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Help and support for bereaved persons who use drugs: a qualitative study

Hjelp og støtte til etterlatne som bruker illegale rusmiddel. Ein kvalitativ studie

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ABSTRACT

Despite high rates of drug-related deaths in many countries across Europe, drug-related bereavement has been sparsely investigated. Given the fact that people using illicit drugs are at particular risk of experiencing bereavement as a result of a drug-related death (DRD), which is then related to increased drug use and the risk of developing complicated grief, there is an urgent need for knowledge about their needs and experiences regarding help and support. The present study aimed to explore the experiences of help and support for DRD bereaved persons who use drugs. Reflexive thematic analysis was used to analyse 13 semi-structured individual interviews. Findings suggest that the bereaved who use drugs are deprived of both social support and professional help. Based on our results, we recommend that social professions gain knowledge of the risk of complicated grief following DRD, and be able to provide adequate help to bereaved persons who use drugs. An important precondition is that the professionals listen to what the bereaved need. Bereaved persons who use drugs can improve their self-care by acknowledging their grief following drug-related death and being open to those around them about what kind of help and support is helpful.

SAMANDRAG

Til tross for at talet overdoserelaterte dødsfall i mange europeiske land er høgt, er livssituasjonen til etterlatne ved narkotikarelatert død (NRD) lite utforska. Personar som bruker illegale rusmiddel er i ein særskilt risiko for å erfare å bli etterlatne ved NRD. Om dei opplever å bli etterlatt etter eit brå og uventa dødsfall som eit narkotikarelatert dødsfall ofte er, aukar risikoen både for auka rusmiddelbruk og for utvikling av komplisert sorg. Dette gjer det sentralt å få kunnskap om deira behov og erfaringar knytt til hjelp og støtte. Målet med den presenterte studien var å utforske erfaringar med å få hjelp og støtte for etterlatne etter NDR med eigne rusutfordringar. Tretten individuelle intervju blei analysert ved hjelp av refleksiv tematisk analyse. Analysen viser at dei etterlatne som bruker illegale rusmiddel hadde opplevd lite sosial støtte og profesjonell hjelp retta mot sorga. Basert på våre resultat, tilrår vi at sosialfaglege profesjonar får kunnskap om risikoen for komplisert sorg etter DRD og om korleis etterlatne som

KEYWORDS
Bereaved; drug-related death; psychosocial follow-up; substance use; support

NØKKELORD
Etterlatne; narkotikarelatert død; psykososial oppfølging; rusmiddelbruk; støtte og hjelp

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bruker rusmiddel kan få adekvat hjelp. Ein viktig føresetnad for god hjelp er at dei profesjonelle lyttar til kva den etterlatne treng. Etterlatne som bruker rusmiddel kan auke sin eigenomsorg ved å anerkjenne sorga etter å ha mista nære ved narkotikarelatert død og ved å vere open til nettverk og profesjonelle om kva for hjelp og støtte som er hjelpsam.

Introduction

Death related to drug use is a major societal problem in many European countries (EMCDDA, 2021) and is a type of bereavement that strongly impacts the lives of the bereaved (Titlestad & Dyregrov, 2022). People who use drugs are a group who are at special risk of losing persons close to them through a drug-related death (Kenny et al., 2012; Wojtkowiak et al., 2019). Despite this, the experiences of bereaved persons with who use drugs who have lost someone close to them have been given little attention in research (Masferrer et al., 2018; Valentine et al., 2016). This article reports on a qualitative study that explored the following question: How do people who use drugs experience the receiving of help and support following the loss of a person close to them as a result of a drug-related death (DRD)?

Bereavement following a drug-related death

A DRD is a death caused by the intake of substances classed as drugs, such as overdoses, as well as deaths among people who use drugs and where the cause of death is violence, accidents, an infectious disease, or other health disorders, which are, in different ways, linked to drug use.

DRD is defined as a *special death* (Guy & Holloway, 2007; Templeton et al., 2016) because of the extreme stress and ambivalence involved in the grief process. Accordingly, bereavement following a DRD is described as *special grief,* which may include an increased risk of complicated grief reactions (Dyregrov et al., 2020). Several characteristics make DRD bereavement special. The circumstances of any death are subject to different social statuses, and DRDs are claimed to usually be of a low status (Guy & Holloway, 2007), often described as a stigmatised death (Valentine et al., 2016; Dyregrov & Selseng, 2021).

The grief someone experiences following a DRD is also characterised as being unacknowledged and disenfranchised (Dyregrov et al., 2020; Titlestad, Lindeman et al., 2021). The lack of recognition of DRD bereavement in society can be internalised by the bereaved and cause them to withdraw and not ask for help and support (Doka, 2002; Titlestad, Mellingen et al., 2021).

There is evidence that there is a mutually complicating relationship between substance use and grief (Parisi et al., 2019). For instance, bereavement can increase substance consumption (Masferrer et al., 2015) and people with substance use issues are especially vulnerable to developing complicated grief (Masferrer et al., 2017). Wojtkowiak et al. (2019) highlight how drug use can inhibit feelings and contribute to a fragmented grief process with denial of the loss and delayed grief reactions. Bereaved persons who use drugs also experienced being socially excluded as grieving persons and having unacknowledged grief (Wojtkowiak et al., 2019).

The cultural and institutional context they live within greatly influences the experiences of drug use-related lives and deaths (Livingston, 2017). This article is written in a Norwegian context, characterised as a Scandinavian welfare state with well-established public services. Many persons who use drugs require services from several sectors use problems require services from several sectors and levels of society and coordinated and consecutive treatment courses are crucial for the services to be successful. However, a recent evaluation of the escalation plan for the field of drugs and addiction concludes that there are significant variations in the service being offered (Hansen et al., 2021).

National guidelines in Norway recommend that municipalities arrange psychosocial follow-ups through crisis teams in the event of a crisis as the experiencing of a sudden and unnatural death

(Norwegian Directorate of Health, 2016). The recommendations describe support principles and various affected groups, such as those bereaved by suicide and accidents, but those bereaved following a DRD are not mentioned (Reime & Dyregrov, 2022). A few international studies have pointed to several conditions that can prevent support and help in the grieving process, e.g. a study from the Netherlands points to the fact that hard drug users did not feel welcome at social occasions such as funerals (Wojtkowiak et al., 2019), studies from UK point to experiences of disenfranchised grief (Valentine et al., 2016; Templeton et al., 2017), studies from the US point to the absence of a public platform to voice their individual and collective grief (Kenny et al., 2022), the lack of receiving grief support service systems (Schlosser & Hoffer, 2022), and to the need for more robust integration of bereavement support (Macmadu et al., 2022). However, there are no studies known that have explicitly examined how DRD-bereaved persons who have substance use problems experience help and support. Considering the vulnerability of this group when facing a DRD bereavement and the mutual connection between drug use and complicated grief processes, this is an essential knowledge gap to fill. This article explores the first-person experiences of the formal help and informal support provided to them following a DRD.

Method

The study employed a qualitative exploration of interviews with people who had been bereaved following a DRD and who used drugs. The study is part of the nationwide Norwegian research project the 'Drug Death Related Bereavement and Recovery Project' ('The END-project'). The objective of the main study is to provide insight into the life situation of different groups of bereaved following a DRD, whereas this paper directs the focus specifically towards bereaved who use drugs.

Recruitment

From March 2018 to December 2018, we invited family members and close friends who had been bereaved following a DRD to participate in the END-project using: the snowball method, flyers, organisations, municipalities, and media channels. From them, we recruited the sample that forms the basis for this article, 13 bereaved persons who reported that they had lost a close friend or intimate partner and that they had at the time or have had used drugs.

Participants

The participants – seven women and six men – were recruited from across Norway and were between the ages of 21 and 54 at the time when the study was conducted. Seven reported that they had ongoing drug use at the time of the DRD, two were in treatment or detoxification, and three were not using drugs at the time at which the person close to them died of a DRD.

The time since the DRD of which they were bereaved ranged from 1 year to 40 years. The age of the deceased spanned between 16 and 39. Nine participants were close friends with the deceased, and three had also previously been intimate partners. Three had lost an intimate partner, and one had lost an ex-partner. Three of the bereaved had children with the deceased. Two of the participants were present when the person died. All except for the person who had lost her ex-partner described an especially close and important relationship with the deceased.

Interviews

The interviews were carried out between July 2019 and October 2020 in settings selected by the participants (office, hotel, treatment institution). The first and last authors conducted the interviews, except for one interview carried out by another researcher in the END-project. Each interview was conducted in Norwegian, lasted for approximately one and a half hours and was audiotaped and

transcribed verbatim by an experienced secretary. The interviews followed a semi-structured interview guide, the interviewer invited the bereaved to talk about their experiences of losing a person close to them from a DRD. Topics that we explored were time after death, grief reactions and formal and informal help and support.

Ethical considerations

All procedures were conducted following the Declaration of Helsinki. The Norwegian Regional Committees approved this study for Medical and Health Research Ethics (reference number 2017/2486/REK vest).

All participants were informed about the study's purpose, method, and procedure and gave written consent. We provided care to the participants following Dyregrov's (2004) recommendations concerning research on vulnerable populations.

Analysis

We conducted a reflexive thematic analysis inspired by Braun and Clarke (2006, 2022). After familiarising ourselves with the data (step 1), the first author coded the data (step 2) and generated initial themes (step 3). After presenting and discussing the initial themes with co-authors and experts by experience participating in the END-project, the authors reviewed the themes (step 4) and then named the themes (step 5). To enhance transparency and trustworthiness we present quotes from the interviews in the result section (step 6). To make the quotes suitable for English publication and to safeguard anonymity, we have slightly edited the extracts, translated them to English, removed identifying details and given participants pseudonyms. We increased trustworthiness through discussions and reflections between the authors and experts by experience around our interpretations and about how our professional backgrounds, personal experiences and socio-cultural anchoring influenced the interpretations. There was a large degree of similarity between the author's interpretations of the data and the experts by experience confirmed the recognition and relevance of these. The conversations led us to change some wording, names of themes, and choice of quotes, but the substance of the analysis remained.

Results

We identified three interconnected themes with related categories: (1) Not being acknowledged as one of the bereaved in need of help (2) Substance use hinders social contact, and (3) Unconditioned help and support. A model consisting of the research question, themes, and codes was produced (Figure 1).

Not being acknowledged as one of the bereaved in need of help

Although the Norwegian municipalities are obligated to assist citizens experiencing a potentially traumatic event, a clear pattern in the data material was that the bereaved told about a lack of psychosocial follow-up related to the fact that they had experienced a sudden and unexpected death. Several of the bereaved described that they felt unseen by others as bereaved persons in need of follow-up. One of those who told of such an experience was Stian. He was visiting a close friend, spending the night there, and found him dead from an overdose the following day. Stian said that he called the police, two policemen came, and one of them said: 'yes, here we have … ' followed by his nickname among people using drugs. After Stian had quickly explained what had happened, one policeman said: 'yes – you can just go'. Stian said that he asked whether he could travel with them in their car to the city centre as it was a long walk. It was Sunday, and it wasn't accessible

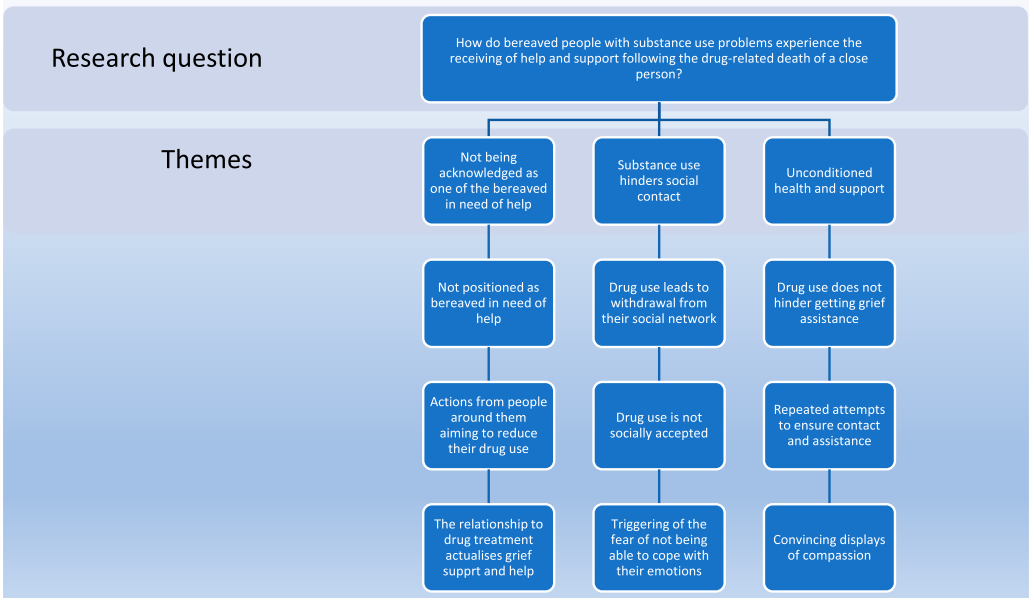

Figure 1. Bereaved person's experiences with receiving help and support.

with public transport. 'No', was the answer from the policeman, so he had to leave alone. And, Stian added, no one else asked how he felt about losing his dear friend.

Several of the bereaved told that due to their drug use, they were in contact with the welfare system at the time of the death, but that the professional helpers did not pay any attention to the fact that they were bereaved, such as Christian who said that he was on detoxification when he found out that his best friend had died. He said: 'No one dared say anything to me that he was dead'. He said that another friend's father was visiting his son. He knew about the death since his son was also a friend. This father urged one of the people who worked there to tell Christian that his best friend had died.

> I had been there five to six days or something like that, and then I got this message. And then this had already happened three to four days ago, and everyone knew except me'.

Our analysis shows that the formal help given was primarily related to reducing their drug use. Several of the bereaved said they handled the grief by using drugs. The drug use caused concern for the people around them, leading to people taking action to help reduce the drug use. For example, Malin told us that she had a substance use problem for several years, but after being in treatment in an institution for six months, she had succeeded in not using drugs. Six months after the treatment, her boyfriend began using drugs again. One day she found him dead from an overdose. To handle the grief, she started using drugs again. Malin explained that both professional helpers and family were worried and arranged for her to go on a detox and, after that, to the specialist substance-use treatment. Malin explained that she did not feel that these efforts focused on helping her cope with the grief:

> At every place I was meant to get help, it never was about me and the fact that I found him dead. […] And even when I came into treatment, it was only about 'now you will be drug free'. So there was nothing specifically aimed at 'hey, you have had this experience, is there anything you need in regard to that?' No one asked me if I needed to talk … I don't know what help I could have gotten, if there is a crisis team or something, I have no idea what there is and I have not been told what there is. […] For me that was what it was all about. I found my boyfriend dead. I want to talk about it, and people were more concerned with 'but you are on drugs, we have to make sure you don't do drugs again'.

Malin's experience confirms a general tendency in the data that the bereaved persons are primarily perceived as needing substance use treatment and not services for bereavement care. Similarly, the bereaved person's informal network also seems to revolve around the substance use services when they are worried about their loved ones, as exemplified by Ida's story. Ida had been in treatment and had not used drugs in the last few months before her boyfriend died. However, after his death, she used drugs intensively and overdosed herself. Her mother called Ida's contact person in the community drug team to get help. The mother was disappointed by the response, Ida told, as instead of responding, the contact person said: 'we will do something soon, we will soon'. Ida's story illustrates how the informal network uses familiar pathways to seek to provide help and support when a crisis occurs, reinforcing the focus on drug use.

The bereaved described the drug treatment services' help as having its advantages and disadvantages. One challenge noted was that the help does not focus on the peculiarity of this mourning period, and the needs associated with grieving. Several of the bereaved pointed out that they wished they had received help from someone competent in grief processing. This was exemplified by Ida, who said: 'I really needed someone to talk to, but not anyone, someone who really understands death'. The bereaved person' connection to the drug treatment services also had advantages. Some of the bereaved highlighted that having previously received help for their substance use problems meant that they had established a relationship with welfare workers who could then jump into action to help when the crisis occurs. The bereaved described their relation to practitioners and institutions in drug treatment as crucial for receiving help during this challenging period. It was, for example, the practitioners at familiar institutions who helped them go to the funeral. Some of the bereaved who, because of their drug use, returned to a drug treatment institution they were familiar with before the death described it as a safe place to come back to, with its well-known structures and people. Ellen, who had lost her best friend to an overdose, explained that the reason she received follow-up after her death was that she had a relationship with her former helpers due to her substance use problems:

> I have been lucky. Because I have a longstanding drug problem, I have had treatment at the centre and a psychologist who has been totally fantastic. I was lucky to have had her and I got help through her, but I have not been offered help as a grieving bereaved.

Substance use hinders social contact

Another theme of the data was how the bereaved person's use of drugs led to mutual withdrawal between the bereaved and those close to them. Several participants told of how the death resulted in increased drug use due to their trying to handle the grief. The drug use then led them to withdraw from others and made them inaccessible for social contact. Christian, who was at a detoxification clinic and did not receive information about his best friend's death until several days after he had passed, said that he reacted by leaving the detoxification clinic and began to use drugs intensively. His way of dealing with the grief made it difficult for the helpers around him to help him. In the interview, Christian elaborated on this:

> The people who I really should have talked to and contacted, like family and people close to him, I pushed away because I didn't have a normal way to deal with it. It was just not talked about, but I was so drugged up then that I can't … I don't know if I have talked about it, but I don't think so.

The bereaved describe that grief is not given attention in their relationships with other drug-using persons. The missing attention to grief is explained as being related to the fact that losing someone to a DRD is so widespread and something that 'everyone' experiences, so your grief is not something special. Furthermore, several of the bereaved explained that drugs are used to curb and cover emotions. In addition, the culture among people using drugs is that there are expectations around someone suffering from a loss and feelings of grief in that you must seem outwardly strong. Trude's comments illustrated this:

> Among drug users, no one talks about emotions, you don't get far with feelings in the drug-world. You become a hardened version of yourself. You know, it is a struggle, everyone is struggling with their own stuff, everyone is trying to drug themselves as far away from feelings as they can, so to discuss feelings, it is like, it doesn't happen. Nobody is interested in it, everyone wants to feel as little as possible. So it is a lonely journey even if many are together.

That the drug use led to withdrawal was intensified by the fact that those who did not use drugs did not accept drug use as a way of dealing with the loss. Thus, the drug-using bereaved experienced that the people around them who do not take drugs kept a distance when they were on drugs. For example, when Gaute was questioned about what others thought of his grief process, he answered:

> They do not agree, of course, they do not agree. No one agrees that you should go out and use drugs and drown their sorrows and such. Everyone thinks that you should talk about it'.

When Gaute experienced the loss of his best friend, it led to immediate, intense drug use, something he chose to be clear about with his current girlfriend:

> I jumped right into drugs, and I said to my girlfriend: "Don't bother saying anything about it. You can just pack your things and go. This is what I am going to do, period!".

Gaute's comments demonstrate how he knew that his way of handling the grief was not accepted and understood, but it was still his choice, even if it meant losing his girlfriend. The feeling of not being recognised and approached as a grieving person is further enhanced by the experience of not being welcomed in gatherings and ceremonies to say goodbye to the deceased. Marie, who had lost her best friend to a DRD, explained how her drug use made her feel that she was not welcome at the funeral:

> It is true that you don't feel welcome at the different funerals either, because you dońt exactly look so good yourself. And is it right for you to be an extra burden for the parents, should they have to sit and look at other drugged up people? Because you cańt come sober, right. […] Most of the time when many of these people die, we hear that the parents do not want anyone other than family at the funeral. It is a little hurtful that you can't go and say goodbye.

Furthermore, in the periods in which they were not using drugs, many of the bereaved described a fear of talking to others about their grief. They feared that they would not be able to cope with the emotions that may arise, which, among other things, could lead to the risk of drug use again. They also expressed that stigma and negative attitudes towards people using drugs created distance. They seemed to associate themselves with the stigma around people who use drugs, for example, describing themselves and people using drugs with stereotypes like 'a shady group' and 'reclusive'. For instance, Gaute described himself as an 'emotionally damaged person' when dealing with the loss of his best friend Morten:

> I'm a bit like that, I was like that before too, but it's gotten worse after Morten died. A little afraid of people. […] When I meet Morten's mother, I'm a little scared that she'll talk about Morten. It hurts a lot for me. It is wounding. So, therefore, I try to compartmentalise it in a way. I can quickly go five to six days where I do not respond to a message from his mother. I may be a little weird like that, but I'm an emotionally damaged person, to put it simply.

Gaute described his fear of people and relates this to his emotional or mental state. He gave examples of how this affects the interactions he has with his informal network. Still, the way Gaute exemplified what he is afraid of also calls attention to how this interplay between his interactions with the formal help system can be a source of mutual distrust or withdrawal. His description of himself as 'damaged' may indicate a lack of belief that his ability to handle emotions can change, which may again influence his attempts to bring about change.

Unconditioned help and support

The last theme revolves around experiences of help and support that were perceived as helpful to the needs of the bereaved as mourners. This is not a dominant theme in the material, but still important for knowledge on needs-based help and support. Vital features of this were help that was unconditioned and adapted to their life situation and that which was offered in ways that enabled the bereaved to actually receive it. An essential dimension of unconditional help was that they were offered help and support even if they were using drugs. Another dimension was that family, friends and welfare workers recognised the use of drugs as a coping strategy for handling the grief and not as a sign of a rejection of contact. Trude was in a treatment institution when her boyfriend died of an overdose. She responded by leaving the institution and started using drugs again. She said that the staff continued to keep in touch with her and tried to help her whenever she was approachable:

> They respected me actually, a lot. They tried to help me there, where I was receptive. […] They knew me in a way that allowed them to know how to talk with me then, and why I shut down, and that it wasn't a type of rejection, it was my survival strategy that kicked in.

The outreaching and repeated efforts from the practitioners made Trude feel respected. The fact that the practitioners already knew Trude made it easier to communicate and help. It was thus essential that the helpers took the initiative to assist in the grieving process and persevered with their attempts. For example, several of the bereaved mentioned that typical situations they encounter were helpers asking, 'how are you?' or 'are you okay?.' The bereaved answered in the affirmative, and thus the follow-up ended. Some of the bereaved said that they didn't think the helpers could reach them, regardless of what the helpers had said during this period, Others said that they did not know whether it had made a difference, but they emphasised that it was not helpful when the helpers give up as soon as they receive a dismissive answer. For example, Ida pointed out that in order to be able to talk about the difficult loss, she would need repeated attempts at help: 'I have built up a defence to protect myself, so if someone has tried, I say, not now, another time, but then they stop trying, so it will never be anything more'. On the other hand, Trude told us about the experiences of helpers who reached out to her. Like the others, she emphasised that key characteristics of the help was unconditional and repetitive:

> A bit unconditional, actually […] you were met and heard and seen even if I perhaps didn't want to be … And they went the extra mile for me, really, everyone. They did. I am not sure if I would be here today if it was not for them, in many ways, not just for that. They were there, they listened if I wanted to talk and asked, and were on to me in a way. They found me during my many relapses, pulled me in and met me at cafes and listened to my rambling thoughts. They persuaded me back over and over again, they were there for me.

A third dimension of the help that the bereaved experienced as being helpful was that of compassionate and convincing care. Informal and formal helpers who were available for the bereaved in different situations and who did not withdraw – who instead did more than expected and were thus highly valued, making the bereaved feel respected and worthy. Those helpers communicated to the bereaved that they had a connection with them, which then affected the choices and actions of the bereaved.

Discussion

The results from this study show that bereaved persons who use drugs do not experience being acknowledged as mourners. Further results show how these bereaved persons experiences being deprived of both formal and informal support, both because the substance use makes the bereaved person less accessible and because others do not accept their substance use. Given the knowledge of the potential risk related to bereavement after sudden and unnatural deaths (Christiansen et al., 2020; Djelantik et al., 2020), it is important to explore how this experienced lack of help and support

can be better understood. The following discussion revolves around the dominant focus on the bereaved person's drug use, disenfranchised grief, drug use as a coping strategy and substance use services as a source of help.

The dominant focus on drug use

The participants' experiences – that it was their subject position as people using substances that received attention and not their subject position as mourners – align with research on social categories and the intersectionality between social categories (Staunæs, 2003). This research tradition points out how people are positioned in certain social categories, and the interactions between these categories are embedded in a social and cultural context. The meaning, power and values attached to social categories foster and create social hierarchies. In the intersectionality of categories, different categories can overshadow, hide, and drown one another (Staunæs, 2003).

Our analysis shows how the category of drug use seems to overshadow the category of grief. The participants told us of repeated experiences where it was the drug use that came into focus, and of missing experiences of being seen, listened to, and met as mourners. The dominance of the social category of drug use over other categories has also been found in other analyses of people with substance use issues (as Lindeman et al., 2021; Selseng, 2017). Both drug use and grief are social phenomena that occur within and are shaped by social environments (Livingston, 2017). Dominant assumptions of how drug use and grief should be solved can prevent professionals from listening to the individual's wishes and needs. The research findings of the dominant substance use position point to the importance of conducting further research on how the substance use position intermingles with other positions in different lived contexts, and if and how the dominant substance use position may hinder seeing and meeting the complex lived experiences of this group of people.

Double disenfranchisement

The lack of help and support as mourners seems to be impaired as their grief appears to be disenfranchised in many areas. Although psychosocial follow-up in the event of sudden and unexpected death is a public responsibility in Norway (Norwegian Directorate of Health, 2016), there were extensive shortcomings in the help that the interviewed bereaved persons had received. In addition, the bereaved also experienced a lack of informal grief support among other people using drugs and they described experiences of not being welcomed to the funeral. Whether and to what extent drug use hinders social contact and leads to withdrawal from coming together in grief can vary between countries. Although alcohol and drug use have a long history of being a part of societal responses to death (Livingston, 2017), the bereaved persons using drugs' experience of disenfranchised grief and social exclusion align with Wojtkowiak et al.'s (2019) study of bereaved people using drugs from the Netherlands. Furthermore, Schlosser and Hoffer's (2022) point out in their study from the US that participants did not attend funerals to avoid social conflicts. It thus seems as if the persons who are bereaved following a DRD and who also use drugs experience two highly cultural disenfranchised conditions. They are both in a position as people using substances, which prevents a recognition of the grief they are experiencing, and they are also mourning a 'special death', which has been described as not being recognised in society (Valentine et al., 2016). This double disenfranchisement can be mutually reinforced and lead to a distinct lack of genuine listening to the bereaved person and hinder access to help and support.

Drug use as a coping strategy

The bereaved in this study describe drug use as a coping strategy when handling such a crisis. This is consistent with other research that shows the risk of increased substance use when facing the death of someone close, both in the general population (Pitman et al., 2020), and among persons who use

drugs (Masferrer et al., 2015). Research has identified how drug use can inhibit feelings and delay the grieving process (Wojtkowiak et al., 2019).

Our results suggest that barriers to help and support are exacerbated by the bereaved person's doubts about the help. Some of the bereaved in our study reflected on whether they were even capable of receiving help in the immediate aftermath of a death. An increase in drug use was one explanation given for this, but some of the participants also described a fear that they would not be capable of talking about the grief and to disclose their feelings about the loss. They feared that getting in touch with their feelings would lead to new episodes of drug use or increased drug use. Belief in one's own coping strategies is essential for the bereavement process (Konaszewski et al., 2021). Low levels of self-efficacy have been shown to predict higher grief symptoms among parents bereaved by a DRD (Titlestad, Schmid et al., 2021). Instead of sharing their feelings of loss, many of the bereaved in this study described how they suppressed intense feelings by using drugs, a strategy that is well known to them but not socially accepted. Using a strategy deemed unacceptable by society and not feeling capable of handling the grief in a socially accepted manner can further exclude the bereaved from receiving the psychosocial help and support they need, and lead to avoidance and withdrawal from their support network.

Substance use services as a source of help

Results show that although not tailored for grief support, substance use services can serve an essential function for those bereaved persons who have a relation to practitioners within the help system. For some of the bereaved, these services represented a pathway to specialised help, such as a psychologist, which they perceived as fruitful for their grieving process. To receive help from psychologists or other grief counsellors has been proved beneficial for persons with substance use problems, specifically in helping to decrease the risk of developing complicated grief (Bethune Scroggs et al., 2022).

The results also show that the complex reactions displayed by the bereaved when facing a DRD represent a challenge for their relation to the professional network and for treatment continuity. The combination of reciprocal strategies used by the bereaved – that of increased drug use, avoidance, social isolation, and suppression of feelings – can make it hard for the professionals to reach out to the bereaved, even when they are in treatment. Ambivalence due to one's treatment needs and lack of belief in one's own abilities to receive help also impact the bereavement process and the bereaved person's experiences of the help they have received. Research has shown that drug use often leads to a fragmented grief process (Wojtkowiak et al., 2019). This unpredictable grief process is also described by the bereaved in this study and represents a challenge for the professionals who need to deliver that help, tailored to the needs of the bereaved.

Bethune Scroggs et al. (2022) describe the co-occurring losses often experienced by patients in substance-use treatment, relating to both drug death bereavement experiences, other losses in life on top of the loss of using drugs as a coping strategy. These multiple losses can be experienced as overwhelming for the bereaved and contribute to relapse in treatment. It is therefore important that the professionals working in substance use treatment understand and acknowledge these different types of losses and grief and have the means to address them adequately. Research has pointed to how important it is for grief and loss to become a part of substance use treatment (Bethune Scroggs et al., 2022; Zuckoff et al., 2006) – however, Zuckoff et al. (2006) warned that triggering the bereaved person's grief emotions too early in the treatment process can worsen their symptoms of things such as complicated grief and which would then reduce the effects of their drug treatment. It is therefore important that the professionals carefully consider the timing of when to address the bereaved person's grief.

The results from our study also point to significant findings relating to helpful grief support. Our findings are consistent with the conclusions of Walter et al.'s (2017) study of bereaved adults after

DRD – in this study, the bereaved described 'good help' as the experience of meeting kind people who acknowledged the strains involved in experiencing such a loss.

Implications and conclusion

Results from this study show a pivotal lack of help and support when those bereaved who use drugs face a DRD. The bereaved who have no established user pathways into drug treatment, but who have an ongoing drug problem, seem simultaneously both easy to ignore and hard to reach. They are deprived of social support, which research has shown as being important in protecting them against developing complicated grief (Dyregrov & Dyregrov, 2008; Løseth et al., 2022; Titlestad & Dyregrov, 2022). On top of this, they are also deprived of professional grief interventions, which might increase the risk of complicated grief.

Our study points to the importance of professionals in the field of substance-use treatment having more knowledge of grief and crisis situations, how to provide grief support, and how to identify the needs of the bereaved and when they require more specialised grief interventions. Furthermore, there is also a need for the professionals who are obliged to provide crisis support in situations of sudden and unnatural death, to be aware of and able to meet the bereaved after they have gone through a DRD of someone close to them. Additionally, the professionals must have sufficient competence and understanding of the fact that the bereaved are a complex group, in which some members of this group use drugs as a coping strategy. By having a legal justification for crisis intervention, Norway has come a long way in recognising the importance of professional bereavement help. Still, some marginalised groups of bereaved people seem to fall outside the scope of welfare services. For all countries, regardless of legal justification, it is crucial that social work research and practice have knowledge of the social, health and welfare effects grief can cause and hence the importance of seeing and listening to the needs of mourners, including mourners who are using drugs. We also advise the bereaved themselves to actively engage in self-care, by acknowledging their suffering associated with a drug-related death, daring to confront the loss and being open to those around them about what kind of help and support that is helpful.

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