marked by persistent deprivation and systemic neglect, PWUD may come to view themselves as invisible or undeserving of care, which in turn discouraged engagement with services and reinforced cycles of exclusion.

Addressing poverty in Saint John, particularly as it affects PWUD, therefore requires not only economic and structural reform but also a commitment to relational justice that centres dignity, belonging, and the restoration of mattering. One potential solution may be implementing a living wage or a Universal Basic Income to alleviate poverty and enhance access to healthcare. Providing a guaranteed income could offer greater financial security to PWUD, enabling them to prioritize their living and

healthcare needs and reduce the economic barriers that prevent meaningful engagement in society (Gibson, 2024). With more stable financial resources, individuals would be better equipped to manage their health and improve overall health outcomes. Furthermore, financial stability may foster a renewed sense of self-worth, social connection, and belonging, as individuals are afforded the means to participate more fully in their communities, provide for themselves and those they care about, and experience a greater sense of mattering, being seen, valued, and recognized by others and by society (Flett, 2018; Elliott et al., 2005). Building on these structural determinants, the following section explores early-life adversity as another critical factor influencing health trajectories and healthcare engagement among PWUD.

6.5 Factors Motivating Access to Emergency Healthcare

There were four distinct motivations that appear to facilitate PWUD accessing healthcare services. Pain appears to be an important instigating force that may initiate consideration to access some form of healthcare service. Another motivation was participants sense of self-worth and connection to others; as they were more likely to continue the trajectory toward accessing healthcare services if they possessed these intrapersonal characteristics. Finally, mattering emerged as an important but not necessary condition for engagement with healthcare services.

6.5.1 Pain as an Initiating Factor

Pain emerged as a pervasive and multifaceted theme in participant narratives, extending beyond physical discomfort to include emotional and psychological suffering. The International Association for the Study of Pain (2020) emphasizes that pain is both a sensory and emotional experience, shaped by individual interpretation and context (Raja et al., 2020). This subjectivity is particularly relevant among marginalized populations, where pain is often rooted in cumulative trauma and social adversity (Lumley et al., 2011). Across the interviews, participants articulated a broad spectrum of pain experiences. Some described untreated physical injuries, while others spoke to the enduring emotional toll of violence, loss, and exclusion. These accounts underscore the complex ways in which pain is experienced, managed, and understood by PWUD, highlighting its significance in shaping their interactions with healthcare systems.

In this study, participants repeatedly referred to pain, the pain of being stigmatized, the pain of experiencing discrimination, and the pain of not being trusted or being able to trust. These findings reflect similar results in other studies where participants reported painful experiences in which substance use became the primary focus of healthcare interactions, overshadowing immediate health concerns and reinforcing feelings of judgment and stigmatization (Pauly et al., 2015; McNeil & Small, 2014). While many PWUD live with persistent acute and chronic pain, it is often a singular, critical incident, injury, or fatal overdose that precipitates engagement with healthcare services. This pattern diverges from some traditional model's health seeking behaviours which requires that individuals cognitively appraise their susceptibility,

seriousness of the issue, and perceived benefits prior to the initiation of health seeking behaviour (Shaikah & Hatcher, 2005). In contrast, participants in this study were typically propelled toward healthcare services by crisis events, without prior cognitive processing or anticipatory planning. This form of health seeking behaviour was more aligned with the Glanz and colleagues (2015) conceptualization which formulates actions, both positive and negative, as "behaviours people take that can influence their health". Hence, pain emerged as an important factor for seeking care.

PWUD face unique healthcare needs that can stem from complications arising from socioeconomic factors, communicable diseases, injuries, fear, and the consequences of substance use. Consequently, they often encounter suspicion and stigma as "drug seeking," leading to hesitancy among practitioners to treat or outright denial of pain management therapies, particularly for chronic pain (Donnelly et al., 2016; Voon et al., 2014). This perpetuates a positive feedback loop where, according to Loh (2021), pain contributes to decreased physical and mental functioning, heightened suicide risk, and an elevated likelihood of self-medication through injection drug use. This cycle can then lead to more health-seeking behaviours, more stigma, and worsening alienation.

Participants in the current study also reported experiencing several types of physical pain, including generalized body aches, muscle pain (myalgias), and pain associated with previously healed injuries. It is noteworthy that the literature reports that individuals with an opioid addiction often experience hyperalgesia, an abnormally high pain sensitivity (Rieb et al., 2020). This underscores the complex interplay between pain and substance use, where the alleviation of pain through substance consumption may reinforce substance-

seeking behaviours, or the pain of withdrawal can exacerbate psychological distress leading to self-medication, which in turn perpetuates addiction. Pain is typically classified as either acute (short term), often associated with immediate injury or trauma, or chronic (long term), defined as persisting for more than three months or both (Treede et al., 2015). This classification was reflected in the current study, as participants described experiences with both acute and chronic pain. One participant, Wendy, described short-term pain associated with emergency situations:

> My boyfriend got pissed off, so he broke both my legs, he jumped on me on the stairs, I thought I was gonna die, I was screamin' and when I was in emerg, two of the nurses laughed at me….they fuckin' laughed…I'm tellin' ya Kim, its not healthcare its deathcare, an I fuckin' hate hospitals.

Others spoke of enduring long-standing pain, such as Cohen, who shared:

> I got hit by a car a few years back and my knees are real bad, but no one cares, they just say ya gotta live with it. I sleep outside or in the shelter, an I hurt so bad I can hardly walk.

Having explored pain as an important motivator, the next section examines connection and its role and influence with PWUD to engage with emergency healthcare services.

6.6 Connection and Social Networks

As previously noted, participants articulated the importance of human connection in various ways. Interestingly, they often quantified their relationships (e.g., "I have x number of friends"), suggesting a pragmatic lens through which they assessed social value and support. This tendency to assign numeric value to relationships may offer insight into how PWUD may conceptualize connection and belonging suggesting quantity of relationships may be more important than quality. This is particularly notable with the findings in the SNA Phase I study that identified dense insular social networks suggesting PWUD in Saint John, N.B. are very aware of the social capital in their relationships.

During the ID Phase II Study participants revealed that a connection to a mother, either by caring for her own children or experienced by an adult child living with an SUD, played a powerful role in their thinking. This was evidenced by statements such as, "All I wanted was my mom. I was crying like a baby inside, but I was like frozen on the outside. Then I kind of died, they had to Narc' me three times." Captain also stated, "It's all about my mom, she is the light at the end of the tunnel for me, otherwise it's just a dark hole, with no one and nothin'." Being a mother also had a profound impact on PWUD, as Sahlena stated during the interviews, "It's my kids that take me out the 'dark holes,' like when I am really bad, they are the driving force that keeps me going." This is important as the published literature reports that a supportive and nurturing relationship with one's mother during childhood and adolescence can significantly influence subsequent health-related behaviours (Parolin & Simonelli, 2016). And earlier work on maternal love as a protective factor, fostering resilience and a sense of self-worth and

care that potentially deters individuals from engaging in risk-taking behaviours appears to also be relevant (Bowlby, 1980). Further, maternal connection as a protective factor and a powerful motivator for change has also been well documented in correctional programming literature. Incarcerated women with strong desires to generate or maintain connection with their children can sometimes experience this as a powerful motivation for change (Brown & Bloom, 2018; Petrillo, 2022). This finding has now been extended to desistance patterns noted in male offenders (Schinkel, 2019). Desistance refers to the process of reducing or ceasing harmful or criminal behaviours over time, and desistance patterns describe the recurring pathways or turning points, such as forming strong family bonds that support this change. Thus, future research probing PWUD's connections between their care for their mothers and/or children and health care decisions may be beneficial in understanding their motivation to access emergency healthcare services. Further, innovative programming initiatives with PWUD need to explore the possibility of change being facilitated by family members, particularly mothers as motivation for connection with their children.

Building on the role of family connections as a catalyst for positive change, another critical factor influencing engagement with emergency healthcare services is the individual's sense of self-worth. The participants in both the SNA and ID studies highlighted the importance of connection and perceived self-worth in shaping healthcare decisions. Connection, described by one participant as "my mom is like a light, she's like my anchor, ya know" and they serve as an important protective factor against isolation and emotional distress for many PWUD. Self-worth, defined as an intrinsic sense of value and confidence in overcoming challenges, and described by an interviewee

describing an interaction with an ED doctor “he made me feel real” was equally essential and is described in more detail in the following section.

6.7 Perceived Self-Worth

In addition to the importance of connection, the current study underscores that self-worth is also important. It requires deliberate efforts by healthcare systems and providers to create environments that validate individuals’ experiences and address the systemic and interpersonal factors contributing to feelings of exclusion (Becker & Folis, 2021). Participants’ low self-worth was evident in many statements, for example, “I feel so bad sometimes, I go play in the traffic…I’d even let Mike Tyson have a go at me, I just don’t care, ya know.” Or as an interviewee with the pseudonym Sidewinder explained, “The hardest thing to do in this world is to ask for help, you feel weak, you’re not thinking straight, it’s degrading, you feel like dirt.”. During ID Phase II interviews, self-worth emerged as an important construct impacted by participants’ interactions with others, including peers, family members, and healthcare providers (Chan et al., 2019). For instance, Candy talked about trying to end her drug habit, stating:

> I went cold turkey, and I was so pill sick, I was pukin’ and shakin’ so after about two days I called an ambulance, and they said ‘we ain’t no cab service.’ So, I said fuck it, who cares anyway, and I went back on and I’m doing way more drugs now.

Sidewinder explained it this way, “It’s bad enough they take you to Emerg in shackles, but then everyone ignores you, like they see right through you, like you ain’t even there, that’s the worst.” These negative experiences diminished

their sense of personal value and may have contributed to hesitancy or outright avoidance of seeking medical assistance, even in situations of urgent need (Strike et al., 2020; van Boekel et al., 2013). Such stigmatization not only eroded trust in healthcare providers but also perpetuated a broader sense of disempowerment and marginalization. Participants expressed that being treated with respect and dignity was essential for fostering their sense of self-worth. When these needs were unmet, feelings of exclusion were compounded and deterred them from accessing healthcare (Dassieu et al., 2020).

While self-worth reflects how individuals perceive their own value, mattering goes a step further by emphasizing whether that value is recognized by others. This distinction is also important for understanding the relational dynamics that influence PWUD engagement with emergency healthcare services. The following section explores mattering as a relational psychological construct and its potential role in shaping healthcare engagement among PWUD (Kendall et al., 2017; Kosteniuk et al., 2022).

6.8 Mattering as a Psychological Construct

Mattering is conceptually distinct from related constructs such as belonging, social support, and self-worth. Belongingness emphasizes fitting into a social structure; for example, an individual may attend group activities and be physically present without feeling that they matter to other members. In contrast, mattering centres on being needed, valued, and significant to others, where participation and having a voice are expected and meaningful. This distinction may be particularly relevant for PWUD, who often

experience marginalization and systemic neglect. The absence of mattering, or "anti-mattering," is associated with heightened emotional distress and maladaptive behaviours, making mattering a pivotal concept for addressing healthcare disparities within this population (Flett, 2022).

Morris Rosenberg's foundational work introduced mattering as the belief that one's existence holds significance to others (Rosenberg & McCullough, 1981). He identified three dimensions: awareness (being noticed), importance (feeling valued), and dependence (knowing others rely on you). A lack of mattering fosters alienation and diminishes self-worth, negatively impacting mental health and well-being. These three dimensions of mattering were evident in participant narratives. For example, one participant's reflection revealed this dimension of awareness stating, "If I die, it all ends, it doesn't hurt me, but my family will be hurtin, in their hearts, and I just' can't do that to them." The second dimension of mattering, feeling valued, appeared in another account:

> It was always mom who helped me. If my mother said, 'You're going to the hospital,' I just went. Sometimes she could fix me up herself, she'd glue me up or stitch me up or whatever. She always took care of me.

Finally, the third dimension of mattering, dependence, was illustrated when Sidewinder shared, "Sassy is my 16-year-old cat, I love her … we've been through a lot…she really, really needs me…we look out for each other."

Recent contributions by Flett (2022) expand mattering to include anti-mattering, the feeling of insignificance, and the fear of not mattering. Both were evident in this

study. Brooksy, who has used heroin since age 13, shared, “Everyone treats me like shit…being treated like shit is nothing new. It happens in the hospital, in the stores, in the street…that’s just the way it is…no one ever gives a fuck about me.” This account illustrates how anti-mattering and the fear of not mattering may reinforce disengagement from healthcare systems. However, mattering alone is not sufficient to engage emergency healthcare services, as evidenced by participants who felt they mattered but still faced barriers such as stigma, fear of judgment, and trauma-related mistrust, which delayed or prevented them from accessing care. Mattering appears to function as an important but not necessary condition for healthcare access; it was important for PWUD motivation yet ineffective without structural supports and nonjudgmental care environments.

6.9 Positioning Mattering in Relation to Alternative Explanations

While the findings of this study centre mattering as a key influence on the decisions of PWUD to access emergency healthcare services, it is important to situate this concept of mattering alongside established explanations for health seeking behaviours in vulnerable populations (Kendall et al., 2020; McNeil & Small, 2014). The findings of this study do not displace these explanations, rather, they extend them by demonstrating how mattering operates as a relational mechanism through which these factors are interpreted and acted upon. For PWUD, decisions to access emergency healthcare services were rarely attributed to a single factor. Instead, they emerged within complex and dynamic environments characterized by competing priorities, constrained resources, and past experiences with formal systems (Pauly et al., 2020; Saine et al., 2020). Within these contexts, and outlined in the next five sections, mattering functioned as a cross-cutting

influence that shaped how individuals understood the significance, urgency, and possible outcomes of accessing care.

6.9.1 Mattering: Pain and Symptoms of Withdrawal

Physiological severity, including acute illness, unmanaged pain, withdrawal symptoms, and fear of death, are typically understood as primary motivators of emergency healthcare access (Chan Carusone et al., 2020; Schaffer et al., 2023). While participants in this study described experiencing these conditions, severity alone did not consistently motivate access to care. Findings of the current study suggest that mattering mediates engagement with emergency healthcare services. When participants anticipated that they would not be believed, stigmatized, would be labelled as drug seeking, receive inadequate pain and or withdrawal management, even severe symptoms were insufficient to prompt seeking access to healthcare services. Conversely, when there was an expectation of being treated with dignity and respect, accessing care became more conceivable and possible. These findings suggest that physiological urgency creates the need for care, but mattering shapes whether that need becomes actionable.

6.9.2 Mattering: Significant Relationships

Relationships played a significant role in shaping healthcare decisions for PWUD in moments of crisis. When PWUD experienced a strong sense of mattering within their relationships, such as those with children, pets, partners, or family members, healthcare access was prioritized. At the same time, when healthcare environments were perceived as spaces where they would not matter to healthcare personnel access was viewed as unsafe and unimportant.

6.9.3 Mattering: Structural and Institutional Constraints

Structural factors such as homelessness and poverty are chronic conditions that influence PWUD to avoid or access healthcare services. Mattering provides insight into how these challenges and constraints, i.e., homelessness, are experienced by PWUD. For example, strict shelter policies or the risk of losing possessions were not simply rules to be followed but were deeply connected to their survival and health. Similarly, when PWUD perceived that they were viewed as insignificant within healthcare and formal systems, these barriers became less negotiable and, at times, insurmountable when considering accessing emergency healthcare services.

Likewise, institutional practices such as security surveillance, policing, and abstinence requirements at local hospitals contributed to experiences of not mattering. In contrast, access to adequate pain management or supports for an SUD signalled that suffering was recognized and that their wellbeing mattered. These signals from institutional supports shaped whether PWUD engagement with emergency healthcare was perceived as worthwhile or potentially harmful.

6.9.4 Mattering: Safety and Vulnerability

Concerns from interviewees related to gendered violence, policing, and personal safety introduced additional layers of complexity influencing access to healthcare services. For some participants, particularly those who had experienced violence, seeking care involved navigating risks beyond their immediate health concerns. Mattering shaped how these risks were interpreted. When PWUD anticipated dismissal, stigma, or exposure to harm within healthcare environments, emergency departments were not viewed as safe

spaces. In these contexts, avoidance of care can be understood as a rational and thoughtful response to environments in which individuals do not expect protection or safety.

6.9.5 Mattering: Competing Priorities and Survival

The daily survival needs of PWUD, including managing withdrawal, securing shelter, maintaining relationships, protecting belongings, and coping with chronic pain and exhaustion, often competed with the perceived need for emergency healthcare services. These priorities reflect the realities of living within constrained, unstable, and often rule bound conditions. Mattering helps explain how these priorities are ordered. When PWUD do not expect to matter within healthcare environments, immediate and tangible needs often take precedence over uncertain or potentially negative care encounters. Conversely, even small experiences of recognition or respect can shift these priorities, making care seeking feel more possible.

Taken together, these findings suggest that mattering does not function as a singular explanatory variable, but as an integrative lens that connects physiological, social, and structural influences on emergency healthcare access. It shapes how individuals interpret symptoms, evaluate risks, respond to social influences, and assess the potential benefits and harms of engaging with healthcare systems. This interpretation aligns with the assumption that relationships influence healthcare decision making among PWUD. Mattering operates within and across these contexts, influencing not only whether individuals seek care, but how they navigate the competing demands and uncertainties that characterize their daily lives.

6.10 Mattering: Integration and Implications

The following section outlines the integration of the findings from Phase I SNA and Phase II ID studies that identified the constructs of pain, self-worth, connection, and mattering as important to understanding healthcare access for PWUD.

6.10.1 Methodological Integration

A key methodological issue arising from this study concerns how an explanatory sequential mixed methods design can be justified when the quantitative phase does not yield interpretable or analytically useful results. In this case, Phase I SNA findings demonstrated uniform network density across all egocentric networks, indicating complete interconnectedness among alters. While this confirmed strong structural cohesion, it eliminated variability and prevented further quantitative analysis. As a result, the quantitative phase did not generate findings that could be directly explained or elaborated through qualitative inquiry in a conventional explanatory sequential design. Importantly, this does not represent a failure of the design, but rather a limitation of applying structural network measures within a small, complex urban population of PWUD. The findings suggest that egocentric network structure, as measured here, may lack sufficient sensitivity to capture differences in motivations related to accessing emergency healthcare services.

Within Creswell's mixed methods framework, such outcomes necessitate a shift in the role of the qualitative phase. Rather than explaining statistical relationships, the qualitative component becomes interpretive and exploratory, aimed at understanding the absence of quantitative differentiation and identifying relational and contextual factors

not captured by the initial measures (Creswell & Plano Clark, 2018; Ivankova et al., 2006). In this study, the interpretive description phase extended beyond explanation to actively interrogate the limits of the SNA findings.

Integration therefore occurred through connection, expansion, and interpretation rather than direct merging of datasets. The lack of variability in Phase I directly informed the need for deeper qualitative exploration. The qualitative findings addressed the central research question by illuminating motivations that could not be accessed through structural measures alone, including pain, stigma, relational experiences, and perceived mattering. At the level of interpretation, the combined findings demonstrate that structural cohesion alone is insufficient to explain healthcare access behaviours without attention to lived experience and relational meaning.

These results contribute to broader methodological discussions in mixed methods research by demonstrating that integration in explanatory sequential designs need not rely on convergence. Instead, integration can occur through compensation and expansion when initial findings are limited. The study also raises important questions about the suitability of standard quantitative measures for capturing the complexity of PWUD social networks, suggesting a need for approaches that better account for contextual and relational dynamics.

6.10.2 Theoretical Contribution

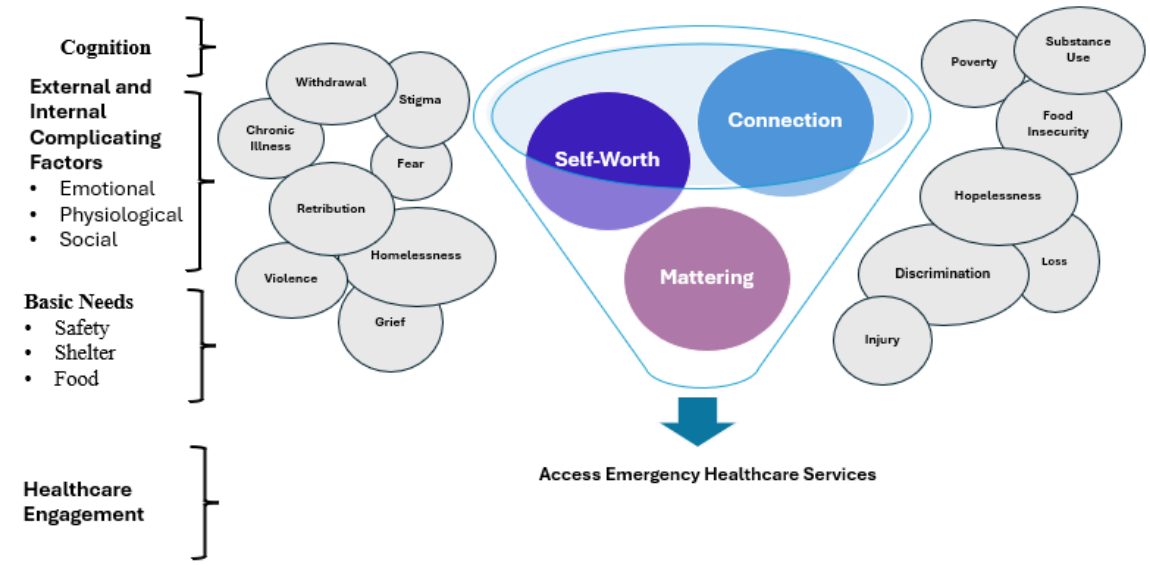
The findings support the inclusion of pain, connection, self-worth, and mattering as key psychosocial factors influencing access to emergency healthcare among PWUD. While pain often functioned as an instigating event, it was insufficient on its own to sustain engagement with services. Participants' decisions to access care were further shaped by their sense of self-worth and the presence or absence of meaningful social connection. Perceived mattering emerged as particularly significant, not as a necessary condition for accessing care, but as a factor that shaped how individuals engaged with and experienced healthcare interactions. These findings extend existing understandings by demonstrating that healthcare-seeking behaviour among PWUD is not determined solely by need or network structure, but by how individuals interpret their relationships and their value within care encounters and their lives. This reinforces the assumption that egocentric networks may influence PWUD behaviour, while emphasizing that relational meaning, rather than structure alone, is central to understanding healthcare access.

6.11 Visual Aid for Healthcare Engagement of PWUD

A schematic was developed as a visual aid that encompasses factors identified by PWUD as important for engagement with emergency healthcare systems (see Figure 12). Studies indicate that PWUD often experience significant trauma, compounded by systemic barriers that hinder their access to care (Shimada et al., 2024; Kolla et al., 2021). This schematic integrates pain, feelings of connection, self-worth and mattering. It also incorporates grief, loss, and fear, as well as others social determinants of health. The cognitive impairments often seen in PWUD are also considered in this schematic.

Figure 12

Visual Aid: Healthcare Engagement of PWUD



Note. Adapted from the concept analysis by Becker and Folis (2021).

Addressing the factors contained in this schematic may improve service design and delivery while fostering trust and promoting inclusivity between PWUD and healthcare providers. Maslow's hierarchy of needs (1943) suggests that basic needs such as safety, stability, and social belonging must be met before individuals can even focus on higher-level goals, including healthcare engagement. Applying this principle to healthcare interventions for PWUD emphasizes the need for holistic approaches that prioritize social support, harm reduction, and trauma-informed care. This shift from focusing on individual decision-making to a more inclusive approach that acknowledges systemic inequities, and the need for feelings of self-worth, connection and mattering in substance using populations may be to necessary for optimizing PWUD to access healthcare services. These services could integrate community-based outreach, peer support, and flexible service delivery models that align with the lived realities of PWUD

as illustrated in Figure 12. Further, public health policies should continue to address structural determinants, such as housing insecurity and criminalization, to create safe spaces in which healthcare engagement can take place. Based on these findings the following section outline recommendations to support PWUD to access emergency healthcare services.

6.12 Recommendations: Knowledge Translation

Pain, connection, self-worth, and mattering all emerged as motivators for PWUD to engage with emergency healthcare services. These findings extend prior research that identified barriers such as discrimination, withdrawal, poverty, and long wait times (Ahern et al., 2007; Pauly et al., 2015), as well as provider bias, restrictive policies, and trauma histories (Knight et al., 2022; McNeil et al., 2014). Healthcare providers should consider intentionally integrating strategies that foster connection and self-worth within care environments. Individuals need to experience choice, respect, feelings of safety and genuine recognition of their worth regardless of their circumstances or disclosures. For example, when working with marginalized clients' personnel need to introduce themselves, greet people by name, and sit at eye level. These findings highlight the significance of mattering for PWUD and can inform future policy development, education, and research. Trauma-informed and harm reduction principles that are embedded in emergency care can also incorporate mattering as a practical extension of best practices. For example, establishing routine monitoring outcomes for punitive measures, i.e., closing files when appointments are missed, that are commonplace need to

be established in healthcare agencies to address structural barriers and inequities for marginalized persons.

Fostering a sense of mattering, ensures PWUD feel seen, heard, and valued, and may represent a critical threshold for engagement. For example, rather than focusing on a missed appointment by a PWUD the healthcare provider should say "I'm glad you came in today. Before we start, what would you like to focus on? We can go at your pace and if anything feels uncomfortable you can let me know." Ensuring staff can identify prejudicial language and are well versed in using non-stigmatising language is important. Providing opportunities to engage in role plays during regular professional development sessions where skills needed to impart a sense of mattering to clients can be practiced. This challenges traditional frameworks that prioritize rational choice or structural access by introducing affective and relational dimensions into healthcare-seeking behaviour Patterns such as leaving against medical advice (LAMA) are often misinterpreted as non-compliance rather than responses to environments where individuals feel they do not matter (Kidd et al., 2007; van Boekel et al., 2013). Reframing these behaviours has significant with implications for clinical practice, education, and policy: services must reduce systemic stigma and actively create conditions where PWUD experience recognition and value. For example, community nurses can reframe a client's LAMA from a hospital through non-judgemental language acknowledging the patient "couldn't stay at the hospital' and expressing care and interest in following up with them in the community.

Achieving this transformation necessitates systemic change across emergency departments, hospital systems, and primary care settings, alongside the meaningful

integration of trauma-informed, relational, and harm reduction principles into routine healthcare interactions. For instance, the rapid assessment and treatment of withdrawal should be established as a standard of care. Implementation of such practices requires comprehensive training for all emergency department healthcare professionals, supported by policy and structural changes at the administrative level.

During the second phase of this research, consensus emerged among all three clinicians regarding the importance of this study. They recognized its value through the lens of their personal and professional experiences with patients who often resist seeking emergency healthcare despite severe health issues. The clinicians' insights support the study's relevance and its potential to inform more effective, empathetic healthcare practices tailored to the unique needs and challenges faced by PWUD in Saint John.

Recommendations for practice must first address system-level influences shaping care for PWUD. Across healthcare, justice, social services, and education systems, providers often work within overburdened and underfunded environments that constrain relational care and perpetuate inequities (Khatri & Perrone, 2020). Organizational commitment to trauma-informed, relational, and harm reduction approaches is essential to mitigate discriminatory practices and improve equitable access.

Within these constraints, patient-level interactions remain critical. Healthcare professionals should routinely obtain consent before procedures such as bloodwork, intravenous access, medication administration, and monitoring, while clearly explaining care. Recognizing that many PWUD are survivors of multiple traumas, practitioners should validate experiences without requiring disclosure, offer choices, and engage

patients as partners in care. These intentional practices foster trust, reduce stigma, and affirm that individuals matter within healthcare encounters.

6.13 Recommendations: Clinical Practice

Trauma-informed care (TIC) is an organizational framework designed to understand, recognize, and respond to the effects of various types of traumas (Harris & Fallot, 2001; Maté, 2024). Trauma-informed care is particularly relevant for PWUD as it acknowledges the widespread impact of violence, injury, and poverty and integrates this awareness into all aspects of service delivery, including policies, procedures, and practices (Substance Abuse and Mental Health Services Administration, 2020). The primary goal of TIC is to create an environment that is safe, supportive, and prevents re-traumatization (Brown, 2019).

Delivering effective TIC involves training all hospital staff from administrative to medical personnel to recognize signs of trauma and intentionally creating safe and welcoming environments (van der Kolk, 2014), as well as offering an empathetic and nonjudgmental path to whatever type of recovery individuals choose (Perry & Szalavitz, 2017). To implement a trauma-sensitive approach for PWUD, several practical steps must be taken: 1) Organizations need to commit to a cultural shift that prioritizes developing meaningful connections with communities where PWUD reside, 2) offering opportunities to generate authentic connections and convey a sincere sense of mattering to those they serve in healthcare settings is essential which necessitates comprehensive training for all staff member on the principles of TIC and the specific needs of PWUD, and finally, 3) physical environments should be designed to feel safe and welcoming, minimizing triggers that could re-traumatize individuals and convey that the individual

matters (Brown, 2019a). Policies and procedures should reflect a commitment to safety, trustworthiness, transparency and inclusivity, as well as building relationships where individuals feel valued (SAMHSA, 2020).

Creating systemic change to implement TIC for PWUD also requires education, advocacy, and policy reform. This involves raising awareness about the importance of connection, fostering self-worth, and communicating care and mattering to PWUD at local, provincial, and national levels, and advocating for the necessary funding and resources to support these initiatives. For example, the requirement of routine non-stigmatizing language training for all healthcare personnel. Collaboration across various sectors, including healthcare, social services, criminal justice, and the broader community is essential to create a comprehensive support network for PWUD. For instance, generating online forums such as podcasts, blogs, vlogs, and social media spaces in addition to more formalized committee work would enhance dialogue, exchange of information, and understanding of local issues that intersect through TIC. Creating a sense of caring and self-worth in PWUD who have experienced trauma requires a multifaceted approach grounded in TIC. This approach acknowledges the complex interplay between substance use and trauma and emphasizes the importance of affirming the intrinsic worth of every individual. For example, creating explicit pathways for patients with opioid tolerance in accordance with current clinical practice guidelines and offering addiction medicine consultation while in hospital. Another strategy is the development of strong, caring, and trusting relationships between human service providers and peer navigators by PWUD. Emerging evidence from Ontario emergency departments demonstrates that integrating peer workers and navigation supports into ED

care can improve patient engagement and contribute to reductions in recurrent or high-frequency emergency department use by strengthening connections to community-based care (O'Neill et al., 2024; Steinberg et al., 2022).

Additionally, and most importantly, involving PWUD in the design and evaluation of TIC programs ensures that their voices are heard and their needs are addressed (SAMHSA, 2020). For example, developing and maintaining a mechanism within healthcare systems to collect patient feedback about their care and using this information to inform future practice would be a concrete measure in establishing TIC programming. By fostering a trauma-informed approach, we can create a more compassionate and effective system of care that not only addresses substance use but also promotes healing and resilience among PWUD (van der Kolk, 2014).

According to Maté (2018), establishing meaningful relationships involves time and providing consistent, compassionate care that validates the person's experiences and emotions. By showing empathy and understanding, providers can help mitigate the feelings of shame and worthlessness often internalized by those with a history of trauma and substance use. For frequent visitors, creating space for participants to have their voices heard and supporting their autonomy in decision-making is critical, as it affirms their sense of mattering. This approach challenges assumptions that individuals must be protected through altering the details of their lived experiences to preserve anonymity (Gagnon et al., 2020; Ti et al., 2012).

Another critical component is the use of strengths-based interventions (Ezell et al., 2023). This approach focuses on identifying and building upon the individual's existing strengths and resources rather than solely addressing their deficits or challenges.

Researcher, van der Kolk (2014) argues that recognizing and amplifying these strengths helps individuals to see themselves as capable and resilient, which can foster a stronger sense of self-worth. Programs that incorporate peer support and empowerment models are particularly effective in this regard, as they allow PWUD to connect with others who have had similar experiences, further reinforcing their sense of worth, belonging, and fostering connection (Brown, 2019). For example, implementing a low-barrier reporting mechanism for patient feedback about receiving stigmatizing care.

Finally, the creation of a safe and supportive environment is crucial in promoting self-worth among traumatized PWUD and could include the offering of safe storage or temporary care options for pets and/or belongings where feasible. Bloom and Farragher (2013) emphasize the importance of nonjudgmental, person-centred care that prioritizes the individual's dignity and autonomy. By actively involving PWUD in their care planning and decision-making processes, providers can empower them to take an active role in their recovery, thereby enhancing their sense of agency and self-worth. In addition, perhaps most obviously, primary care providers need to be informed, educated, trained, and encouraged to include PWUD in their medical practice where "house calls" could be made to shelters or community sites, appointments scheduled during evening hours considerate of PWUD lifestyles, and accommodations sensitive to the client's condition and needs.

6.14 Recommendations: Education

Education plays a pivotal role in applied and professional practice disciplines, shaping their understanding and response to an SUD. This study highlights the evolving nature of an SUD, marked by the emergence of fentanyl, a contaminated drug supply, and the profound social, justice, and medical consequences associated with these trends. Existing literature reveals a gap in educational content on substance use within undergraduate nursing programs, leaving graduates unprepared to support PWUD upon entering practice (Gagnon et al., 2020). Therefore, formal education on substance use disorders, particularly in applied disciplines, such as social work, medicine, dentistry, nursing, occupational therapy, physiotherapy, and allied health professions is essential. Curriculum development must integrate the perspectives of individuals with lived experience and members of community organizations, not merely as token volunteers but as active, contributing, and equal partners. Their insights enrich educational initiatives and ensure a comprehensive approach to addressing an SUD within professional practice (Gagnon et al., 2020).

Public health education is equally important in changing perceptions and improving care for PWUD. Harm reduction is a public health approach that minimizes the negative health, social, and legal impacts associated with drug use without necessarily requiring cessation. It encompasses a wide range of strategies and practices designed to reduce the risks and harms that come with drug use, especially for individuals who are unable or unwilling to stop using drugs. This approach recognizes that health and well-being of PWUD can be significantly improved through practical, evidence-based interventions that prioritize safety and dignity (Guta et al., 2024).

Ultimately, mattering is not merely a psychological construct but a fundamental human need. Its presence affirms existence, fosters connection, and sustains resilience. Its absence, by contrast, can lead to profound psychological distress, isolation and social consequences. As such, integrating mattering into research, practice, education and policy represents a vital step toward promoting positive health outcomes, equity and recovery (Table 5).

Table 5

Dimensions of Mattering, Description, Examples and Intended Outcomes

Dimension of Mattering	Description	Concrete Examples	Intended Outcome
Awareness (being noticed)	Individuals feel visible, acknowledged, and heard. They are valued and what they say is recognized as valuable.	- Greet individuals by name - Make eye contact - Sit rather than tower over - Active listening without interruption - Ensure they realize their absence has an impact , they will be missed - Allow individuals to share their full story	Visibility and acknowledgement

		- Create safe spaces for conversation	
Importance (being valued)	A perception of being respected, cared for and taken seriously	- Use non-stigmatizing language - Validating experiences without judgement - Providing TIC - Respectful in interactions - Contributions are seen as valuable	Dignity, respect and ensuring a sense of worthiness
Autonomy (having influence)	Individuals have agency and autonomy	- Create plans of care through a shared decision-making model - Ensure informed consent - Provide choices - Be adaptable and flexible - Offer harm reduction approaches to care	Creating a sense of empowerment and engagement in decision making processes about their health and care
Sense of Making a Difference (impact)	An individuals actions matter and have meaning	- Self-advocacy - Support of personal decision making - Individuals have value and can meaningfully contribute to their care - Opportunities for	Develop a sense of efficacy and personal control

		volunteerism, mentoring, and employment	
Social Determinants	Housing Food Security Access to Services without prejudice	- Deserving of basic food and shelter - Equitable services within a philosophy of harm reduction	Autonomy

6.15 Recommendations: Harm Reduction Services

The health implications associated with substance use encompass physical, mental, emotional, and social harms (McNeil & Small, 2014). All these harms were evident in the current study. The combination of the researcher's community nursing experience, the use of a mixed methods approach, and the interdisciplinary Committee that guided this research allowed for a broad understanding of the complexity of substance use, an understanding that would not have been possible through a single disciplinary lens.

In the context of PWUD, harm reduction strategies include needle and syringe programs, supervised consumption services (SCS), opioid substitution therapies such as methadone and buprenorphine, and the distribution of naloxone to prevent overdose deaths. These interventions aim to reduce the transmission of infectious diseases such as HIV and HCV, prevent fatal overdoses, and provide PWUD with access to healthcare services and support systems (Critchley et al., 2020). By providing sterile injecting equipment, safe spaces for drug consumption, and medication assisted treatments, harm reduction programs help mitigate the immediate risks associated with drug use while also serving as entry points to other health and social services.

Harm reduction is grounded in principles of pragmatism, human rights, and social justice (Stockwell, 2008). It operates on the understanding that drug use is a complex and multifaceted issue that cannot be eliminated; therefore, efforts should focus on reducing its harmful effects. This approach seeks to empower PWUD by involving them in the development and implementation of harm reduction programs, ensuring that services are tailored to their specific needs and circumstances. Moreover, harm reduction acknowledges the social determinants of health that contribute to substance use, such as poverty, homelessness, trauma, and social exclusion (Mikkonen & Raphael, 2020). By addressing these broader factors, harm reduction initiatives not only reduce the immediate harms of drug use but also support long term improvements in the health and well-being of PWUD. This integrated approach is crucial for promoting choice, health equity, and enhancing the quality of life for marginalized populations (Hosseinpoor et al., 2015). Building on the findings and theoretical contributions of this study, future research should aim to deepen out understanding and address gaps in the care of PWUD.

6.16 Future Research

Thorne (2008) suggests returning to the original research question to determine how to "articulate the potential role of this study within what could become a much more vigorous, focused, and productive program of research" (p. 207). The recommendations below outline directions for future inquiry.

6.16.1 Comparative Mixed Methods Studies

Conduct follow-up mixed methods research using SNA and in-depth interviews at other urban and rural sites for comparative analysis.

6.16.2 Participatory Action Research

Implement a participatory action study that includes both community members and PWUD to generate ideas and strategies aimed at fostering connection and self-worth among individuals living with an SUD.

6.16.3 Mortality Data Analysis

Collaborate with the Chief Medical Officer and Coroner's Office to identify and collect mortality data on individuals with an SUD who die in the community from medical conditions unrelated to overdose.

6.16.4 Longitudinal Studies on Mattering

Design longitudinal studies to evaluate the implementation of mattering strategies that encompass self-care and social connections. Utilize validated tools such as the *General Mattering Scale* developed by Marcus and Rosenberg (1987), which assesses an individual's perception of their significance in social relationships. In contrast, the *Anti-Mattering Scale* developed by Flett (2022) measures feelings of insignificance, invisibility, and rejection. While both scales address perceptions of significance, they capture distinct psychological experiences, one emphasizing positive perception of value and importance, the other focusing on the painful impacts of isolation and low self-worth.

6.16.5 Primary Studies on Loneliness and Disconnection

Prioritize longitudinal studies that use validated, multidimensional instruments to assess feelings of disconnection and loneliness among individuals

with an SUD (Ingram et al., 2020).

6.16.6 Tailored Program Interventions and Evaluation

Develop and evaluate interventions specifically designed to address mattering for PWUD, as this construct has not yet been systematically applied to this population. Conducting research with people who have lived experience enhances the relevance and accuracy of findings by incorporating authentic perspectives from those directly impacted by the issues under study (Giorgi, 2009). Participants provide valuable insights into the complexities of their lived realities, which are often overlooked or misunderstood by those without similar experiences. Research that includes PWUD and their perspectives on connection and self-worth would promote deeper and more meaningful outcomes.

This study represents an initial investigation into what influences and motivates PWUD to access emergency healthcare services; next steps require the inclusion of PWUD as co-researchers. Such co-production of knowledge would support the development of solutions that are socially responsive and grounded in the realities of those affected.

Finally, the subculture that exists on the streets requires thoughtful reflection on how best to share this knowledge with other researchers interested in working with precariously housed individuals living with an SUD. This may take the form of a comprehensive guidebook or publication developed collaboratively with PWUD. While these recommendations point toward future directions for advancing knowledge and improving care for PWUD, it is equally important to reflect on the strengths of the current study that provide a solid foundation for this work.

6.17 Strengths of the Study

One of the strengths of this study was the use of egocentric SNA and its ability to systematically map out the complex relationships and interactions within the four egonets. The analysis revealed a striking and unexpected descriptive pattern g: the individuals and their networks were unexpectedly dense. Egocentric SNA enabled the researcher to visualize and quantify the patterns of connections in these dense egonets, which in turn provided insight into the limited social capital and influences available to the study participants (Borgatti et al., 2018). These results have the potential to inform strategies for intervention and future policy development in various fields, including public health, organizational studies, and community development (Borgatti et al., 2018).

The primary strength of ID lies in its ability to generate clinically relevant insights through a flexible yet rigorous qualitative approach. The researcher was able to select methods that worked well for PWUD and draw on both empirical evidence and clinical expertise to develop meaningful interpretations that directly inform practice (Thorne, 2016a). This methodological approach also emphasized the co-construction of knowledge between researchers and participants, fostering deep engagement to explore what motivated and influenced them to seek healthcare services (Hunt, 2009). Interpretive Description bridges the gap between qualitative research and clinical application, making it an invaluable tool for generating actionable findings that resonate with practitioners, educators, and policymakers (Thorne, 2008).

6.18 Limitations of Current Study

Limitations within this research that must be acknowledged and includes purposive convenience sampling, lack of mortality data, underrepresentation of diverse groups, social desirability bias, geographic and socioeconomic constraints, and the impact of substance use on cognition. These are described further below.

6.18.1 Purposive Convenience Sampling

While beneficial for its practicality and targeted approach, purposive convenience sampling presents limitations that can impact the validity and generalizability of the research findings. The non-random selection process introduces the risk of selection bias, as participants were recruited based on their availability at the local needle exchange (Palinkas et al., 2015). This method may exclude individuals who are harder to reach and do not visit the needle exchange, whose experiences and perspectives are equally important meaning the exclusion of the most isolated individuals who do not access harm reduction services (Creswell, 2014). Although three agencies received REB approval as recruitment sites, at the study's initiation, only the needle exchange was deemed safe for participants and the researcher.

6.18.2 Study Period

The period in which sampling was conducted was a volatile period in the overdose crisis that coincided with local housing instability, disruptions in service access related to the pandemic response, and volatility of the drug supply. This gap during the data collection does not invalidate the design of the current study but it does make the

term “sequential explanatory” more complicated in that vulnerability of participants increased as drug supplies were no longer coming from known sources, housing situations were more tenuous, resources were limited, isolation was enforced under pandemic mitigation, and mental health, i.e., paranoia was exacerbated.

6.18.3 Mortality Data

The researcher contacted both the Chief Medical Officer and the Saint John Coroner, who confirmed there is no mechanism in place to collect mortality data for individuals who are recognized as having an SUD and die in the community from a medical condition. There was, however, an interest in further discussions to potentially begin collecting this data. Although this was a limitation, it also represents an opportunity for policy change. If the Coroner’s Office want to look retrospectively at the mortality data, it would not have been possible. Healthcare information linkages would not be verified due to the absence of medical record validation. In this population, they often do not have a permanent address, their identification is often lost and many use pseudonyms to protect their identities, further limiting the ability to establish accurate healthcare linkages. As a result, connections between reported deaths in this population from causes other than overdose would not have been possible.

6.18.4 Formal Measurements

The current study did not collect formal measurements of relevant constructs such as mattering; pain, trauma, mental health, and/or substance use severity with reliable, valid quantitative instruments. There were a number of constraints in the current study with this local population that limited the data that could be collected, for instance,

financial constraints of the researcher in offering remuneration, i.e., taxi vouchers/meals, the interviewees capacity and cognitive resources to meaningful engage with such measures, and limited time with interviewees in precarious circumstances. Further, the lack of timely and accessible mental health supports for participants if there were any triggering questions in the measures necessitated focusing on the interview protocol developed for this specific population. The lack of formal measures therefore limits the current study's ability to establish the association of these factors for PWUD accessing emergency healthcare services.

6.18.5 Underrepresentation of Diverse Groups

The study's underrepresentation of gender and culturally diverse, immigrant, refugee, and Indigenous peoples is a limitation. Ethnicity was not explicitly asked in the demographic questionnaire as this highly vulnerable population has limited ability to focus and allocation of time for interviews was very limited, and although some participants self-identified as minorities, this was not formally captured. This is a limitation as the current study has a strong equity framing however the lack of data prevented any lens for analysis or conclusions to be drawn related to ethnicity and/or underserved populations. A lack of diversity limits the breadth of perspectives and experiences reflected in the findings.

6.18.6 Social Desirability and Bias

Social desirability and bias are considerations due to the researcher's familiarity with many participants in her role as a community health nurse (Krumpal, 2013). To minimize this bias, the researcher reassured each participant before enrollment that their

participation was voluntary and that they were under no obligation to participate or continue participation if at any point they wanted to withdraw from the study. Honorariums were not contingent on completing the interview Despite these efforts, the potential for biased responses cannot be eliminated.

6.18.7 Geographic and Socioeconomic Limitation

All participants were recruited from the same densely populated, high-priority, low-income neighborhood in Saint John. While qualitative studies are inherently time and resource intensive, and it would have been desirable to include a diverse range of participants from other rural and urban centres, this was not financially feasible. Further, the UNB Research Ethics Board had approved data collection from two other sites in the Saint John, however, the non-profit staff deemed it to be too unsafe for the researcher and the participants to engage in interviews at this time due escalating violent incidents in these areas of the city. Consequently, the findings from this single data collection site may not be generalizable to other settings or populations within New Brunswick.

6.18.8 Impact of Substance Use on Cognition

Recognizing the impact of substance use on cognition, memory, and the ability to focus was important for this study. Participants in the Phase I egocentric SNA study reported that longer interviews requiring sustained memory and focus were challenging. Therefore, interviews were kept within a one-hour period. The literature indicates that substance use and experiences of overdoses can significantly impair cognitive function and increases paranoia (Volkow et al., 2017), affecting the depth and accuracy of the data collected. Not surprisingly, interviewees asked that interviews not be audio recorded as it

reminded them of past traumatic events related to recordings with social workers and police. While attempts were made to reduce these limitations, it is essential to recognize them to provide context to the study's results and to understand the relevance of the research completed. Prior to the interview proper, the researcher engaged in an ice-breaker type conversation to assess their capacity for engagement in the full interview, as well as monitoring throughout the interview for drug-induced sleepiness, reduced comprehension, and attention.

Acknowledging these limitations provides essential context for interpreting the study's findings. Despite these constraints, the research contributes to the growing body of knowledge on the concepts of self-worth, connection, and the theoretical construct of mattering as influential factors in emergency healthcare access among PWUD.

6.19 Situating Mattering

This study situates mattering within a broader psychosocial framework, identifying its relevance for marginalized populations. This dissertation identifies mattering as a promising interpretative lens and provides the basis for future empirical testing, intervention development, and healthcare system change. Self-worth, characterized by intrinsic value, and connection, which denotes meaningful relationships and belonging, emerged as motivators for PWUD in accessing emergency healthcare services. These findings align with Rosenberg and McCullough's (1981) seminal work on mattering, which identified awareness, importance, and reliance as dimensions that buffer against stress and foster psychological resilience. The mixed methods study extended these insights by demonstrating how relational dynamics and positive interactions

reinforced participants' sense of self-worth and trust, facilitating engagement with healthcare despite existing barriers.

The resurgence of research on mattering (Flett et al., 2020) is timely for the PWUD population. While mattering fosters self-worth and connectedness; anti-mattering, highlights the deleterious effects of feeling unnoticed or unvalued. These dual perspectives offer a nuanced understanding of how social experiences shape mental health and behaviour, particularly for individuals facing stigma and marginalization (Prilleltensky, 2020; Flett et al., 2023) and hold practical implications for effective human services.

Furthermore, this dissertation underscores the importance of integrating mattering-focused interventions into healthcare practice. Strategies that prioritize empathy, inclusivity, and affirmation can address systemic inequities that perpetuate feelings of invisibility among PWUD. Training healthcare providers to cultivate trust and respect is essential for mitigating stigma and fostering a sense of belonging for marginalized populations, which, as this study reveals, influences emergency healthcare seeking behaviours.

Future research should expand on these findings by exploring how mattering-based interventions impact long-term health outcomes and social reintegration for PWUD and potentially other populations. Longitudinal studies could investigate the interplay between self-worth, connection, and healthcare engagement, while policy-driven research could assess the scalability of mattering-centred programs in diverse settings.

In summary, the integration of self-worth, connection, and mattering within healthcare systems offers a framework that supports greater emergency healthcare access for this

marginalized population. By bridging theoretical constructs with applied practices, this study advocates for a compassionate and equitable healthcare model that values the dignity and humanity of all individuals. Such an approach is not only critical for advancing healthcare outcomes but also for fostering a society in which every individual feels seen, valued, and connected, a society in which everyone matters.

6.20 Conclusion

In conclusion, this chapter presented findings from a mixed-methods sequential explanatory design that integrated SNA and ID methodological approaches. Through a comprehensive examination of the interplay between self-worth, connection, and emergency healthcare-seeking behaviours among PWUD, this study offered a more nuanced understanding of how relational dynamics and structural vulnerabilities shape access to care. A visual aid was introduced to illustrate the factors that were found to influence decisions to access ED services within substance using populations. Recommendations for educational, policy, and clinical practice were outlined, along with future research directions to advance this work. Collectively, the findings highlight the impacts of pain, self worth, connection and mattering on healthcare engagement. The study allows for reflection on how systems and communities might be reshaped to affirm the inherent worth of PWUD and foster environments where dignity, safety, and accessible support are available for all members of our society.

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Appendix A

Practical Guide to Working on the Streets

Introduction

This appendix follows the completion of the SNA and ID research studies to share lessons learned while working with PWUD. The aim is to provide practical recommendations and guidance for researchers to support successful and positive study opportunities and experiences. The insights in this chapter are based on the writer's knowledge of street drug culture as a community health nurse and additional knowledge transitioning to the role of researcher working with PWUD in Saint John, New Brunswick.

The Code of the Streets

The concept of the "code of the streets," extensively studied by sociologist Elijah Andersen in his seminal work *Code of the Street: Decency, Violence, and the Moral Life of the Inner City* (1999), provides a framework for understanding the behaviours, interactions, and social norms within marginalized urban communities. This code, which emphasizes respect, self-presentation, and toughness, intersects significantly with the dynamics of street drug culture, shaping the lives of individuals in these environments. Felix, a participant in the study cautioned the researcher to be careful, stating, "If you don't know what you're doin,' you don't know what you're sayin' or who you're talkin' to, you could be dead." Knowledge of the street code enhances the quality of data collected by building trusting relationships and creating a safe, respectful environment for participants (Rhodes et al., 2017). Understanding the cultural context of the streets

encourages researchers to develop active listening skills and accurately interpret language, gestures, and behaviours.

The Art of Active Listening

Psychologist Carl Rogers (1951) initially defined "active listening" as the listener's ability to skillfully paraphrase what is being communicated by the speaker (Rogers, 1951). The role of the listener is not passive; it requires engagement, attentiveness, and a focused, non-judgmental attitude toward the speaker's message. Research has shown that active listening is particularly beneficial, as listening with genuine care and sensitivity can reduce any sense of threat or antagonism that PWUD misinterpret, especially when opposition is anticipated (Rogers, 1951). During one of the interviews, a participant insisted on having his girlfriend present. She applied her make-up, curled her hair with a curling iron, and completely ignored the participant throughout the interview. He repeatedly told her he loved her, with no response. She purposively ignored him, until he mentioned a history of attempting to end his life, she looked up directly at the researcher stating “yeah, that’s what he does.” No response from the researcher was expected. Active listening requires the full attention of the listener who remains neutral, engaged, and empathetic.

The Use of Street Language and Gestures

Street language is vibrant and rich with colloquial expressions (Appendix P). Observations from four decades of clinical experience taught the researcher that the use of street language must be done with sensitivity. There are often gestures and nonverbal cues that accompany street language; if the researcher is unaware of these, it leads to misunderstandings and negative interactions. Caution is advised when using street

language, as it may be misunderstood by PWUD as mocking or disrespectful. An example would be the word “goof,” as this word is a highly derogatory term and should never be used in conversation. The researcher is always perceived as an outsider and as someone who does not have lived experience. A calm, neutral demeanor and the use of appropriate professional language is more likely to be well-received than awkward attempts to use unfamiliar street language.

Nonverbal cues and gestures also play an important role in communication within substance-using populations. In the researcher’s experience, nonverbal cues significantly contribute to building trust, respect, and rapport. Researchers must be mindful not to unintentionally convey disrespect or condescension. Demonstrating deference, not making eye contact, and standing to the side rather than directly in front of respected and influential individuals is important, as a full-on direct stance may be perceived as defiant and aggressive. Additionally, keeping one’s hands in pockets can be viewed as secretive and that the researcher is 'hiding something.' Asking too many questions, trailing behind someone uninvited, or searching for participants without a legitimate reason is also deemed highly suspicious.

Researchers must also avoid the pitfalls of academic tourism and voyeurism, which can further erode trust. In the researcher’s experience “do-gooders” are viewed with derision (Capicchioni et al., 2022). Academic tourism is the act of researchers exploiting communities for data without genuine engagement or contribution to the community's welfare, and voyeurism involves intruding into people's lives in a manner that is disrespectful or sensationalized (Clark-Kazak, 2020). In the researcher’s

experience, academic tourism, and voyeurism, pointing at individuals and whispering, in the community can lead to confrontation and altercations.

PWUD are extremely sensitive to power dynamics. In the researcher's experience, the act of bathing and dressing in clean clothes can create unintended power imbalances, as individuals experiencing homelessness may not have access to shower and laundry facilities. In an interview with Newf, he stated "It's not right, it's just not right man… I haven't had a shower for a week… and here I am sittin' with a lady, and it just doesn't feel right." Therefore, it is encouraged that the researcher be sensitive to the poverty participants are experiencing by dressing casually, using scent-free products, and minimizing make-up, jewelry, and the use of electronics. Women who use substances and involved in the sex trade may view other women, including female researchers and students, as competition, potentially leading to violence and territorial behaviours.

Safety on the Streets

The researcher must be aware of and address safety concerns. This requires meticulous planning, adherence to ethical guidelines, and knowledge of the neighborhoods where the research is conducted. The first step is to secure REB approval and obtain informed consent from participants to ensure they understand the researcher's role, the study's purpose, procedures, risks, and benefits. Maintaining transparency is essential. The researcher must be clear about their presence in the area and their objectives. Comprehensive training in harm reduction, cultural competence, nonviolent crisis intervention, and emergency response is beneficial. Developing and maintaining safety protocols, such as a buddy system, regular check-ins, parking in well-lit and visible locations, and working during daytime hours, is crucial. It is wise to choose mutually

acceptable and safe interview locations for the safety of both the researcher and participants. Ongoing monitoring and communication with local non-profit agencies will help the researcher avoid emerging risks (e.g., gang-related activities). Awareness of potential dangers and how to mitigate them ensures the safety of the researcher, participants, and community members.

Street Drug Culture

Street drug culture is a subtype of the broader street code, encompassing the specific behaviours, norms, and economic activities related to the illegal drug trade. This culture is marked by its own set of rules and hierarchies and is deeply intertwined with the code of the street. The drug trade is a primary means of economic survival for many individuals, offering a way to achieve financial stability and gain respect within the community. In this context, respect and reputation are even more critical. Drug dealers and users must navigate a perilous environment where trust is scarce, and betrayal can lead to violence (Treloar et al., 2016). In the researcher's experience, PWUD are very matter of fact when they speak about how respect is enforced through violence, as the Captain stated, "It's just how it is here, you know, respect is everything and not havin' it can get you killed." The need for respect can at times create unsafe environments in the neighbourhood.

Building Trust and Respect

Study success requires that the researcher be considered trustworthy. This trust is earned, unspoken, and in the researcher's experience a respected member of the community often grants it. In this study, it was the long-standing professional relationship of the researcher with an influential and powerful drug dealer that signaled to others that

they had permission to participate. At the beginning of the study, he came to the needle exchange and there was a palpable shift in the room as people quietly moved out of his way, no one made eye contact, and the boisterous chatter dissipated into silence. He commanded respect. As a researcher, being aware of personal and participant safety, having respect and permission to be in the community, cannot be overemphasized.

Distrust of Authorities

The code also includes an inherent distrust of authorities such as the police and the judicial system. This distrust is rooted in experiences of discrimination and perceived systemic corruption, leading to a reliance on informal, often violent, methods of conflict resolution (Ross, 2021). Individuals learn these unwritten rules through socialization and observation so that they can navigate the dangers of street life successfully. Being aware of the code and previous experiences of PWUD with police officers, social workers, and healthcare professionals must be a consideration when developing a study (Appendix N). The academic researcher may also be viewed with distrust despite their well-intentioned efforts. There is "a high level of suspicion and distrust of university-based researchers, particularly in low-income ethnic minority communities" (Peacock et al., 2011, p. 279). In one interview when discussing trust, the participant looked at the researcher and stated, "We're okay with you because you don't want nothin' from us… and you're not gonna take nothin' from us." The assumption that academic researchers have the right to "visit and study" phenomena in high-risk neighborhoods puts everyone's safety in jeopardy (Jeffrey & MacDonald, 2006). Peers can be instrumental in ensuring safety of the research team and supporting community-based research studies (Benoit et al., 2017).

Peers and Cultural Affinity

Peers share a common language and experience, a cultural affinity, and an understanding of the life circumstances of living with addiction (Lennox et al., 2021). Peers have a unique ability to develop trusting therapeutic relationships with participants and add a certain level of credibility to the research project. A peer's insight, knowledge, and perspective will add depth to the study that can ultimately "improve program accessibility and acceptability" (Kennedy et al., 2017). A peer at the needle exchange stated, "We know the highs… we know the secrets… the tricks… and we know all about the lows and there's nothin' they've done or said that we haven't done ourselves." The intuitive ability of peers to demonstrate empathy, create safe spaces, and develop non-judgmental relationships through shared experiences can signify mutual respect (Pauly et al., 2018; Weissman, 2016).

Intersection of Street Drug Culture and Street Code

The relationship between street drug culture and the broader code of the street is symbiotic. The drug trade provides economic opportunities that reinforce the need for the behaviours dictated by the street code, such as toughness and the capacity for violence. Simultaneously, the code of the street legitimizes and perpetuates the norms of the drug culture, creating a cycle that is difficult to break (Andersen, 1999; Ross, 2021). One participant relayed an incident when the paramedics were on route to the ED following an overdose: "I told them, I'm like, please don't take me to the hospital man, please, I don't wanna go" … "I was cryin,' because I was like scared to death, I'd tell them who I got the drugs from" … "I was right out of it, and if I said anything to them, man, I'd be

dead." Researchers must recognize the fear associated with retribution and street violence at all times.

Effective Engagement

Understanding the intersection between the code of the street and street drug culture is essential for researchers and practitioners working in high-risk urban environments. The norms governing respect, reputation, and violence shape the daily lives of individuals in these communities, influencing their interactions with each other and with outsiders. Often there is a deep-seated distrust towards professionals, including healthcare providers, social workers, police, and researchers, which stems from a history of discrimination and exploitation (Andersen, 1999). This distrust can hinder efforts to engage with communities in meaningful and supportive ways, therefore effective engagement with individuals in street drug culture requires a nuanced understanding of the street code.

Conclusion

Trust and respect are invaluable in determining the success or failure of a research project. Researchers who practice ethical reflexivity and recognize their personal biases and assumptions will have the capacity to approach the community with both cultural humility, and sensitivity (Clark-Kazak, 2020). Being reflexive enables the researcher to respond to unforeseen challenges, power imbalances, safety concerns, communication issues, and ethical dilemmas in a manner that will contribute to positive relationship building (Pillow, 2003). Investing time to become familiar with the neighbourhood the researcher will not only advance academic knowledge will also support the well-being

and resilience of PWUD, helping them to navigate the complex interplay of the code of the streets and street drug culture.

Appendix B

Phase I SNA Informed Consent

EXPLORING THE HEALTH DECISIONS OF PWUD

Kimberly Wilbur, RN MN

University of New Brunswick, Faculty of Nursing

Kimberly.Wilbur@unb.ca (506) 648-5664

Doctoral Supervisor

Dr. Robert Moir

rmoir@unb.ca

(506) 648-5726

Assistant Dean IDST

Dr. Daniel Downes

downes@unb.ca

(506) 648-5984

This project has been reviewed by the REB **at UNB and is on file as # 050-2021.**

I am invited to be a part of the research study conducted by Kim Wilbur under the supervision of Dr. Robert Moir. I understand that the study is a part of a research project for Kim Wilbur's Interdisciplinary Studies Ph.D. The reason for the study is to increase the understanding of health decisions made by PWUD, in Saint John, New Brunswick.

- I volunteer to take part in an interview that could last from 60 to 90 minutes or more and I can do this in more than one visit.

- I understand I will be asked for general information about my age, gender, education, and substance use.
- I understand that the interviews will be recorded and once it is typed and reviewed the original electronic files will be deleted from all devices.
- I understand I can refuse to have the session recorded and the researcher will make notes during our conversation.
- I can stop or withdraw from the study at any time, it is my choice.
- If I am not comfortable, Kim Wilbur will stop the interview so that I can gather my thoughts or decide to stop the interview at any time.
- Taking part in this study will allow me to talk about my network of friends and the people I interact with as well as my health and well-being.
- All my information will remain confidential. My name will never appear in a presentation, publication, or report.
- The study information will be kept in a locked cabinet in the secure office of Dr. Robert Moir, Faculty of Business, for three years. Once the study is finished the information will be destroyed as per the requirements of the UNB Research Ethics Board.
- I have the right to decide to withdraw from the study at any time. All my information and recordings may be withdrawn at that time.
- I understand I will receive a $30 Gift Card in appreciation for my time and to cover any travel costs. This cash gift will be given to me after my interview even if I decide to stop or withdraw from the study.

I understand that the study has been reviewed and given approval by the University of New Brunswick Research Ethics Board. I agree to take part in the study being done by Kim Wilbur and may get in touch with her if I have any questions.

I may get in touch with her Supervisor, Dr. Robert Moir, Associate Dean of the Faculty of Business, or Dr. Daniel Downes, Associate Dean, Interdisciplinary Studies if I have any other questions. I can also get in touch with the Chair of the Research Ethics Board, Dr. Beth Keyes at (506) 648-5994.

A copy of this consent form will be given to me at the time of my interview. I would like to have a copy of the Executive Summary of the final thesis document. Yes, __No __

I am giving my consent and understand the following:

- I am being asked to talk about my everyday health and life experiences. I can decide whether the conversation will be recorded.
- My name will never appear in any reports or presentations about the study. The results may be published and presented at meetings.
- I will receive a $30 Gift Card as a thank you for taking the time to be interviewed.
- I have been given the chance to ask questions, and they have all been answered.

_____	_____
Participant's Printed Name	Date [day/month/year]
_____	_____
Participant's Signature	Date [day/month/year]
_____	_____
Researcher's Signature	Date [day/month/year]

Appendix C
Phase I SNA Study Interview Guide

Phase I SNA Study: Exploring the Health Decisions of PWUD: Explanatory Sequential Design: Social Network Analysis and Interpretive Description

The study will inform the broader network analysis and provide valuable information and insight in terms of questions, language, and the drug-using community. The intention is to enroll three to five individuals with lived experience of substance use.

Following the informed consent process, the interviews will align with the SNA Interview Guide documents attached. Any additional information provided by the participants will be noted in the researcher's journal notes.

The information Guide documents include an Informed Consent (approved by REB), a demographic information sheet, an SNA Questionnaire, Alter-Question Responses, an Alter-Alter Grid, and a map of Saint John. Each participant will receive a $30 Gift Card of their choice (Visa/Tim Hortons).

Introduction

Thank you for agreeing to be a part of my study and helping me to understand decisions are made about your health. The interview will take about 60-90 minutes, however, if you need a break at any time or want to stop for any reason, just let me know and we can do that.

Being part of the study is completely voluntary, and you may withdraw at any time. All the information you discuss and provide to me is strictly confidential and your name only appears on the consent; your identity will not be revealed. Outside of the informed consent for the study all the information related to your interview such as the notes or audio recordings will be identified using your initials, a unique name that you can choose.

If you have any questions, are not sure about something, or have questions during the interview, feel free to stop me at any time. You indicated in your consent that you would allow me to record the interview, is this still okay with you? Are you comfortable and is there anything you need before we begin?

Appendix D
Phase I SNA Study
Ego Demographic Information

Ego Demographic Information **Date :** _____(d/m/y) Participant ID_____

1	What is your age?	Numeric
2	What is your gender?	Male = 0 Female = 1 Other = 2
3	Looking at the map, where are you living?	Geographical Map
4	Can you tell me what drugs you've used in the past month?	Crystal Meth = 0 Heroin = 1 Cocaine = 2 Crack = 3 Fentanyl = 4 Dilaudid = 5 Marijuana = 6 Other = 7
5	How often have you used these drugs in the past month?	Once a day = 0 Every 3-4 days = 1 Every week = 2 Every 2 weeks = 3 Once a month = 4
6	When you use, do you use with another person or persons?	Never = 0 Rarely = 1 Sometimes = 2 Often = 3 Always = 4
7	What long-term chronic health conditions do you have?	Diabetes __ High Blood Pressure__ Heart Disease __ Infections __ Skin Conditions __ Lung Problems (asthma/bronchitis) __ Chronic Pain Issues __ kidney disease __ Other or anything you would like to add.

Appendix E
Phase I SNA Study
Alter Name Generator and Attributes

Alter Name Generator

1.	List 20 people you know by name and who know you by name, that you could easily call out to say on the street "Hey Joe" and they would respond "Hey Bill". This would be someone you connected with over the past year. You only need to provide initials or a nickname or any label of some kind so that you can easily recognize them on the list.	See Alter Name Generator Below

Alter Attributes *(see Alter Question Responses)*

1.	What is the gender of this person?	Male = 0 Female = 1 Other = 2
2.	How old is this person?	Numeric ____
3.	Where on the map does this person live?	Geographical Information
4.	How long have you known this person?	Numeric will allow for the development of categories.
5.	How do you connect or get in touch with this person?	In-person = 0 Phone = 1 Text = 2 Facebook / social media = 3 Email = 4 Other = 5
6.	In the past year, how often have you been in touch with this person?	Daily = 0 Weekly = 1 Monthly = 2 Every 2-3 Months = 3 Every 6 Months = 4 1-2 times a year = 5

7.	How often do you use drugs?	Never = 0 Rarely = 1 Sometimes = 2 Often = 3 Always = 4
8.	How much do you trust this person?	Never = 0 Rarely = 1 Sometimes = 2 Often = 3 Always = 4
9.	Would you go to this person for healthcare stuff?	Never = 0 Rarely = 1 Sometimes = 2 Often = 3 Always = 4

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Appendix F
Phase I SNA Study
Ego Attributes Questionnaire

1	Who would you go to if you have a health concern?	Do not see anyone about health concerns. MD Nurse / NP Relative Friend Pharmacist Agency Worker Shelter Staff Other Person(s)
2	In the past year, how often have you seen this person about your health?	Never = 0 Rarely = 1 (1-2x/year) Sometimes = 2 (2-4x/year) Often = 3 (4-6x/year) Frequently = 4 (6+ times/year)
3	If you were to get very sick, what would you do?	Make an appointment with a doctor/nurse. Call an ambulance. Go to the hospital. Go to a clinic or pharmacy. Talk to a friend or relative. Go to an agency. Connect with someone you use with Talk with your dealer. Not do anything.

Appendix G
Phase I SNA Study Responses to Questions About Alters

Alter Question Responses

Alter ID	1	2	3	4	5	6	7	8	9
1									
2									
3									
4									
5									
6									
7									
8									
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19									
20									

Appendix H
Phase I SNA Study Alter – Alter Ties

Alter-Alter Ties

1	If Alter X met Alter Y on the street and you weren't there, would they know and talk to one another?	See Alter-Alter Ties

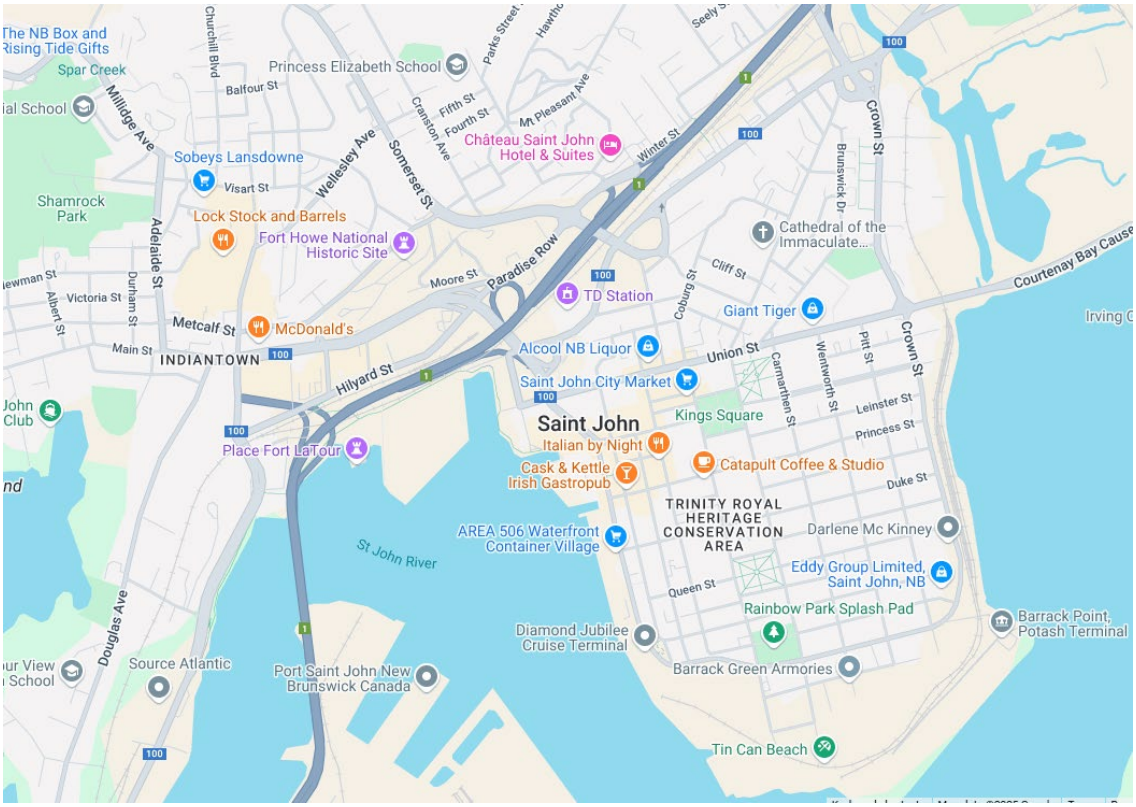
Alter ID																		

Appendix I
Master List of Participant Identification Codes

Name (First – Last)	Unique Identifier

Appendix J
Phase I SNA Study Map

Map of Uptown and South End Area of Saint John, New Brunswick



Google Maps for Saint John Tourism https://streetlookup.com/city/saint-john-map/

Note: Question 3 was removed as the participants were uncertain of addresses and whether individuals were currently living in shelters or were homeless

Appendix K
Part II ID Study Informed Consent

Kimberly Wilbur, RN (Registered Nurses) MN, PhD (ABD)

University of New Brunswick, Faculty of Nursing

Kimberly.Wilbur@unb.ca (506) 648-5664

Doctoral Supervisor Dr. Robert Moir

rmoir@unb.ca (506) 648-5726

The Research Study Part II has been reviewed by the UNB REB (file #2022-076)

I am invited to be a part of the research study conducted by Kim Wilbur under the supervision of Dr. Robert Moir. I understand that the study is a part of a research project for Kim Wilbur's Interdisciplinary Studies PhD. The reason for the study is to increase the understanding of health decisions made by PWUD, in Saint John, New Brunswick.

- I volunteer to take part in an interview that could last 60 minutes or more and I can do this in more than 1 visit.
- I understand I may be asked questions about my thoughts on drug use and the challenges of living with drug use.
- I understand that the interviews will be recorded and once it is typed and reviewed the original electronic files will be deleted from all devices.
- I understand I can refuse to have the session recorded and the researcher will make notes during our conversation.
- I can stop or withdraw from the study at any time, it is my choice.

- If I am not comfortable, Kim Wilbur will stop the interview so that I can gather my thoughts or decide to stop the interview at any time.
- Taking part in this study will allow me to talk about my network of friends, the people I interact with as well as the decisions I make about my health and well-being. OBJ
- All my information will remain confidential. My name will never appear in a presentation, publication, or report.
- The study information will be kept in a locked cabinet in the secure office of Dr. Robert Moir, Faculty of Business, for three years. Once the study is finished the information will be destroyed as per the requirements of the UNB Research Ethics Board.
- I have the right to decide to withdraw from the study at any time. All my information and recordings may be withdrawn at that time.
- I understand I will receive a $30 Gift Card in appreciation for my time and to cover any travel costs. This cash gift will be given to me after my interview even if I decide to stop or withdraw from the study.

I understand this project has been reviewed by the UNB Research Ethics Board and is on file as REB 2022-076. I agree to take part in the study being d1 by Kim Wilbur and may get in touch with her if I have any questions.

I may get in touch with her Supervisor, Dr. Robert Moir, Associate Dean Faculty of Business if I have any other questions. I can also get in touch with the Chair of the Research Ethics Board, Dr. Beth Keyes at (506) 648-5994.

A copy of this consent form will be given to me at the time of my interview. I would like to have a copy of the Executive Summary of the final thesis document. Yes, __No __

I am giving my consent and understand the following:

- I am being asked to talk about my everyday health and life experiences. I can decide whether the conversation will be recorded.
- My name will never appear in any reports or presentations about the study. The results may be published and presented at meetings.
- I will receive a $30 Gift Card to thank you for taking the time to be interviewed.
- I have been given the chance to ask questions, and they have all been answered.

_____	_____
Participant's Printed Name	Date [day/month/year]
_____	_____
Participant's Signature	Date [day/month/year]
_____	_____
Researcher's Signature	Date [day/month/year]

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Appendix L
Part II ID Study
Demographic Questionnaire

	What is your age?	Numeric
	What is your gender?	Male = Female = Other =
	Where are you currently living?	Own home Shelter Apartment Tent City With Friend Homeless
	What grade did you complete in school?	Grade 9 Graduated from Highschool Graduated from College Graduated from University Other:
	Tell me about the substances you've used in the past month.	Crystal Meth = Heroin = Cocaine = Crack = Fentanyl = Dilaudid = Marijuana = Benzodiazepine = Alcohol = Nicotine = Other =
	How often have you used these drugs in the past month?	Once a day = Every 3-4 days = Every week = Every 2 weeks = Once a month =

	How often do you use it with another person?	Never = Rarely = Sometimes = Often = Always =
	What chronic health conditions do you have?	Diabetes __ High Blood Pressure__ Heart Disease __ Infections __ Skin Conditions __ Lung Problems (asthma/bronchitis) Chronic Pain Issues __ Kidney Disease __ Other: anything you would like to add
	Have you ever gone to the hospital for a health problem?	Yes No
.	Was your health issue addressed?	Yes No
.	If yes, in the past year, how many times have you gone to the hospital? If yes, were you admitted? Did you stay?	

Appendix M
Phase II ID Study Interview Guide

Following the informed consent process, interviews will align with the ID Study Interview Guide. Any additional information provided by participants will be noted in the researcher's journal. The ID Study Information Guide documents will also include REB-approved Informed Consent. The sessions will be audio-recorded and transcribed with permission by the participant; otherwise, handwritten notes will be taken. Each participant will receive a $30 Gift Card.

Introduction

Thank you for agreeing to be a part of my study and helping me to understand what factors influence your decisions about your health and going to the hospital. The interview will take about an hour, and if you need a break at any time or want to stop for any reason, just let me know and we can do that.

Being part of the study is completely voluntary, and you can withdraw at any time. All the information you discuss and provide to me is strictly confidential and your name and signature only appear on your consent and your identity will not be revealed. Outside of the informed consent for the study all the information related to your interview such as the notes or audio recordings will be identified using your initials, and a unique name that you can choose.

If you have any questions, are unsure about something, or have questions during the interview, please stop me at any time. You indicated in your consent that you would

allow me to record the interview, is this still okay with you? Are you comfortable and is there anything you need before we begin?

A constant comparative approach, in which new data is compared to emerging themes from previous interviews allows for additional understanding of concepts and the refinement of themes.

Data collection and analysis occur in a concurrent and iterative process. Initial question:

"Can you tell me about a time when you were concerned about your health and what happened before you decided to go or not to go to the hospital?

Tell me about the day and what was happening in your life at that time? On that day, were you by yourself or with someone else.

Appendix N
Practical Guide for Working with PWUD

Guideline	Recommendations
Building Relationships and Gaining Trust	Identify the key community gatekeepers who provide unspoken permission for you to be in their neighborhood. Get connected, volunteer, participate, and become a familiar face. Be informed about the streets, including past and present stressors. Explore current traumas, homicides, suicides, deaths, and missing persons. Walk the streets with a trusted member of the community, someone who can vouch for you being in the neighborhood. Quietly spend time in the neighborhood, and talk with people, shop owners, volunteers, drop-in clinics, and professionals (i.e., police, paramedics, and firefighters).
Power and Conducting Yourself Appropriately	Dress down, don't wear name-brand clothing or expensive jewelry, and don't be 'flashy.' Do not bring expensive technology to the community. Do not arrive in the community freshly showered and 'perfumed' as this can be viewed as confrontational and disrespectful. These amenities may not be available to people on the street, and it can immediately set up a power imbalance. Do not arrive with hair done, make-up on and freshly showered as sex trade workers may view this competition. Be discreet in your appearance. Introduce yourself to the local pharmacists, workers at the methadone clinics, and needle exchanges when appropriate. Wait to be introduced to PWUD on the street, do not insinuate yourself into the group. Do not extend eye contact, as it may be viewed as disrespectful or as a sign of aggression. Do not use street language or use unfamiliar body language to "fit in." You may be ridiculed and not taken seriously, or it may be viewed as disrespectful. Always be professional and do not ask too many questions, PWUD and those who are homeless do not want pitied or treated as if they are a curiosity or tourist attraction. Be respectful of an individual's personal space. Do not be overly familiar or flirtatious.

Providing Support and Compensation	Pay people for their time when they are assisting you with your research (e.g., peers). Remuneration in the form of a variety of gift cards or cash is best. Do not use Visa gift cards as there is a fee to cash them in. Be aware that most PWUDs on the street either do not have a cell phone or do not have data packages.
Timing and Logistics	Conduct research within four hours of PWUD receiving their substitution therapy (i.e., methadone, suboxone). Do not conduct research when social assistance cheques are due to arrive. Mornings are better for interviews as most PWUD receive their substitution therapy early in the day. Do not book interviews on Friday evenings as this is usually a busy time for PWUD. Do not interfere or make comments about the drug trade or sex trade, stay focused on why you are in the neighbourhood.
Interview Etiquette	Recognize that dentition is an issue, hard crunchy fruits and vegetables are difficult to chew and usually PWUD are very self-conscious of their teeth. Bring sugary, soft snacks to research meetings, it 'helps reduce with the cravings.' Snack bags to go are always appreciated once the interviews are completed. Do not close the door of the interview room, ask first. Do not assume that audio recording is permissible, ask first. Be aware that PWUD has triggers that may heighten their cravings, like the sound of crinkling paper. Ask the participant if they have triggers, it is appreciated. Be genuine and admit that you do not understand something. Remember that research interviews that extend beyond 30-60 minutes is difficult for PWUD. If possible, conduct interviews when the participant agrees to be enrolled. Making appointments and booking specific times usually do not work for PWUD on the street. Choose a mutually agreed upon safe space for interviews. Comfortable silence is a skill. Watch the weather – snow and rain keep people inside. Be patient, be kind, and be informed.

Appendix O
Phase II ID Study
Template Analysis

Participant: _____ Date: _____

Trauma

- Robbed, Stabbed, Shot
- Broken Bones, Sledgehammer
- Danger, abandoned
- Car Accident
- Sexual Assault, raped
- Injuries, retribution, hurt as a kid
- Beaten, grief, hopelessness
- Sex Trade

Poverty **PAIN**

- Food Insecurity
- Homelessness, shelter, tent
- No money, no place to go, jail
- No phone, no money for medication, no way to get anywhere

Substance Use

- Withdrawal, Narcan
- Stigma, discrimination

- Discrimination, trust
- Fear, overdose, scared
- Infections, HIV, Hepatitis
- Feel Good, why not, no one cares anyway

Pain

- Violence, police, friends died, I'm dying
- Loss and Grief
- Chronic Health Conditions, endocarditis, gangrene, kidney disease, diabetes, lung problems

Value and Connection

- Love my mother **VALUE AND CONNECTEDNESS**
- Love my kids
- Love my boyfriend
- Love my cat
- Friends care about me, my sister helps me, doctor was good to me

Files: *Angie, Cathy, Yung, Chelly, City Momma, Captain*

Appendix P
Street Terminology

1. Rig - needle

2. Cooker – pan/spoon

3. Hit - drug

4. Hot Shot – shooting up with the intent to murder

5. Jib - meth

6. Shorts – needles

7. Longs - needles

8. Opioids – fentanyl, morphine, Percocet, oxycontin, codeine, oxycodone, heroin

9. Oxycodone - oxycodone

10. Dixies - dexamphetamine

11. Uppers - stimulants

12. Weed – Marijuana

13. Coke - cocaine

14. Dealer – drug supplier

15. Hook-up - meet

16. Crack – cocaine that is smoked

17. Blow – cocaine

18. Snow - cocaine

19. Ice – crystal meth – a stimulant to be smoked, snorted, ingested, or injected

20. Crank – crystal meth

21. E - ecstasy

22. Hash - cannabis

23. X - ecstasy

24. Ripped - high

25. Pill Sick - withdrawal

26. Smack - heroin

27. Juiced - high

28. J1sing - withdrawal

29. Meth Head – crystal meth user

30. Goof – pedophile hopes you get stabbed in prison

31. Benzos - benzodiazepines

32. Magic Mushrooms

33. Straight Shooter - Crack Pipe

34. Junkie – lowest of the low/dirty

35. Meth pipe or flower pipe – crystal meth pipe

36. Crack Whore – sex trade worker who uses crack cocaine

37. Crack House – meeting place for selling and ingesting crack cocaine

38. Bang – shoot up or intravenous drug use

39. Wash – diluted drugs to be used intravenously

40. Sex work/sex trade

41. Downers – alcohol/ benzos/cannabis

42. Narcan and use of Fentanyl – an opioid 50-100x more potent than morphine

Curriculum Vitae

Kimberly Anne Wilbur

Education

2026 Doctor of Philosophy, Interdisciplinary Studies

University of New Brunswick

Dissertation: *"Mixed Methods, Social Network Analysis and Interpretive Description –Explanatory Sequential Design: What Influences and Motivates People Who Use Drugs to Access Emergency Healthcare Services*?"

2020 Master of Nursing, Thesis Stream

University of New Brunswick

Thesis: "*Community Health Worker Experiences with People Who Use Drugs: A Phenomenological Study*."

2004 Bachelor of Nursing

University of New Brunswick: First Division

1982 Diploma of Nursing

L'École des Infirmières - Bathurst School of Nursing – Valedictorian

<u>Professional Courses and Education</u>

2026 Indigenous Vision Quest: Koti-Monussehkasultimok

2026 Cultivating New Pathways for Post-Secondary Educators

UNB TLS (March 24, 2026)

2026	Unlearning Colonialism Through the Wisdom of Relational Renewal: A Public Circle UNB TLS (March 24, 2026)
2026	mijua'ji'jk temk wasiosak temk Youth Carrying Our Language Forward Conference Mi'kmaq - UNB – Future Generations Foundation (March 18-21, 2026)
2026	Indigenous Scholars Webinar Series: Photovoice as a Community Based Participation Research: John Hopkins University
2026	Medicine Wheel Training Course offered over 12 weeks by Elder Noel Millier in collaboration with the University of New Brunswick.
2025	Wabanaki Traditional Leadership Certification Course, offered over 10 months in collaboration with the Mi'kmaq-Wolastoqey Centre (MWC)/UNB TLS
2025	Faculty of Nursing Future of Nursing Education & Practice Lecture Series, Rethinking Learning: Preparing Students for World of Instant Information (Feb. 24, 2025)
2025	Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2: CORE 2022) Certification (January 1, 2025)
2024	Stages of Psychotherapy for Trauma and Stress-Related Disorders Paper by Mardi Horowitz MD and facilitated by Dr. Jackie Kinley MD Halifax, Department of Attachment & Relationship Therapy (DART) (April 4, 2023)

2024	The Impact of AI in Education and AI in Curriculum Development Pearson Leaders in Learning Series – 2-hour Workshop (February 28, 2024)
2023	Two-Eyed Seeing Approach to Medicine at Dalhousie: Decolonizing Medical Education Elder Albert Marshall Elder Imelda Perley
2023	Steps Toward Decolonization: Reimagining Our Teaching. Workshop Dr. Mary Battiste and Dr. David Perley (October 2023)
2023	Indigenous Health & Healing Health Circle Workshop with Elder Andrea Simon (June 2023)
2023	Integrating Indigenous Perspectives in the Classroom: Insights from Students and Educators. Pearson Education Webinar Series (May 2023)
2023	Words Matter: Inclusive Language in the Classroom (Workshop) Pearson Education Webinar Series (April 2023)
2023	Discovering vSim for Nursing Mental Health (Next Generation) KW Global, Lippincott & Laerdal (March 2023)
2023	Canadian Schools of Nursing (CASN) Integrating the Truth and Reconciliation Commission Calls to Action in Nursing Curricula (3-hour workshops - January – June 2023)
2023	CIHR Academic Workshop (Grants/Strategic Direction) Facilitator CIHR President Dr. Michael Strong
2023	Centre for Teaching and Learning, University of Alberta (Workshop) Confessions of an “EDI Killjoy”: Just Acronyms...Or Academic Justice? Facilitator Dr. Tommy Mayberry, Executive Director

2022	Research with Indigenous Communities
	Canadian Association of Schools of Nursing
2022	Suicide Alertness Training – safe*TALK* ©
	Arpeggio – Workplace Mental Health (recertified annually)
2021	CPR Level C / AED With Health Care Provider (recertified annually)
	Heart & Stroke Foundation of Canada
2021	Social Network Analysis (Graduate Specialty Course)
	University of Florida
2020	Diploma of University Teaching
	University of New Brunswick
2020	Canadian Certified Nurse Educator (CCNE)
	Canadian Association of Schools of Nursing (CASN)
2019	Ally & Safe Space Program for Wabanaki and Indigenous Peoples
2018	Non-Violent Crisis Intervention Certificate
	Crisis Prevention Institute (CPI)
2017	Comprehensive Systematic Review Certification
	Joanna Briggs Institute
	University of New Brunswick (UNB) Saint John
2016	Canadian Certified Clinical Instructor (CCCI)
	Canadian Association of Schools of Nursing (CASN)
2016	Tri-Council Policy Statement 2: Course Research Ethics
	Government of Canada

Awards & Distinction

2024	Canadian Nurses Foundation Doctoral Scholarship Award
2024	National Catholic Women's League Scholarship
2022	Future NB - Excellence in Experiential Education - UNB Faculty Award
2022	UNB Maecenas Graduate Scholarship
2022	UNB 3MT Three Minute Thesis Competition (2nd)
2021	UNB Teaching Innovation Award
2020	Canadian Nurses Foundation Award of Excellence
2019	NANB Award of Merit: Nursing Practice
2018	Jane Stikeman Ekers Scholarship
2017	Cutler Memorial Scholarship Graduate Studies
2017	Graduate Studies Travel Scholarship
2014	Flewelling Memorial Scholarship for Graduate Studies
2012	Medavie Health Foundation Youth Mental Health Grant
2013	NB Clinical Scientific Mental Health Advisory Committee – CIHR Grant

Employment History

2022 – *present* Lecturer

Department of Nursing & Health Sciences

UNB, Saint John, NB

2021 – 2022 Assistant Teaching Professor

Clinical Lead Programming & Placement

Department of Nursing & Health Sciences

UNB, Saint John, NB

2018 - 2021	Clinical Instructor Department of Nursing & Health Sciences UNB, Saint John, NB
2016 - 2018	Nurse Clinician Department of Nursing & Health Sciences UNB, Saint John, NB
2015 - 2016	Contract Academic Employee Department of Nursing & Health Sciences UNB, Saint John, NB
2009 - 2015	Program Manager – Community Health Mental Health & Addiction Services Horizon Health Network, Saint John, NB
2001 - 2009	Senior Atlantic Government Affairs Associate Eli Lilly Canada
1998 - 2001	Director - New Brunswick Clinical Trials Division Research Services Horizon Health Network, Saint John, NB
1995 - 1998	Research Manager Oncology Clinical Trials Horizon Health Network, Saint John, NB

1982 - 1995 Staff Nurse – Saint John Regional Hospital

Oncology & Outpatient Chemotherapy Department / Labour & Delivery/ Emergency Department / Float- ICU - Recovery Room - Interventional Radiology

Professional Membership

Nurses Association of New Brunswick

Harm Reduction Nurses Association of Canada - Ex Officio Atlantic Canada Board Member

Community Health Nurses of Canada – Mental Health & Addictions Committee

Canadian Association of Nurses in HIV AIDs Care

Canadian Association of Schools of Nursing (EDI and Community Health Working Group Membership)

Atlantic Region Canadian Association of Schools of Nursing

Atlantic Canadian Academic Teaching Communities

Community Committee Membership

Canadian Association of Nurses in HIV Aids Care (CANAC) Atlantic Board Member

National Lacrosse/Crosse Canada Founders Cup 2026 Organizing Committee

New Brunswick Harm Reduction Symposium Committee

City of Saint John Mental Health and Harm Reduction Task Force

Saint John Community Sex Trade Action Committee

Saint John Community Housing Committee

IDST Master Student Supervisory Committee

2024 - *Natalia Fana*

Clinical Teaching Grants

2026 - Co-operative Education and Work Integrated Learning Canada $194,667.20 (N1333) - *pending*

2025 – Co-operative Education and Work Integrated Learning Canada $152,292.32 (N1333/N3067)

2023 – Co-operative Education and Work Integrated Learning Canada - $191,711.00 (N1333/N3067)

2022 – Future Ready NB – Office of Experiential Education - $7200 (students)

2021 – Future Ready NB - Office of Experiential Education - $39,000 (students)

2020 – Future Ready NB - Office of Experiential Education - $8000

2019 – Future Ready NB - Office of Experiential Education - $6500

2018 – Future Ready NB - Office of Experiential Education - $3000

SECTION III - RESEARCH

Program of Research

I focus on highly complex vulnerable individuals living with severe substance use and mental health challenges and am engaged in both qualitative studies and mixed methods approaches. I completed a UNB REB Approved Phase I Social Network Analysis and Phase II Interpretive Description mixed methods explanatory sequential design to complete my doctoral research, with completion in 2026.

Conference Presentations/ Research Dissemination Activities

Truth and Reconciliation Panelist October 2025

October 17, 2025 – Panel Discussion

K Wilbur. Guest and Panel Member.

Healing Through Knowledge: Advancing the TRC Calls to Action in Post-Secondary Education and Practice

UNB Research Conference

June 24-26 Research Poster Presentation

K, Wilbur. "Mattering Matters".

Atlantic Regional Canadian Association of Schools of Nursing National Conference

March 31, 2025 - Images in Research

Wilbur, K. "Game Over"

University of New Brunswick Graduate Research Competition

Fredericton, New Brunswick

November 2, 2024 – Workshop Presentation

Wilbur, K., "Podcasts and Broadcasts"

Association of Atlantic Universities Annual Conference

Wolfville, Nova Scotia

October 25, 2024 – Annual General Meeting Presentation

Wilbur, K., "What Influences People Who Use Drugs to Access Emergency Healthcare Services"

Avenue B Harm Reduction Inc.

Saint John, New Brunswick

May 24, 2024 – Presentation Canadian Association Schools of Nursing

Wilbur, K., & D. Mazerolle. UNB Saint John – Men in Nursing.

Social Justice and Anti-Racism Interest Group

April 11 - 12, 2024 – Poster Presentation

Wilbur, K. "Exploring Factors that Influence Acute Care-Seeking Behaviours of People Who Use Drugs"

AstraZeneca Integrated Health Initiative Research Symposium

Saint John, New Brunswick

August 31, 2023 – Presentation

Wilbur, K. "Exploring the Health Decisions of People Who Use Drugs through Interpretive Description"

UNB Nursing Faculty

Fredericton, New Brunswick

June 28, 2023 – Presentation

Wilbur, K. "Implementing Indigenous Perspectives – Inclusivity, Diversity, Equity, and Accessibility"

UNB Nursing & Health Sciences - Faculty Resource Education Workshop

Saint John, New Brunswick

January 19, 2023. Presentation

Wilbur, K. "Exploring the Health Decisions of People Who Use Drugs (PWUD): An Explanatory Sequential Design of Social Network Analysis and Interpretive Description"

UNB QUEST - Qualitative Health Research.

Saint John, New Brunswick.

September 1, 2022. Presentation

Wilbur, K. "Exploring the Health Decisions of People Who Use Drugs (PWUD): An Explanatory Sequential Design of Social Network Analysis and Interpretive Description"

27th Annual UNB Nursing Research Day "*Partnerships and Opportunities for Impact"*

Fredericton, New Brunswick.

May 27, 2019. Presentation

Wilbur, K. "*Harm Reduction Education for Healthcare Providers."*

National Annual Community Health Nurses of Canada Conference (CHCN).

Saint John, New Brunswick.

September 27, 2018. Abstract Poster Presentation

Brunt, C., **Wilbur, K**., Giles, S., & Brennan, E.

"Harm Reduction Policies from the Street to the Bedside."

Canadian Society of Addiction Medicine Scientific Conference.

Vancouver, British Columbia.

November 20, 2018. Poster Presentation

K. Wilbur "*Exploring the Lived Experiences of Community Health Workers"*

Canadian Research Initiative in Substance Misuse Atlantic Symposium (CRISM 2018). Moncton, New Brunswick.

January 10, 2017. Poster Presentation

Wilbur, K. *"Housing Analysis and Needs - Definition for Success" (HANDS)"* Poster Presentation. Conference for Fresh Start Services for Women Inc., Saint John, New Brunswick.

June 8, 2017. Presentation

Weaver, K., **Wilbur, K**., Leblanc, H., & Reid, A. *"Metaphors of interdisciplinary collaboration to overcome the theory-practice gap when transitioning from RN to Advanced Practice Nurses.*"

Atlantic Region Canadian Association of Schools of Nursing AGM & Research Conference.

Université de Moncton, Moncton, New Brunswick.

SECTION IV - PUBLICATIONS

Publications

Weaver, K., **Wilbur, K**., LeBlanc, H., & Reid, A. (2017). Metaphors of interdisciplinary collaboration to overcome the theory-practice gap when transitioning from RN to Advanced Practice Nurses. *International Journal of Advanced Nursing Education and Research, 2,*(2), 63-74. http://dx.doi.org/10.21742.ijaner.2017.2.209

Nagel, D. A., Keeping-Burke, L., Pyrke, R. J. L., Boudreau, C. L., Goudreau, A., Luke, A.**, Wilbur, K.**, Waycott, L., & Hamilton, C. (2019). Frameworks for evaluation of services and outcomes for community health centers: A scoping review protocol. *JBI Database System Rev Implement Rep (4),* 451-460. https://doi.org/10.11124/JBISRIR-2017-003843

Gagnon, M. Payne, A., Denis-Lalonde, D., **Wilbur, K**., & Pauley, B. (2020). *Substance use education in Canadian nursing programs: A student survey. Journal of Nursing Education 59,* (9), 510-513. https://doi.org/10.3928/01484834

Other Research In Progress

Wilbur, K., Webster, D., Shamputa, C., Murugeson, A., Barker, K., & McKinney, J. "Development and Implementation of a Latent Tuberculosis Infection (LTBI) Management Protocol for New Employees at a Tertiary Care Hospital.' 2025, Principal Investigator.

Collaborating with Dr. Peter Centre in Vancouver, British Columbia, Dr. Duncan Webster, **Wilbur, K.,** CIHR Grant, Letter of Intent accepted. Harm Reduction and People Who Use Drugs. 2024

Keeping Burke, L., O'Brien-Larivee, C., & **Wilbur, K**. (2022) Learning in dyads: Nursing students working in pairs during their clinical practice placement

Research Journal Reviewer and Scholarship Committees

July 2024 - 2025 – Reviewer for the Canadian Journal of Emergency Nursing

January 2024 - 2025 – Canadian Nurses Foundation PhD/Graduate Scholarship Merit Review Committee

January 2022 – Reviewer for the Qualitative Health Research Journal

SECTION V - SERVICE

Annual Service on University, Campus, Faculty, and Divisional Committees

2026	Chair – Indigenous Curriculum Content Working Group UNB Faculty of Nursing
2025	Dalhousie Medicine New Brunswick Research Council Clinical/Education Research - Member
2024/25/26	Menahqesk Indigenous Wellness Circle Saint John Health Advisory Circle University of New Brunswick - Member
2024/25/26	Canadian Association of Nurses –Member of Community Health Special Interest Groups:

	Rural & Remote Health; Social Justice & Anti-racism; and Indigenous Health
2025-26	Senate Student Standings and Promotions Committee University of New Brunswick – Member
2025	UNB Curriculum Committee Year 3 Representative Faculty of Nursing & Health Sciences
2024/25	Faculty of Nursing, Research Ethics Committee University of New Brunswick
2024/25	Equity, Diversity, Inclusion & Accessibility Symposium Planning Committee UNB Saint John – Working Group
2024	Course Support Working Group – Nursing & Health Sciences Department UNB Saint John – Department Committee Member
2024	Centre for Enhanced Teaching and Learning - D2L Committee UNB Saint John
2023-25	UNB Inclusivity, Diversity, Equity & Accessibility Department Committee - Chair Department of Nursing and Health Sciences, UNB Saint John
2023-25	UNB Nursing & Health Sciences Department Assessment Committee Department Committee Member
2023-25	UNB Equity, Diversity & Inclusion Working Group – Lead Department of Nursing and Health Sciences, UNB Saint John
2023	UNB Nursing & Health Sciences - Chair Search Committee Member

UNB Saint John Office of the Dean Faculty of Science, Applied Science and Engineering

2023 Department of Nursing & Health Sciences, UNB Saint John
Department Committee Member

2023 Department of Nursing & Health Sciences, UNB Saint John
Curriculum Committee Member

2022 Nursing Advisory Committee – UNB and Horizon Health Network
Department of Nursing & Health Sciences, UNB, Saint John

2022 Hiring Committee: Term Instructor, Member
Department of Nursing & Health Sciences, UNB Saint John

2022 Hiring Committee: CAE Instructor, Member
Department of Nursing & Health Sciences, UNB Saint John

2022 Dean of SASE Review Committee, Member
UNB Saint John, Vice President's Office

2022 Admission, Transfer & Progression Committee, Co-Chair
Department of Nursing & Health Sciences, UNB Saint John

2022 Tri-Campus Placement and Programming, UNB Representative
Department of Nursing & Health Sciences, University of New Brunswick

2022 Working Group Clinical Placements NBCC/UNB Member
Department of Nursing & Health Sciences, UNB Saint John

2022 Advisory Committee - Indigenous Health and Healing Circle, Member
Department of Nursing & Health Sciences, UNB Saint John

2022 Working Group – Workload Equity, Member

Department of Nursing & Health Sciences, UNB Saint John

2022 Working Group – Writing Skills Across the Curriculum, Member

Department of Nursing & Health Sciences, UNB Saint John

2022 Year 1 Nursing Coordinator

Department of Nursing & Health Sciences, UNB Saint John

2022 Nursing Advisory Committee, Co-Chair

UNB Saint John and Horizon Health Network

2022 Harm Reduction Policy Advisory Committee, Co-Chair

UNB Saint John and Horizon Health Network

2022 Stay Strong Oncology Executive Committee, UNB Representative

Irving Family – Horizon Health Network – UNB Saint John

2022 Collaborative Nursing Practice Committee, Member

UNB Saint John and Horizon Health Network

2022 UNB Faculty Hiring and Promotion Assessment Committee, Member

Department of Nursing & Health Sciences, UNB Saint John

2022 UNB Scholarship of Discovery, Member

Department of Nursing & Health Sciences, UNB Saint John

2022 Advisory Family Caregiver Curriculum Development Committee, Member

NBCC / PETL / UNB Department of Nursing & Health Sciences

2022 UNB Post Graduate Certificate Clinical Nursing in Leadership: Charge Nurse

Department of Nursing & Health Sciences, UNB Saint John

2022	Department of Nursing & Health Sciences, UNB Saint John
	Department Committee Member
2022	Department of Nursing & Health Sciences, UNB Saint John
	Curriculum Committee Member