

MEETING PEOPLE WHERE THEY ARE AT:
HOW NURSES, USING THE FRAMEWORK OF HARM REDUCTION,
MAKE SENSE OF NURSING PRACTICE
WITH PEOPLE WHO USE DRUGS

by

PATTI ZETTEL, RN

BScN. University of Victoria, 2001

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ABSTRACT

Nurses who work with people who use drugs in the Downtown Eastside of Vancouver (DTES), British Columbia are on the forefront in advancing a harm reduction framework in very controversial, cutting-edge practice environments. The purpose of this study was to explore how these nurses, using the framework of harm reduction, make sense of their nursing practice. It is hoped that the results of this study may advance adopting a harm reduction framework in nursing practice, education and policy development and serve as the foundation for further nursing research.

This study utilized a qualitative interpretive descriptive methodology to gather data from eight nurses who work with people who use drugs in harm reduction practice environments. The nurses were divided into two focus groups and data was collected through a semi-structured focus group interview. Following initial data analysis, each focus group was reconvened and a second semi-structured group interview was held to clarify and to further discuss the emerging themes.

The data analysis proceeded simultaneously with the interviews utilizing a process of constant comparative analysis. I completed the thematic analysis as I moved between the transcripts and identified commonalities and variations within the emerging themes. Ultimately, I described one overarching theme, which encapsulated the range of experiences described by the nurses. The theme that I identified was: meeting people where they are at. The importance to the nurses of both the therapeutic nurse-client relationship and a commitment to praxis were apparent. In conclusion, the value the nurses placed on “meeting people where they are at” was integral in gaining an understanding of how they make sense of their nursing work.

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CHAPTER ONE

Despite controversy, utilizing the philosophy and interventions of harm reduction has proven to be an effective public health strategy for people who use drugs. The British Columbia (BC) Ministry of Health Services defines harm reduction as:

... public health philosophy that makes the reduction of potential harm from substance use the highest priority. It supports policies and practices aimed at addressing risky substance use behaviours without requiring abstinence ... success is not reflected primarily through a change in use rates but rather by a change in rates of death, disease, crime and suffering.

Every Door is the Right Door, 2004, p.80.

Unique not only to Canada but also within North America, the City of Vancouver, BC has implemented a comprehensive continuum of harm reduction interventions. In the downtown eastside (DTES) community, the large number of drug overdoses, overdose-related deaths and the soaring human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), hepatitis C (HCV) and hepatitis B (HBV) rates amongst people who use drugs contributed significantly to the adoption of a harm reduction approach in public health policy in the city (MacPherson, 2000). Evidence-based harm reduction interventions include the following: (a) education and outreach; (b) health and social services referrals; (c) low threshold support services (typically considered to be services with minimal requirements for participation and that seek to address the basic health and social needs of people who use drugs); (d) law enforcement cooperation; (e) needle exchange programs; (f) methadone maintenance treatment; (g) supervised consumption facilities (legally sanctioned and medically supervised facilities

where people use pre-obtained illegal drugs in a safe, clean environment so that immediate responses to overdoses can be provided, access to health and social services can be increased and problems associated with the public consumption of drugs can be decreased); (h) street drug testing and warning systems (illegal drugs are not subjected to any government controls or manufacturing safety standards; drug testing and early warnings are used to alert health and other authorities to changes in drug use or the drug market and they, in turn, alert people who use drugs to potential risks); and (i) physician-prescribed heroin (BC Ministry of Health, 2005).

For many hard-to-reach people who use drugs, harm reduction services provide the point of first contact with the health care system (Wood et al., 2005). In the DTES, nurses are the frontline health care professionals with whom many people who use drugs engage (Brennan & Gilles, 1996; Brown, 1998). Currently, Vancouver is the only city in North America where nurses may legally supervise people inject street drugs in a dedicated medically supervised safer injection facility (the facility is called InSite). DTES nurses also work in one of only two North American cities (the other being Montreal) where physician-prescribed heroin to long-term opiate users is being studied in a randomized clinical trial (North American Opiate Medication Initiative or NAOMI Study).

Harm reduction remains a controversial public health policy, in large part, because of the pragmatic acceptance of the reality of ongoing drug use for some people. Harm reduction interventions are designed to mitigate the potential for harms associated with drug use and many nurses working in the DTES with people who use drugs have incorporated a harm reduction orientation into the scope of their daily nursing practice

(Hilton, Thompson & Moore-Dempsey 2000; Hilton, Thompson, Moore-Dempsey & Hutchinson, 2001; Hilton, Thompson, Moore-Dempsey & Janzen, 2001; Thompson, Hilton, Moore-Dempsey & Hutchinson, 2000). While the rationale for why and how nurses implement the interventions of harm reduction into their nursing practices with people who use drugs is understood, what has not been explored is how nurses personally make sense in utilizing a harm reduction framework in their daily nursing work. Nurses, working in cutting-edge harm reduction practice environments in the DTES of Vancouver, may have a unique perspective on the issues inherent in using harm reduction. In this study, it is my intent to explore the perspectives and experiences of a group of nurses working in the DTES in order to better appreciate how they make sense of adopting a harm reduction framework for use in their daily nursing practice with people who use drugs. It is my hope that this will benefit the larger nursing profession by providing an increased understanding of the complex realities informing the daily lives of people who use drugs.

A Note about Terminology

In writing this thesis I made some decisions around terminology; for purposes of clarity I will explain them here. The focus of this thesis is on the public health problems associated with injection drug use. When the term harm reduction is used, it refers to a philosophy and set of measures aimed at the problems associated with injection drug use to people who use injection drugs. Drug(s) refers to illegal drugs, street drugs, drugs of misuse, illicit drugs, problem drugs and drugs of abuse etc. While I do not underestimate the magnitude of the public health problems of drugs taken by other routes (alcohol,

tobacco, crack cocaine to name but a few), this thesis will not focus on drugs taken by routes other than injection unless specifically mentioned. In the context of this paper, drug use will refer to the non-medical use of stimulants and depressants.

Injection drug use is an inherently risky practice, and because people who use drugs routinely inject drugs of unknown purity, strength or type it can never be completely safe. For that reason, in Vancouver, the supervised consumption site is officially referred to as a medically supervised safer injection facility (David Marsh, personal communication, August 18, 2006). The abbreviation IDU will only refer to injection drug use and will never mean injection drug user. People who use drugs find such terms stigmatizing and wish it acknowledged that they are much more than a label that identifies only an aspect of their lives (Jurgens, 2005). Informed by that knowledge, I will use the term people who use drugs.

Background to the Problem

The DTES of Vancouver has been described as one of Canada's most impoverished urban neighbourhoods and its twelve-block radius is home to approximately five thousand people who use drugs (Kerr et al., 2006). In 1996, in Canada, it was estimated that about 47 percent of new HIV infections were among people who use drugs (Jurgens, 2005). Drug injecting with contaminated equipment is the major mode of HIV transmission in many countries (Aceijas, Stimson, Hickman & Rhodes, 2004). By 1997 in the DTES neighbourhood, the HIV infection rates among people who use drugs rose to among the highest reported in the industrialized world (Small, Palepu & Tyndall, 2006). The health board operating at that time responded by declaring a public

health epidemic (Kerr et al.). By 1998, overdose from injection drug use (IDU) had become the leading cause of death for British Columbians aged 30-49 year (BC Coroners Service, 2003). Currently, nine out of ten people who use drugs in the DTES are HCV positive and three out of ten are HIV positive, a rate thirty-eight times higher than the provincial average (VCH, 2007a). In Canada, the economic costs of illegal drugs, including health care (for example, HIV/AIDS and hepatitis), lost productivity, property crime, and enforcement are estimated to exceed \$5 billion annually (Hayden, 2005).

In the midst of controversy, the scope of the public health problem in the DTES contributed to a shift in public policy as a response to IDU in Canada (Small, Palepu & Tyndall, 2006). The City of Vancouver working in concert with all levels of government, the local health authority (Vancouver Coastal Health (VCH)), the local police department (Vancouver Police Department (VPD)) and various community stakeholders, including nurses, expanded the available harm reduction services (BC Ministry of Health, 2004). InSite, a medically supervised safer injection facility, opened in 2003 as a three-year scientific research pilot project. Subsequently, it received a fifteen-month extension and it has just received an additional six-month extension (to expire in June of 2008) by the Federal Minister of Health (Health Canada, 2007). In 2005, the NAOMI study, the randomized controlled trial comparing whether long-term opiate users had better outcomes with either physician- prescribed heroin or methadone maintenance programs (MMPs) began enrolling study participants (NAOMI, 2005). Both InSite and NAOMI operate legally under Section 56 scientific exemptions from the Controlled Drugs and Substances Act granted by the Canadian Federal Minister of Health (VCH, 2003a; NAOMI).

Nurses working in the DTES community, as practitioners whose client group comprised large numbers of people who use drugs, advocated for the implementation of more harm reduction initiatives for years (Gold, 2003; Griffiths, 2002). They were key members of the Harm Reduction Action Society (HRAS), a group of DTES community members from all walks of life, which was particularly instrumental in the opening of InSite (Gold). Nurses also worked collaboratively with their provincial regulatory body, the College of Registered Nurses of BC (CRNBC), in confirming that it was within the scope of nursing practice for nurses to supervise their clients who use drugs for the purposes of health teaching, education and health promotion (Griffiths). Nurses constitute the largest sector of healthcare professionals in both of these harm reduction interventions; they can rightly be considered the harm reduction pioneers within the North American nursing practice context.

Problem Statement

In 2001, Hilton, Thompson, Moore-Dempsey, and Janzen, nurse researchers from the University of British Columbia (UBC), called for research to build support for a harm reduction orientation in nursing practice and policy formulation. In this thesis, I will begin to address that call. The central problem that I will explore is the lack of insight into and understanding of the experiences and viewpoints of nurses who use a harm reduction framework in their nursing service provision to people who use drugs. The adoption of a harm reduction framework in nursing practice can be difficult and requires the evaluation of personal values and beliefs related to drugs, the people who use them, and the reality of ongoing drug use for some people (Wood, Zettel & Stewart, 2003). To

explore the problem, I provided a forum in which a group of nurses working in a harm reduction-focused health care setting were asked to describe how they made sense of nursing practice using a harm reduction framework with people who use drugs. It is my hope that through the research process, new knowledge of benefit to the larger profession of nursing will be generated. I further hope that a greater understanding of the philosophy and interventions of harm reduction as a public health approach for nursing practice with people who use drugs may be achieved.

Purpose of the Study

In this study I used the interpretive descriptive method, as outlined by Thorne, Reimer Kirkham and MacDonald-Emes (1997), to describe the practice experience and perceptions of nurses, who use a harm reduction framework, in their work with people who use drugs in the DTES of Vancouver. While nurses have contributed significantly to the large body of scientific evidence demonstrating the efficacy of harm reduction interventions in decreasing the risks associated with IDU, the perspective of nursing has not yet been described.

The design of the study allowed for the potential to generate new knowledge and insights through an interpretation of the experience and viewpoints described by nurses who work in a harm reduction-focused health care setting with people who use drugs. Exploring the benefits, challenges and successes of nursing practice utilizing a harm reduction framework with people who use drugs may contribute to a greater awareness of how these nurses understand their work. The findings may inform future research in this area and provide insight - through an interpretation of the perspective of nurses who are

leading the way in using harm reduction to guide their nursing practice - into how to deliver holistic nursing services to best meet the needs of people who use drugs in a client centered, pragmatic, effective and accessible manner.

The research question addressed in this study is: How do nurses, using the framework of harm reduction, make sense of nursing practice with people who use drugs?

Organization of the Thesis

In this chapter, I have reviewed the background for my study, stated the study problem and discussed the purpose of the study. In chapter two, research based literature which locates the problem that I have identified within existing knowledge will be reviewed and related literature will be identified. In chapter three, I will describe the research design, including theoretical perspectives, methodology, ethical considerations, and scientific quality. Chapter four will contain a review of the findings based upon my interpretation after analysis of the interviews with the study participants. In chapter five, I will discuss the findings and relate them to existing literature. And in the final chapter, I will explore the implications of the research findings for the larger profession of nursing and will outline recommendations for future research, as well as policy and program development.

CHAPTER TWO

Review of the Literature

While a large body of evidence attests to its efficacy, harm reduction remains a controversial public health care approach for people who use drugs (BC Ministry of Health, 2004). This would appear to be, in large part, due to divergent and frequently polarizing beliefs that have long been associated with the issues of addiction. One of the most predominant socio-cultural attitudes toward addiction in the western world has positioned people who use drugs as morally inferior in comparison to the rest of society. A second and frequently accompanying attitude views abstinence as the only solution to the problems of addiction. People who use drugs are subjected to a host of values and beliefs directed towards them from members at all levels of society. These values and beliefs are then coupled with the multiple theoretical perspectives underpinning the phenomena of addiction (Alexander, 1990; Carstairs, 2006). It might be assumed that nurses, as members of the larger cultural collective, have not been immune to exposure to the various attitudes, beliefs, and worldviews informing the dominant cultural discourses on addiction. It is my intention to develop this review of the literature in order to gain an appreciation for the multiple lenses that have influenced how nurses may understand the complexity of beliefs surrounding addiction. In addition, a review of the existing literature on harm reduction will provide the foundation for understanding how nurses may come to adopt the framework in their practice with people who use drugs.

This approach is congruent with the interpretive descriptive method that I employ in this study wherein Thorne, Reimer Kirkham and MacDonald-Emes (1997) recommend beginning the research process by locating findings within existing knowledge. The

review of the literature will be useful in establishing context for new knowledge specifically relevant to nursing. Previously published literature from other disciplines is discussed in light of its applicability to furthering an understanding of harm reduction for nurses (Burns & Grove, 1997). The literature review serves to provide a critical analysis of the existing knowledge necessary to support the design of my study. It also allows for the construction of findings with attention to the linkages drawn by others in the field of harm reduction.

My personal story of coming to work with people who use drugs provides the template, of sorts, for the influences that I will explore in this chapter. I am well aware that my experience and perceptions may not be the same as other nurses. Yet the predominate messages that I received throughout my life from my family of origin, from the media, from peers and through my education that influenced my understanding of drugs and people who use drugs may resonate similarly with others.

I began working in community nursing with people who use drugs ten years ago. I found myself challenged by a barrage of stereotypes about drugs and people who use drugs; my personal biases and lack of insight were standing between me and my ability to develop therapeutic relationships with my clients. I was required to examine the beliefs, values, assumptions and worldviews that had shaped my knowing of drugs, drug use and people who use drugs. When I critically disimpacted the stereotypes related to drug use, harm reduction as a philosophy and set of interventions began to seem to me to be the sensible solution in beginning to address some of the problems associated with addiction. I remain cognizant of the fact that my journey, professionally and personally, which culminated in a changed worldview related to drugs and people who use drugs may not

be shared by other nurses; knowledge of that reality and a desire to understand the experience and perceptions of other nurses is the genesis for this study.

A combination of influences have converged to inform societal and cultural constructs associated with addiction; an examination of some of them might prove helpful in understanding the experiences and perceptions of nurses in making sense of adopting a harm reduction framework in their practice with people who use drugs. For this reason, I have chosen to begin the review of the literature with a discussion of some of the abiding cultural narratives on addiction as described by the addiction habitus, developed by Small, Palepu and Tyndall (2006), in order to focus a lens on the central problem to be addressed in this thesis. I will then move to an examination of the historical context, which has informed the cultural narratives. Following this, I will describe the various biomedical models for addiction and addiction treatment that have arisen and continue to exert influence on values and beliefs attached to drug use. Next, I will discuss the geopolitical role of the United States (US) in entrenching drug prohibition through the war on drugs and also the strong influence the US continues to exert on western socio-cultural attitudes and drug policy. I will then discuss the role that the global pandemic of HIV/AIDS has played in the increasingly widespread adoption of harm reduction philosophy and interventions in communities throughout the world. Finally, I will conclude the review of the literature with the influences that led nurses who work in the DTES of Vancouver with people who use drugs to expand their scope of practice to include harm reduction. I begin with a description of the addiction habitus.

The Influence of Socio-Cultural Constructs

The Addiction Habitus

Small, Palepu, and Tyndall (2006) described the cultural change that they believe occurred in Vancouver in order for InSite to open. In their article, they credit Bourdieu (1999) for first using the word habitus as a concept to explain how people “have regular and observable collective practices without rigidly complying to rules or involving the need for thoughtful awareness” (Small et al., p.74). To explain more fully, they quote Bourdieu as saying “the habitus - embodied history, internalized as second nature and so forgotten as history - is the active process of the whole past of which it is the product. As such, it gives practices their relative autonomy with respect to external determinations of the immediate present” (Small et al., p.74). In adapting the concept of habitus to addiction, Small et al. contend that narrative elements about addiction become culturally embodied and include key values that underpin how people with addictions are understood. They believe that it is necessary to confront each of the narratives associated with addiction in order to create cultural change. As previously mentioned, Small et al. assert that cultural change can occur, and did occur in Vancouver, as a result of an increasing evidence-base of knowledge that destabilized the narrative elements and entered the public perception about drug addiction. The authors include the following elements to summarize, what they believe, are the enduring cultural narratives pertaining to addiction:

1. People choose to be addicts; therefore addicts are to blame for their addiction and corrupt lifestyles
2. Services for addicts attract addicts, promote and spread addictive behaviour

3. Drugs promote violence
 4. Drugs are seen as inherently addictive and the inherent properties of the drug itself, rather than the mental pain of the drug user, account for addiction
 5. Addicts should be made more uncomfortable to prevent and not enable addiction
 6. Drug addiction exists in a large part because drugs are widely available
 7. Harm reduction addiction services (supervised injection services and needle exchanges) promote addiction and keep people on drugs
 8. Drugs are illegal for a reason; they are dangerous
 9. All resources spent on enforcement are justified
 10. Each new drug is dramatically worse than the preceding focus of the addiction habitus: people are more violent, more mentally ill and more morally bankrupt
- (Small et al., p.74)

If one accepts the authors' premise that cultural change happened in Vancouver and culminated in the opening of InSite, one might assume that nurses, too, were engaging in a parallel process in which they reexamined their own beliefs in relation to addiction. It is probable, that at least for some of the nurses, the cultural change occurring in Vancouver in relation to the problems of drug use may have influenced their adoption of a harm reduction framework in nursing practice with people who use drugs. According to Small et al. (2006), one of the challenges in creating cultural change, in this instance adopting a harm reduction approach, appears to be the ability to strip away the social constructs and to address, understand, and deconstruct each of the elements included in the operational habitus, in their example, addiction. The pragmatism inherent to a harm reduction approach in addressing problematic drug use is congruent with the biomedical

and pharmacological knowledge that nurses have about drugs, after stripping away the attached social constructs. For nurses who practice in harm reduction contexts, their process of reevaluating their values and beliefs in regard to drugs and the people who use drugs might well include an understanding of how some of the elements were originally created. In the following paragraphs, I will describe briefly the seemingly normal human affinity for drugs and then provide the background leading to the historical constructs which continue to exert social influence, on what might be labelled “the good and the bad drugs” of addiction.

The Influence of History

The Cultural Norm of Drugs

People use drugs for many reasons; drug use is deeply enmeshed in human culture and behaviour (Alexander, 1990; Boyd, 1991; Carstairs, 2006). Boyd reported that historically (with the possible exception of the Inuit who were unable to grow the plants that produce drugs in the Arctic Circle and who thus had to wait until colonialization brought them alcohol, tobacco and other drugs), every culture on earth used intoxicants. People ingested opium and marijuana, chewed the coca leaf, drank medicine men’s potions, made alcohol, and inhaled tobacco smoke. Drugs have always been used to provide pleasure, relieve pain, increase productivity, alter mood, and, occasionally, to allow for the possibility of spiritual or emotional insight (Alexander; Boyd). Cocaine, marijuana and opium use was a cultural norm and was largely unregulated until the beginning of the 20th century (Alexander; Boyd; Carstairs).

Neurobiology has shown that the use of psycho-active drugs stimulate the same pathways in the brain as the pleasure received from the same things human beings need to survive, such as eating and sex (Alexander, 1990; Boyd, 1991; Kendall, 2004). Drug use and the control of drugs vary across time and geography, are the products of specific nations and communities, and operate within specific historical contexts. In their lifetimes, most human beings will use drugs in various ways, quantities and for certain time periods (City of Vancouver, 2004). Current thinking in the field of addictions is that not all drug use is problematic and that not all problematic drug use results in dependence or addiction (City of Vancouver).

Many theories purport to explain why drug use behaviours and patterns are so varied amongst people and why they become problematic for some and not for others (Alexander; Boyd; Carstairs). Changing social, cultural, moral, and religious beliefs have over the years, served sometimes to erode and sometimes to strengthen the various attitudes, particularly amongst North Americans, about drugs and the people who use them.

Prohibition

An early example of the vilification of a specific drug and the subsequent creation of an underclass of people who used that drug occurred with alcohol. Before the turn of the last century, the powerful Christian Temperance movement in the United States came to prominence. This group was the first to attack a drug, alcohol, and to blame it for the social problems of the times. The movement quickly gained momentum and went from encouraging the temperate use of alcohol to calling for its universal prohibition (Alexander, 1990, citing Levine, 1984). During the time alcohol was prohibited in the US

(1920-1923), violence increased and over one thousand Americans were killed by enforcement agents (Alexander, citing Kobler, 1973). Interestingly, although rampant alcohol abuse was blamed for the social ills of the time, when the US enacted prohibition, the per-capita consumption of alcohol was lower than in the previous hundred years (Alexander).

The Canadian Christian Temperance movement was also influential. In Canada, the North-West Mounted Rifles was formed in 1873 by parliamentary decree to enforce the total prohibition of alcohol in the “wild west”, and nationally alcohol was prohibited for the year 1918 (Alexander, 1990). Stories of corruption, violent enforcement and the deep-rooted sense of “British Justice”, led Canadian provinces to repeal prohibition in a series of plebiscites held across the country in the early 1920’s (Alexander, p.29). The prohibition of alcohol created a lucrative, violent and corrupt underworld market selling banned substances because, despite legislation, people continued to use alcohol (Alexander; Basham, 2001; Boyd, 1991).

Numerous drugs, for example opium and cocaine, had been freely traded since colonization. When cocaine, opium, and morphine were legal for medicinal and recreational purchase at drug stores and by mail, public consumption rose, peaked, plateaued, and fell away (Boyd, 1991). There is much evidence that the prohibition of opium in Canada initially grew out of racism (Alexander, 1990; Basham, 2001; Boyd, 1991; Carstairs, 2006). In Canada, Emily Murphy, the first female judge in the British Empire, published a very influential book, *The Black Candle*, in 1922. In it, she recommended strict penalties and the drafting of harsh laws to stop drug use and to prevent its “control of the white man” (Boyd, p.32). Tensions in Western Canada

between the predominantly Caucasian society and Chinese immigrants, who came to build the national railway, culminated in the Anti-Asiatic riots in Vancouver in 1907 (Carstairs). The smoking of opium was a cultural norm continued by this immigrant group in their new country. When Caucasians began to spend time in opium dens, public fears rose and opium became a foreign social scourge in need of controls. In North America, marijuana was prohibited, in large part, as a result of increasing social fears that the black men who smoked it lured white women into promiscuity (Alexander; Boyd; Savas, 2001).

Repeated pressure from the BC government and the medical community interested in wresting control of opiates from patent medicine producers, led to the passing of the Opium Act in 1908 in Canada. For similar reasons, the US followed suit with the passing of the Harrison Act in 1914 (Alexander, 1990; Carstairs, 2006). At the same time, the use of cocaine in patent medicines was prohibited entirely in North America and Europe (Alexander; Boyd, 1991). A second reason this occurred was because, by the end of the 19th century, doctors had gathered enough political power to exclude homeopaths, midwives and others from the practice of medicine (Carstairs).

In both of the aforementioned North American acts, opiate users were considered to be addicts and not patients; therefore doctors were prohibited from treating them medically with opiate substitution programs. In the early 1920s, The Rolleston Commission in Britain was convened to decide whether British physicians should have the right to prescribe opiates to their opiate addicted patients (Andersen, Priest & Seymour, 2007). After studying how the prohibition of opiates in the US had created an underclass of people who were marginalized from mainstream society and

disenfranchised from the medical system by their addiction, the commission's final report recommended that doctors in Britain be allowed to prescribe opiate substitutions to patients who were addicted (Andersen et al.). This led to the creation of the so-called "British System" which provided British doctors with the autonomy to address some of the issues associated with opiate addiction. It also served to foster markedly different social beliefs about the problems of addiction in Europe. In North America, the prohibition of cocaine and heroin, the inability of doctors to prescribe them and the creation of an underworld populated with people who procured drugs and of people who used drugs led to the social designation, which labelled cocaine and heroin "the bad drugs" of addiction.

Most nurses are aware that in contemporary society, the abuse of alcohol and tobacco overshadow illicit drugs in impact on health and health care costs (Alexander, 1990; Basham, 2001; Boyd, 1991; Room, 2001; York, 2004). There is no logical basis for the differing legal treatment of drugs because the dangers of alcohol and tobacco exceed those of opiates, cocaine and marijuana (Alexander; Basham, citing WHO Report, 1998; Boyd). Nine-tenths of the Global Burden of Disease for all drugs can be attributed to these two legally sanctioned drugs (Room). Health Canada reports that the use of tobacco is the number one cause of preventable death in this country (Puder, 2001). Yet, in a completely socially constructed way, it might be said that alcohol and tobacco remain the "good" drugs of addiction because they are not prohibited and the people who use them, while subjected to considerable public pressure, are not ostracized to the degree that people who use cocaine and heroin, the "bad" drugs, have been.

In the last one thousand years of human history, in different times and in different places, the prohibition of tobacco, alcohol, marijuana, cocaine, and opium led to the torture, imprisonment and execution of their users and distributors (Alexander, 1990; Boyd, 1991; Carstairs, 2006). Problem drugs are usually conceived by government and industry to be issues of concern to the public health and require criminal enforcement, but drug use is rarely understood to be a normal cultural phenomenon (Boyd). Nurses, because of the nature of their professional exposure to the problems of drug use, may also be particularly aware of the influence of the various models of addiction and how the models influence beliefs and attitudes about people who use drugs. In the following paragraphs, I will discuss the most common theoretical models that underpin our understanding about addictions.

The Influence of the Models of Addiction

Alexander (1990) cited Jaffe's (1985) definition of addiction as "a behavioural pattern of drug use, characterized by overwhelming involvement with the use of a drug ... the securing of its supply, and a high tendency to relapse after withdrawal" (p.105). For at least the last hundred years, people who are, according to Jaffe, "overwhelmingly involved" in drug use, and those that are not, have had an array of beliefs, values, and world views about addiction informing both individual and collective belief systems.

In a report released in 2004, the BC Ministry of Health described four preeminent addictions models: the moral model, disease model, behavioural model(s) and the holistic model. Each model is illustrative of both the strongly entrenched beliefs underpinning it and of the special interests that uphold it (In this section, the reader is referred to the

source, *Every Door is the Right Door*, 2004 for a more in-depth treatment of the four models, except where specifically referenced in the text as otherwise). The models are outlined briefly in the following section:

1. The Moral/Criminal Model of Addiction

This theory is based on a dichotomous moral theory. Simply stated, people are said to be responsible for their behavioural choices, which may be either good or bad. Those who choose good behaviour warrant praising and those that choose bad behaviour require punishing. The rationale plays out in the following sequence: addiction is a bad behaviour, people who are addicted are bad people and bad people should be punished. The bad people who use drugs integrate feelings of guilt, blame and shame. The good people who don't engage in the bad behaviours stigmatize those who do and blame them for their own moral failure.

2. The Disease/Medical Model of Addiction

This theory gained prominence in the mid-20th century, with alcohol as the prototype of addiction, and in this view addiction is a disease caused by genetic and biological factors. This is despite the fact that research has not yet been able to pinpoint a genetic basis for alcoholism or other forms of addiction. The concept has been extended from alcohol to other drugs in recent years, and has served to position addicts as patients deserving of treatment as opposed to criminals requiring punishment.

In this model, addiction is a progressive disease without cure, requiring a lifelong commitment to total abstinence. The 12-step recovery model in North America endorses the disease model. Although pharmacological treatment methods exist to mediate the symptoms of addiction, people who embrace the disease model frequently are against

their use. The ability for people who use drugs to change their addictive behaviours is difficult to explain by those who believe it is an incurable progressive disease.

3. The Behavioural Model(s) of Addiction

Multiple theories surround addiction as a behaviour that can be learned and unlearned. Behavioural theorists draw on behavioural and social cognitive theory that is based on the assumption that addictive behaviour has multiple determinants and that the risk to people varies depending on their individual bio-psycho-social history. The cognitive-behavioural model emphasizes the processes involved in habit acquisition and habit change, which are primarily influenced by cognitive and behavioural principles. Major emphasis is also placed on the reward consequences of engaging in addictive behaviours. Behavioural theorists in the field of addictions have also borrowed from the field of behavioural economic theory. The assertion is that given the option of short-term reward over long-term reward, not only most people who use drugs but most consumers, would chose immediate gratification as a normal decision-making process in the psychology of choice.

Treatment options are presented to the individual in a manner acknowledging that addictive behaviours represent a problem in self-management. This can be resolved by the individual through a variety of goals ranging from abstinence to reductions in harmful consequences. Some proponents of the cognitive-behavioural model eschew the use of medications in treating addictions as strongly as those in the medical /disease model.

Another behavioural model, the Adaptive Model of Addiction, views addictions as a learned response to multiple overwhelming factors that contributes to the individual's ability to maintain any degree of functional capacity (Alexander, 1990).

Within this framework, change theorists conceptualize specific stages of change for a variety of problem behaviors. An example of yet another behavioural change model is the Transtheoretical Model of Change (Prochaska & DiClemente, 1983) in which five stages of change are described: precontemplation, contemplation, preparation, action, and maintenance. In this behavioural model, people are understood to move through the stages in non-linear ways, at different rates, and for different periods in their lives.

4. The Holistic Model of Addiction

This is an emerging model, with a holistic approach to addiction, in which the strengths of the various traditional addiction models are acknowledged. The social, economic, cultural, and environmental conditions, as well as individual behavioural choices that have an impact upon both psychological status and biological states are also acknowledged within a holistic framework. In the holistic model of addiction, the importance of the individual in self-care, treatment and recovery activities associated with their own chronic disease management is countenanced. Healthy public policy and changing social norms are considered important criteria within a holistic approach. In this model, the unique risks associated with gender, age, cultural identity, concurrent mental health problems, and the differences in both preventing and responding to addictive behaviour problems are realized. Also, the complex relationship between addictive behaviours and harmful consequences for the individual and community are foregrounded and the key public health goal, defined within the model, is the reduction in problem consequences. Harm reduction philosophy and interventions are included in a holistic approach to addiction.

The models of addiction reflect the dominant social mores of particular historical times and the abiding influence of the underlying beliefs and values continue to inform the cultural collective today. It might be assumed that nurses who work with people who use drugs are not only aware of the influence that the models of addiction exert on attitudes related to their client population but are also cognizant of the geo-political influence of the US, its role in the global war on drugs and its influence on Canadian drug policy.

The Influence of Geo-Politics

“Just say No to Drugs”

The influence of the geo-political proximity of Canada to the US cannot be underestimated, especially in a discussion of drugs and drug prohibition. The United States of America has driven global drug prohibition for the last one hundred years primarily through a war on drugs (Drug War Facts, 2004). Nancy Reagan’s (the wife of former US President Ronald Reagan) battle cry of “just say no to drugs” continues to be informed by the moral theory of addiction and underpins a war on drugs orientation to the problems of drug use. In espousing this ideology, proponents assert that although people make choices to use drugs and are consequently responsible for their resulting life circumstances, they should not have given in to the temptation to use drugs in the first place. Further, in order to help protect those too morally weak to fight the temptation to use drugs, a war on drugs ideologue believes that through drug control strategies both drug use and the sequelae of drug use will be prevented. Many believe that experimentation with any prohibited drug always leads to more drug use (the gateway

theory) with subsequent addiction, violence, poverty, the disintegration of families and family life, and will cause the collapse of civilized society (Erickson, 2001). All efforts should therefore be concentrated on the global eradication of drugs. For those who uphold this belief system, it follows that a war on drugs and the ongoing prohibition of drugs is not only moral, but also necessary.

The War on Drugs

Despite the fact that not a single empirical study has demonstrated that the social and economic benefits of drug prohibition outweigh the social and economic costs, a war waged against drugs remains the preeminent global response to the problems of drugs (Basham, 2001). In the war on drugs, efforts are focused on the criminal prosecution of people involved at all points along the international supply and demand chain of illicit drug production. The cost to American taxpayers is great; the war on drugs currently costs approximately six hundred dollars per second (War on Drugs Clock, 2007).

The prohibition of drugs is lucrative. Prohibition and the creation by international laws of licit and illicit drugs have produced a massive black market. The UN has estimated that the annual global sale of illicit drugs is between \$450 and \$750 billion (Haden, 2005). This amounts to 8% of all international trade and is comparable to the annual turnover in textiles, according to the Office of National Drug Control Policy (Drug War Facts, 2004). Third World farmers are not motivated to cultivate other crops because growing coca and opium plants is well remunerated by illicit drug organizations intent on supplying drugs to meet the demand of people who use them (Alexander, 1990). British Columbia's top commodity is marijuana (\$6 billion), followed by construction (\$5.7 billion) and then logging and forest products (\$5.6 billion) (Haden, 2005).

According to the UN (Drug War Facts), profits in illegal drugs are so inflated that three-quarters of all drug shipments would have to be intercepted to seriously reduce the profitability of the business. Current efforts are estimated only to intercept 13% of heroin shipments and 28% - 40% of cocaine shipments (Drug War Facts). In actual fact, the war on drugs empowers organized crime, corrupts governments, distorts the marketplace, hinders health care, feeds an ever-increasing law enforcement and penal industry, and marginalizes people who use drugs (Basham, 2001).

The Human Cost of Prohibition

The U.S. spent three billion dollars on the incarceration of its drug offenders in 2003 (Drug War Facts, 2004). In China prior to the 1949 revolution, 20 million people were reportedly addicted to opium imported from the “Golden Triangle” of Burma, Laos, and Thailand (Alexander, 2000). The Chinese government self-reportedly eradicated all addiction by sending users to labour camps and executing traffickers. Currently, the Chinese government conservatively estimates to having 679,000 heroin addicts and to have failed to stop “surging narcotics abuse despite crackdowns” (Associated Press, Taipei Times, 2005, p.1). Russia predicts that based on the 900 % increase in drug use in the last decade, that they will have 35 million people who use drugs by the year 2014 (Drug War Facts).

As drugs are everywhere, every community in the world is impacted. According to the UN Office on Drugs and Crime (UNDOC) in 2003, the most widely used substances worldwide are cannabis (160 million people), followed by amphetamine-type stimulants (34 million people abusing amphetamines and 8 million abusing ecstasy)

(Drug War Facts, 2004). The number of opiate users is close to 15 million (10 million of whom use heroin) and the number of cocaine users is 14 million (Drug War Facts).

The casualties of drug prohibition are the people who use drugs and the communities in which they live. Alexander (2001) postulates that the necessary precursor to addiction is dislocation from families and communities of origin and that as free market globalization speeds up, so does dislocation and addiction. He contends that “people become addicted to harmful substances or behaviours when they are dislocated from the many intimate ties between people and groups - from the family to the spiritual community - that are essential for every person in every type of society” (Alexander, p. 1). Boyd (1991) asserts that drug use is seen as a rejection of, and threat to, the dominant cultural values. It would appear that the belief in the moral theory of addiction continues to permeate much of the cultural collective. One result of this is the perpetuation of the notion of direct causation between drug use and bad behaviour. Alexander (1990) stated, “There is no good evidence that drugs cause any substantial part of the social pathology attributed to them ... on the contrary, there is good evidence that social pathology causes destructive forms of drug use” (p.17).

People who use drugs are forced into the sub-culture created by prohibition and are afforded little opportunity to escape arrest, incarceration, adverse health consequences, poverty, and anti-social drug seeking activities and behaviours. Systematic disenfranchisement from the rights and privileges afforded to other members of societies’ results. At local levels, police interventions aimed at people who use drugs have deleterious effects on public health (Cohen & Csete, 2006; Eby, 2006; Haden, 2006; Kerr, Small & Wood, 2005; Wodak, 2006; Wood, Spittal, Small, Kerr, Li et al., 2004). In

1997, the estimated direct costs arising from law enforcement and health care related to IDU and HIV/AIDS in BC was \$96 million annually (MacPherson, 2000). The cost of enforcement was 4.5 times higher than the cost of treatment (MacPherson). There is much evidence that prohibition kills more people than the drugs it prohibits (Alexander, 1990; Basham, 2001; Boyd, 1991; Drug War Facts, 2004; Le Dain, Lehman, Campbell, Steins & Bertrand, 1973; Oscapella, 2001; Room, 2001; Stevenson, 2001). Nurses are watching with particular interest the increasingly punitive responses of the Canadian federal government to the issues of problematic drug use and the apparent erosion of support from the current federal government for harm reduction strategies.

The Influence of the US on Canadian Drug Policy

The influence of changing government policy, ongoing controversy and the attendant media coverage on upholding historically divergent values and beliefs associated with addiction and addiction treatment strategies continues. In Canada, the current federal government has been accused of adopting a moral stance on addiction and of ignoring the growing body of evidence generated by the scientific team charged with evaluating InSite (Davies, 2007; globeandmail.com, 2006; Lou, 2007; Roberts, 2007). InSite opened in 2003 as a three-year scientific research pilot project. At the completion of the three-year period, the scientific evidence supported the facility as a harm reducing strategy (Insite for Community Safety, 2007). Subsequently, InSite received a fifteen-month extension (to have expired in December of 2007) and then received an additional six-month extension (to expire in June of 2008) by the Federal Minister of Health. The scientific evaluation team was further tasked with studying how medically supervised safer injection facilities affect crime, prevention and treatment (Health Canada, 2007).

The federal funding to conduct the scientific research has been stopped (Kerr, 2007). No further applications by other communities across Canada requesting permission to open medically supervised safer injection facilities will be accepted by the minister's office in the interim (Health Canada, 2006). Federal permission is required to obtain a Section 56 scientific exemption to the Controlled Drugs and Substances Act granted by the Canadian Federal Minister of Health (VCH, 2003b; NAOMI, 2005). An exemption allows Canada to remain in compliance with international law as a signatory of the International Narcotic Convention. Two legal challenges representing key organizational stakeholders and people who use drugs are making their way through the BC Supreme Court system. Lawyers for both cases are arguing that because addiction is a health issue a federal exemption is not necessary to keep InSite open because health care is a provincial matter (Conroy, 2007; Pongracic-Speier, 2007).

The US continues to lead the War on Drugs and to promote prohibition, abstinence and criminal consequences for people who use drugs (Drug War Facts, 2004). The US influence on the world stage is immense and therefore the global spread of harm reduction has not been without challenges. The US and Japan continue to oppose harm reduction in international meetings (Stimson, 2007). The Canadian federal government appears to be basing its national drug policy strategies on moral ideology instead of scientific research; some people believe that the government is bowing to the external pressure of the US government (Davies, 2007). Within the Vancouver addictions services community, many people are concerned that InSite may close and they are actively galvanizing public support to challenge the government's position in the matter (Davis, 2007).

One could assume that these multiple influences may permeate how nurses understand the uptake of the philosophy and interventions of harm reduction. The general notion of harm reduction as a strategy used to ensure public health is both well known and well accepted by nurses. The shift in the term's accepted usage to mean the specific interventions and philosophy aimed at the reduction of risks to people who use drugs, is relatively new and only entered the public health lexicon after the advent of HIV/AIDS (Drucker, 1995). In the following section, I will provide a general overview of harm reduction, explore the impact of the HIV/AIDS pandemic on the uptake of harm reduction specific to the problems associated with people who use drugs and conclude with a discussion of the DTES of Vancouver which created the locus for the expansion of harm reduction interventions in Canada.

The Influence of Harm Reduction in Public Health Policy

Harm Reduction as Public Health Policy

Harm reduction as a broad lens approach both predates and goes beyond the risks associated with drug use. Mandatory seat belt laws, safer sex education, cigarette package warnings and designated bicycle paths are all examples of policies, legislations, and strategies aimed at minimizing harms. Alcohol and tobacco use are legally sanctioned drugs that have had their use subjected to criminal law, social pressure, public health policy, and education. Every North American schoolchild now knows that drinking and driving is punishable by law and that the smoking of tobacco can cause lung diseases.

Within this context, "harm reduction" is a term collectively describing a variety of interventions designed to minimize the adverse consequences associated with potentially

risky behaviours to individuals and communities (Des Jarlais, 1993). After AIDS infiltrated the drug using population, the concept of harm reduction narrowed in application. It became synonymous with policies, programs, services and actions that work to reduce the health, social, and economic harms to individuals, communities, and society specifically associated with injection drug use while not requiring a reduction in drug use itself (MacPherson, 2000; Single, 2000). Harm reduction can best be described by what it is not: prohibition. Harm reduction has two main pillars: the first is pragmatic public health strategies and the second is, “based in human rights, especially the rights of drug users to life and security, health protection, to the provision of medical treatment and the protection against hurts from the community and state” (Stimson, 2007, p.68).

In the literature, harm reduction has been called: an approach informed by pragmatism (BC Ministry of Health, 2004; 2005; CCSA, 1996; Erickson, 2001; Hilton, 2001; MacPherson, 2000; Riley, Sawka, Conley et al., 1999); a response (Des Jarlais, 1993); a strategy (Drucker, 1995); a set of principles (Fischer, 1995); a set of interventions (Stimson, 1998); a population health movement (Single, 2000); a social policy (O’Hare, 1998); and a public health model (Marlatt, 1998; Reid, 2002; Single, 2000).

Regardless of descriptor, harm reduction is now most commonly used to refer to a public health response aimed specifically at people who use drugs. Since 1999, when the Federal/Provincial Harm Reduction Working Group in B.C. adopted strategic operating principles to maintain harm reduction as the primary conceptual basis for the province’s drug strategy, Vancouver nurses and others working with people who use

drugs in BC have been guided by the following principles in reconceptualizing harm reduction:

1. First, do no harm
2. Respect the basic human dignity of people who use drugs
3. Focus on the harms caused by drug use, rather than drug use per se
4. Maximize intervention options
5. Choose appropriate outcome goals giving priority to effective programs with practical, realizable goals

(Single, 2000, p.10)

These principles, according to Single, provide a better sense of priorities and focus as well as a clear sense of strategic direction. While not excluding abstinence-based approaches, priority is “given to immediate steps to prevent drug-related harm in situations where the user cannot be reasonably expected to cease use at the present time” (Single, p. 9-10).

Another influence for nurses and others interested in harm reduction which served to further ground the application of harm reduction as responses aimed specifically at drug use was the seminal English language text, *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviours*. The text was edited by Dr. G. Alan Marlatt, an American psychologist and was first published in 1998. One of the most often-cited and key conceptualizations of harm reduction came from these writings: “rather than defining drug use as a disease or a moral failing, harm reduction proponents stake out a humane and practical alternative - meeting clients “where they are at” to help them understand the risks involved in their behaviours and make appropriate decisions about their own treatment goals” (Marlatt, 1998, p. ix). It is not unfamiliar to hear nurses who work with

people who use drugs say “meeting people where they are at” to succinctly illustrate the pragmatism and compassion inherent to a harm reduction orientation to their nursing practice (Griffiths, 2002; Wood, A. et al., 2003).

At the international level, the United Nations program on HIV/AIDS, UNAIDS, separates the measures aimed at reducing at least one harm associated with IDU, that of HIV transmission among and beyond drug users, as harm reduction and the measures aimed at dissuading people from using drugs in the first place, therefore reducing the number of people who use drugs in the population as demand reduction (UNAIDS, 2004). Nurses are aware that the adoption of harm reduction as a public health strategy as a result of the AIDS epidemic, not only promotes health for people who use drugs and the communities in which they live, it also promotes an ever increasing social dialogue in regard to the issues of drug use.

Harm Reduction in Pre-AIDS Public Health

Many countries in Europe had implemented harm reduction strategies to address the issues associated with drug use well before the onset of AIDS. A long history of British social justice does much to explain why harm reduction as a health and social policy for people who use drugs is not new in the UK (Alexander, 1990). In Europe, the tradition of civil rights has done much to moderate more strident anti-drug beliefs (Alexander). Despite having strict drug trafficking laws, Britain, Germany, Holland and Switzerland pioneered pragmatic public health and social programs aimed at mitigating the harm of drug use. Harm reduction as a public health policy, directly related to problems of drug use, can be traced back to the Rolleston Commission in 1926 and the

adoption of the first opiate substitution programs, as discussed earlier in this chapter (Drucker, 1995).

A second opiate substitution program is methadone maintenance programs (MMPs), which have operated since the early 1960s in several European countries, Australia, Canada and the US. MMPs for people who use drugs were seen as harm reduction for society, usually in terms of reducing crime or restoring people who use drugs to the workplace and therefore, quickly became available in most of the western world (Riley, 1993). Methadone is the most widely used and researched opioid replacement therapy (Health Canada, 2002; Hunt, 2003; Hunt, Trace & Bewley-Taylor, 2005; NAOMI, 2005; Ribeaud, 2004.)

The role of needle sharing among people who use drugs in the transmission of HBV has been documented since the 1970s (O'Hare, 1998; Reid, 2002; Strathdee, et al., 1997; WHO, 2004a; 2004b). The first needle exchange program (NEP) was established in Amsterdam in 1984, by an advocacy group, for people who use drugs. The Junkie Union, as they called themselves, wished to prevent an epidemic of HBV when an inner-city pharmacist planned to discontinue selling syringes to people who use drugs (O'Hare, 1998). The city of Amsterdam recognized that drug use is a relapsing disorder, that medical and social care should be provided, and endorsed a pragmatic and non-moralistic attitude toward drug use (Millar, 1998; Riley, 1993).

The first unofficial supervised injecting sites opened in the Netherlands during the 1970's. The longest operating government authorized injecting sites have been open in Switzerland since 1986. The initiations of these centres came about largely because of public nuisance factors (for example, the litter of drug use paraphernalia) and were run by

health officials concerned with overdoses and blood borne infection transmission (MacPherson, 2000). Increasing social acceptance of the reality of drug use, and the health consequences of unsafe injection practices, culminated in the adoption of a continuum of pragmatic harm reduction strategies in Europe that remain the gold standard for the rest of the post-AIDS world's approach to the problems of drug use.

The Influence of Blood-Borne Pathogens and Drug Overdoses on the Public Health of People who use Drugs

By the mid-1980's HIV/AIDS had migrated to the population of people who use injection drugs primarily through the sharing of dirty needles. When HIV reached the injection drug using population, it crossed over to their non-drug using partners and was vertically transmitted by pregnant women to their unborn children.

Blood-borne infections and overdoses are the most widespread and serious causes of mortality and morbidity related to IDU (Griffiths, 2002; Health Canada, 2004; Hilton et al., 2001; Martin, 2003; Millar, 1998; WHO, 2004a; 2004b; 2004c; 2004d; 2004e; 2004f; Wood et al., 2005). The statistics are staggering. A global overview of the linked epidemics of IDU and HIV infection, documenting prevalence in 130 countries, reports that there are 13.2 million people who use drugs worldwide (Aceijas et al., 2004). These epidemics, IDU and HIV infection, are substantially attributed to the sharing of injecting equipment and sexual transmission (WHO, 2004a; 2004b; 2004c; 2004d; 2004e; 2004f; Wood, E. et al., 2003; Wood, Kerr et al., 2005; Wood, Tyndall et al., 2005).

HBV and HCV are also widely prevalent amongst people who use drugs and are even more readily transmitted by needle sharing than HIV (WHO, 2000a; 2004b; 2004c; Wood, Tyndall et al., 2005). Globally about 170 million people are estimated to have

HCV and in developed countries about 90% of people infected with HCV are people who use or have used drugs (Aceijas, 2004; Hunt, 2003; Hunt et al., 2005). Infections including abscesses, cellulitis, endocarditis and septicemia are prevalent amongst people who use drugs (Griffith, 2002; Hunt; Hunt et al.; Wood, E. et al., 2003). Methicillin Resistant Staphylococcus Aureus (MRSA) is increasingly common and has major public health implications (Hunt et al.; Kirkey, 2007).

Overdose associated with opioids among young adults is one of the leading causes of death internationally (Hunt, 2003; Hunt et al., 2005). During 2000, more than five times as many people who use drugs died of overdose within Europe as those who died of AIDS (Hunt et al.). Currently, in the city of Vancouver about 14,000 people reportedly use some type of illicit drug (VCH, 2007b). People who use injection drugs account for 65 % of this number; approximately 450 are believed to be young people between the ages of 10 and 19 (VCH). Nurses are aware of the potential implication of these statistics in terms of the costs to human lives globally and locally (Pauly, Goldstone, McCall, Gold & Payne, 2007). Along with others in the health care sector, nurses have been marshaling for the adoption of a more holistic model of addiction and the integration of more harm reduction strategies to offset the risks attached to drug use (Gold, 2003; Wood et al., 2003).

Harm Reduction in Post-AIDS Public Health

Harm reduction is now the driving public health response globally to the AIDS epidemic for groups of people who use drugs (Stimson, 2007). In 2005, after much international debate regarding harm reduction, UNAIDS made a clear call for the urgent expansion of harm reduction measures amongst people who use injection drugs in

countries experiencing or at risk of HIV epidemics (Hunt et al., 2005; Trace, Riley & Stimson, 2005). The scope of application of harm reduction varies from country to country and community to community (Hunt, 2003). In countries where harm reduction initiatives have been implemented early and comprehensively, there is evidence of the containment of AIDS (INHR, 2005). There is a massive body of evidence supporting the efficacy of harm reduction interventions in decreasing the risks associated with IDU (Hunt; Hunt et al.).

Merseyside, in Liverpool, UK, is the first example of a community introducing a range of harm reduction interventions as a response to the problems of IDU (MacPherson, 2000). The Merseyside region's adoption of harm reduction strategies and treatment programs in 1986 provided the template for communities in other parts of the UK and the world. Germany, the Netherlands, Australia, and Switzerland also provide examples of countries where communities marshaled health, enforcement, and municipal resources to provide harm reduction strategies to mitigate the impact of surging HIV rates amongst people using injection drugs (MacPherson; Riley, 1993). Locally, the particular challenges of a small neighbourhood in the inner city of Vancouver may have exerted some influence on how nurses who work with people who use drugs have come to understand adopting a harm reduction orientation as a public health response.

The Influence of the DTES of Vancouver

The concentration of people who use drugs in the DTES has resulted from the gentrification of other neighborhoods, the concentration of available services, and consistent in-migration from across the province and country (Caine, 1994; MacPherson, 2000; Millar, 1998). In 1998, the then BC Provincial Health Officer, wrote a report

detailing many important factors that he believed provided an explanation for what he called the drug epidemic in the province. He included:

“a failure to provide optimal environments for large numbers of young children growing up in deprived circumstances or with dysfunctional families; inadequate provision of care for the chronically mentally ill; the availability of cheap heroin, often in unexpectedly high concentration, and cocaine for injection use; the illicit nature of drug use, forcing users to criminal activity and jail; a persistent societal attitude that forces drug users to the margins of society, where they are compelled to live without adequate housing, food, health care, and social supports; and inadequate organization and capacity for addiction treatments”

(Millar, 1998, p. 3-4).

The ghettoization of the DTES drug using community made it fertile ground for the AIDS epidemic to gain a foothold. In large part because of the challenges associated with the DTES, the city of Vancouver adapted the Merseyside experience in developing *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver* (MacPherson, 2000). The four pillars referred to in the document are: treatment, prevention, enforcement and harm reduction. The primary aim of the city's drug strategy is to increase the public health and the public order. Public health, in the document's context, is described as working towards addressing the drug-related health crisis in Vancouver by: reducing harm to communities and individuals; increasing public awareness of addiction as a health issue; reducing the HIV/AIDS /HCV crisis; reducing overdose deaths; reducing the number of those who misuse drugs; and providing a range of services to groups at increased risk such as youth, women, Aboriginal persons, and the

mentally ill. In the document, public order is described as reducing the open drug scene in Vancouver by reducing the negative impact of illicit drugs in the community, reducing the impact of organized crime on communities and individuals, and implementing crime prevention techniques to increase public safety.

Despite the adoption of harm reduction as a public health response in Vancouver and many other communities, it remains controversial and continues to challenge the accepted values and beliefs of many people, some of who work in the addictions services field itself. Therefore, it is understandable that philosophic tension might be seen to exist between those who espouse an abstinence-based approach to the problems of addiction and those who sanction the adoption of a harm reduction-based approach. In the following paragraphs, I will describe some of the factors that inform the polarity of beliefs along the addictions services continuum and I will conclude the section with a discussion of the most commonly held concerns about harm reduction as a strategy for people who use drugs.

The Influence of Competing Interests on Addictions Services Provision

Ongoing ideological polarity regarding drug use and drug users, at both micro and macro levels of harm reduction practice and policy, remains common. At the micro-level, harm reduction services range from interventions directed towards harm minimization for people who currently use drugs to services with a goal of drug abstinence on the other end of the service continuum. Specific interventions aimed at service provision to drug users (i.e. needle exchanges, methadone programs, supervised injection sites (SIS), prescription heroin programs) are labelled by some, at the abstinence end of the continuum, as enabling the ongoing misuse of drugs (DuPont & Voth, 1995). In the same

manner, drug abstinence programs (i.e. mandatory drug treatment, zero tolerance treatment facilities, Narcotics Anonymous), the other end of the micro-harm reduction level, are seen by some, on the harm reduction end of the continuum, as unrealistic options for many people who use drugs (Drucker, 1995; MacPherson, 2000; Millar, 1998; Riley, 1993; Single, 2000; Wood, A. et al., 2003).

Within the greater harm reduction movement itself, civil libertarians, anti-prohibitionists, criminal law reformers, people who use drugs, some religious groups and many health care service providers have embraced harm reduction as a platform to advance pragmatic public health strategies, social change, and drug law reform (Alexander, 1990; Pauly, Goldstone, McCall, Gold & Payne, 2007). On the other end of the macro-level harm reduction continuum are the proponents of the War on Drugs, prohibitionists, advocates for stricter criminal laws, former drug users, some religious organizations, and many health care service providers wishing to continue to control drug supply and to demand the protection of individuals and communities from drug harm through drug interdiction and enforcement strategies (Boyd, 1991; Clement, 2007).

As stated previously, harm reduction, as a public health policy remains controversial. Illustrating this, the BC Ministry of Health (2005) document, *Harm Reduction: A BC Community Guide*, describes five of the most commonly held beliefs and counter-beliefs about harm reduction. Each commonly held belief described is in italics and the counter belief is in the accompanying underlying text. (The reader is referred to the source for a more in-depth discussion of the content included):

1. *Harm reduction enables drug use and entrenches addictive behaviour*

This belief is rooted in the notion that drug users need to hit bottom before they will seek help and that harm reduction prevents that from happening. For many people unable or uninterested in quitting, harm reduction can provide the point of first contact with health services that could, over time, lead to opportunities for change.

2. Harm reduction encourages drug use among non-drug users

This belief is that harm reduction sends the wrong message and that it undermines primary prevention strategies. Scientific data, that found no evidence of an increase in drug use when needle exchange programs and safer injection facilities open, is ignored.

3. Harm reduction drains resources from treatment services

Harm reduction services are relatively low-cost and easy to implement; they prevent the transmission of disease processes and save cost to the public through disease prevention and health promotion.

4. Harm reduction is a “Trojan Horse” for decriminalization and legalization

Harm reduction attempts to deal with the problems of drug use within the current global regulatory system of narcotics. Some proponents would like to see the way governments regulate narcotic control changed, and others do not. Harm reduction is neutral regarding legalization.

5. Harm reduction increases disorder and threatens public safety and health

The evidence is conclusive that harm reduction facilities do not produce a “honey pot effect”, attract drug dealers, and compromise the safety of the surrounding

community (*italics added*). Needle exchanges often recover more needles than are distributed.

It appears necessary for nurses to negotiate the influence of polarizing beliefs regarding the efficacy of harm reduction interventions when working with people who use drugs (Griffiths, 2002; Wood et al., 2003). For some nurses who had been working in the DTES with people who use drugs for years incorporating harm reduction interventions into their practice experience appeared to be simply pragmatic and made sense (Gold, 2003, Wood et al.). A review of the nursing literature specific to their individual contributions and in general to harm reduction in nursing practice with people who use drugs follows.

Nurses and Harm Reduction in Practice

Despite the fact that Canadian nurses, particularly in Vancouver, have utilized a harm reduction orientation with people who use injection drugs for years, little is known about how the nurses, themselves, make sense of using a harm reduction framework in their nursing practice. An electronic review of the English language nursing literature (CINAHL, EMBASE, MEDLINE, and Academic Search Premier) revealed relatively few nursing articles relevant to a harm reduction orientation in the provision of nursing services to people who use drugs. In the only nursing text found specifically related to drug use and nursing practice, *Addictions and Substance Use: Strategies for Advanced Practice Nursing*, Naegle and Erickson D'Avanzo (2001) devote a paragraph to harm reduction. I could find no nursing research related to my specific focus of practice interest.

The most comprehensive body of nursing literature that I found on harm reduction in general is that of Dr. Ann Hilton (Hilton, Thompson & Moore-Dempsey 2000; Hilton, Thompson, Moore-Dempsey & Hutchinson, 2001; Hilton, Thompson, Moore-Dempsey & Janzen, 2001; Thompson, Hilton, Moore-Dempsey & Hutchinson, 2000). These articles were generated as a result of an evaluation of the work of nurses employed through the BC Centre for Disease Control (BCCDC) Street Nurse Program that was undertaken by Dr. Hilton and her team. The other relevant literature that I found was written by nurses working in BC and primarily with practice experience in the DTES (Brennan & Giles, 1996; Giles & Brennan, 2001; Garm, 1999; Gold, 2003; Griffiths, 2002; Mattinson & Hawthorne, 1996; McCall, 1999; Self & Peters, 2005; Wood, A. et al., 2003). This collected body of work currently informs nursing practice knowledge in using a harm reduction approach with people who use drugs in Canada. While not specifically harm reduction in nature, literature exists that examines the relationship between attitudes, beliefs, and nursing service provision with disenfranchised populations; specifically: the relationship between nursing addiction education and beliefs about persons with alcohol problems (Martinez & Murphy-Parker, 2003), changing attitudes towards substance misuse service users (Biley, 2006) and nursing attitudes towards homeless clients (Zrinyi & Balogh, 2004). Nursing knowledge relevant to the importance of social justice, arising in part from the awareness by nurses of societal marginalization and its impact upon individual and community health, might also be seen to influence the day-to-day nursing practice of nurses who work with people who use drugs. In support of this assertion, a discussion of social justice in the nursing literature and a description of the nursing theory of marginalization follow.

Harm Reduction and Social Justice in Nursing

Reimer Kirkland and Browne (2006), citing Rawls (1971), define social justice as “the morally proper distribution of social benefits and burdens among society’s members” (p.326). The marriage of harm reduction with the tradition of a social justice commitment in nursing has precedent. The 2002 CANAC conference held in Vancouver had as its theme: Social Justice: the Essence of HIV/AIDS Nursing. Harm reduction orientation to practice was repeatedly advanced and endorsed by those in attendance. Recent nursing scholarship continues to exhort nurses to be aware of the ongoing relevance of a professional commitment to issues of social justice (Browne, 2001; Giddings, 2005; Fahrenwald, Taylor, Kneipp & Canales, 2007; Reimer Kirkland & Browne, 2006; Myers Schin, Benkert, Bell, Walker & Danford, 2006). The nurse pioneers who advanced a harm reduction orientation with people who use drugs in Canada were no doubt influenced by an understanding of a professional commitment to social justice issues in advancing health for all client groups. Nursing knowledge of the impact of impact of social marginalization on people who use drugs was most likely also influential. Next, a description of the nursing theory of marginalization is provided in order to describe another dimension demonstrating why nurses might understand the utility of adopting a harm reduction framework in their nursing practices.

Marginalization Theory for Nursing

The elements of marginalization, as described in a critical feminist nursing theory developed by Hall, Stevens and Meleis (1994) and elaborated upon by Hall (1999), provides an important perspective to the lived experience of people who are systematically peripheralized within societies. Marginalization was proposed by Hall et al

(1994) in the nursing literature as a guiding concept for valuing diversity in nursing knowledge development yet its applicability transcends any one discipline. Vasas (2005) view the concept of marginalization as particularly salient to the study of health disparities.

In the theory, Hall et al define margins as the peripheral, boundary-determining aspects of persons, social networks, communities, and environments. Margins are established in several ways: in contrast to a central point, according to the separations they maintain between the internal and external, or as distinctions between the self and others. Mainstream society is depicted as being at the centre of a community, and those excluded from power and resources are at the periphery; diversity increases with greater physical and social distance from the centre. From this perspective, Hall et al contend that persons who are viewed as relatively different from the norm are cast out to varying degrees from the societal centre to its periphery. Marginalization is the process through which persons are peripheralized to the margins on the basis of their identities, associations, experiences, and environments. Marginalization theorists suggest that there are, within marginalized individuals and groups, resiliencies that may or may not be seen as countering the inherent oppression of marginalization (Cuttler & Malone, 2005).

Harm reduction, as a public health strategy, may then be seen by nurses as a response arising from the nursing knowledge of social justice, a respect for individual capacity and resiliency and the individuals' right to make their own choices in its focus on the marginalized groups of people who use drugs.

Nursing Leadership and Harm Reduction

While there may be a paucity of nursing research relevant to my specific area of interest, nurses have been clear in their support of harm reduction principles and interventions. In 1998, the American Nurses in AIDS Care (ANAC) published a position paper supporting harm reduction strategies (Fisk, 1998). The Canadian Association of Nurses in AIDS Care (CANAC) incorporated the philosophy of harm reduction into their mission statement in 2000 (CANAC, 2000). The organization recently sent an open letter to the federal minister of health condemning the government's new anti-drug strategy and the dropping of harm reduction from its strategy (CANAC, 2007). The Canadian Association of Nurses (CNA) and the International Foundation of Nurses (IFN) have also acknowledged the need for ongoing development and education for nurses in the area of harm reduction (CNA, 2005; 2006).

Nurse leadership in harm reduction on the international stage is increasingly visible. The 17th International Harm Reduction Association (IHRA) Conference was held in Vancouver in 2006. Vancouver nurses organized a one-day nursing satellite conference, which was officially sanctioned by the main conference. As a result of this first meeting, the International Nursing Harm Reduction Network (INHRN) was formally constituted within the IHRA in 2007 (Boyjoonauth, 2007). Irene Goldstone RN, MSc and Dr. Bernie Pauley led the lobby of Vancouver nurses with the IHRA and were also successful in ensuring that the International Journal of Drug Policy commit to publishing an edition of its journal exclusive to nursing practice and harm reduction (slated for June of 2008). BC nurses continue to lead the way in advancing a harm reduction orientation in the nursing practice of people who use drugs.

In keeping with a long history of social activism, specifically when the public health is compromised, members of the nursing profession are being encouraged to take political action as a response to the current threat to harm reduction services in Canada. As recently as the October, 2007 edition of the nursing journal, *The Canadian Nurse*, a group of BC nurses, wrote an article in which they explored the ethical, legal, and social context of harm reduction. The authors specifically reference how “societal values ... towards those who use illicit drugs”, amongst many other determinants, “challenges nurses in their ability to provide safe, competent and ethical care” ((Pauly et al., 2007, p.22). The emergence of nursing leadership in support of harm reduction strategies and calls from that leadership for social justice activism serves to influence and support the day to day practice of nurses who work closely with people who use drugs. It also challenges nurses to remember the historical influence of earlier nurses, like Margaret Sanger, who emphasized public health and broad system change as necessary public health interventions aimed at improving the health of groups and populations (Reimer Kirkland & Browne, 2006).

Harm Reduction in Nursing Practice

As noted earlier, the English language literature on harm reduction and nursing practice, although small, is almost exclusively Canadian and largely written by Vancouver nurses involved in the emerging practice of harm reduction. It could be assumed that living in a city in which the unique challenges of a community such as the DTES exists, provides much of the rationale for why Vancouver nurses have been on the foreground in advancing harm reduction in the Canadian nursing context. In the following paragraphs, I will describe how Vancouver nurses contributed to the harm

reduction dialogue as an approach for practice with people who use drugs. Two of these nurses, Mattinson and Hawthorne first described a harm reduction approach in the nursing literature in 1996. In light of the “age of AIDS”, the authors exhorted health care workers to reexamine the “moralistic attitude toward illicit drugs and their users” in which stopping drug use was the only answer and move from that “dangerously simplistic stance” (p.22). McCall (1999), an emergency room nurse working in a Vancouver inner city hospital, also described harm reduction strategies and urged nurses to adopt a positive attitude with people who use drugs so that they might be encouraged to “seek out resources and treatment that can lead to beneficial changes in their health status and lifestyles” (p.19).

Vancouver nurses from the BCCDC Street Nurse Program, the Dr. Peter AIDS Foundation and two community health nurses (CHNs), also described the perspective of nurses working in community settings largely, but not exclusively, with people who use drugs (Brennan & Giles, 1996; Giles & Brennan, 2001; Gold, 2003; Griffiths, 2002; Wood, A. et al., 2003). A brief description of each, describing their contributions to advancing a harm reduction framework in nursing practice, follows.

Nurses became even more highly visible to people using drugs in the community of the DTES when the Street Nurse Program was established. In January 1988, the BCCDC, in direct response to the growing HIV/AIDS epidemic in Vancouver, developed a project in which specially trained CHNs, within a larger context of health promotion and harm reduction, would target HIV/AIDS and sexually transmitted disease (STD) prevention (Hilton, Thompson, Moore-Dempsey & Hutchinson, 2001). Through a program evaluation (Hilton et al), the nature of the street nurse’s work was described by

the nurses themselves as reflected in five themes: “reaching the marginalized high-risk populations for HIV/AIDS; building and maintaining trust, respect and acceptance; doing HIV/AIDS and sexually transmitted disease prevention, early detection, and treatment work; connecting with and negotiating the health care system; influencing the system and colleagues to be responsive” (p.275). The pragmatic notions of reducing harm framed their nursing activities.

Fiona Gold (2003), a nurse and team leader with BCCDC Street Nurse Program, played a pivotal role in the advocacy and activism that would lead to the opening of the first dedicated medically supervised safer injection facility in North America. In the late 1990s, she was delivering three to four positive HIV test results a week to her clients who used drugs (NFB/Canada Wild Production, 2007). Motivated by this reality, she became a co-chair of the Harm Reduction Action Society (HRAS) in 2000, an organization comprised of “people who use drugs, parents and friends of users, representatives of AIDS organizations, health care professionals, and social service providers who were frustrated with government inaction and the escalating rates of HIV, HCV and overdose deaths in the community” (Gold, p.16). With Gold in the lead, HRAS staged mock-supervised injection sites for two consecutive years on World AIDS Day to increase public awareness and education and repeatedly lobbied city hall, the provincial Ministry of Health, and the federal Ministry of Health.

Wood, Zettel and Stewart (2003), nurses then working at the Dr. Peter Centre (DPC), a day health program and residence for people living with HIV/AIDS, were also members of HRAS and aware that the health issues associated with people who use drugs required a greater percentage of their nursing time than those who were not. Since its

opening in 1998, the centre had embraced a number of harm reduction strategies including needle exchange, free condoms, and safe storage of money for clients who were triggered to binge drug use when they received their social assistance cheques. Increasingly, the nurses were also seeing clients with abscesses, cellulitis, endocarditis, and osteomyelitis, all associated with IDU (Griffiths, 2002; Wood, A. et al., 2003). After consultation with the then Registered Nurses Association of British Columbia (RNABC), and one and a half years before the opening of InSite, the DPC nurses began to supervise injection of street drugs for their clients for the purposes of health teaching and promotion (Gold; Griffiths; Wood, A. et al.). The clear and unequivocal practice clarification from the province's regulatory body led to the inclusion of nurses in the professional staffing model at both InSite and the NAOMI study. Both Gold and Zettel were seconded by VCH as part of the team drafting the application for the exemption under Section 56 of the Controlled Drugs and Substances Act (VCH, March, 2003b).

Since the mid-1980s, Brennan and Giles (1996, 2001), the two CHNs mentioned previously, have provided home care in the single room occupancy (SRO) hotels of the DTES, which comprise their geographical catchment area. Over time, Brennan and Giles became aware that the inner urban population had changed from primarily indigent, single, elderly men to clients who were increasingly multi-diagnosed, living with AIDS or mental health issues, and using injection drugs. They also felt that conventional policies and protocols, which guided outreach nursing in the health authority in which they worked, did not translate to the realities of their day-to-day practice.

In response, Brennan and Giles developed their own nursing model, "Action Based Care" (ABC) to better describe how they saw their work; they also embraced the

pragmatics of the harm reduction approach (Brennan & Giles, 1996). Brennan and Giles describe the key components necessary to the relationship building process for their client group as: “being consistent and reliable-such as regularly scheduled visits by the same nurses whenever possible; having a non-judgmental approach and accepting that abstinence from drugs is often not a viable option for the population in this drug saturated entrenched environment; refusing to be put off by an abrasive welcome and remembering we are guests in their home; working collaboratively with the client to establish a plan of care; seeing past the behaviour on the street to the person within recognizes the client’s autonomy; and supporting the client but not the habit”(p.3). These pioneering nurse leaders in the field of harm reduction described ABC in the literature five years before the City of Vancouver endorsed and released A Framework for Action.

The BCCDC Street Nurses have recently addressed the lack of materials available to teach Canadian nurses about adopting a harm reduction framework in nursing practice with people who use drugs. They have completed a film, “Bevel-Up: Drugs, users and outreach nursing”, which documents scenarios of their daily work, includes discussion on values and beliefs related to people who use drugs and is of particular relevance to nurses wishing to engage in harm reduction in nursing practice (NFB/Canada Wild Productions, 2007). The film is interspersed with commentary from nurse experts in the field of harm reduction, HIV and addictions. An accompanying teaching module was developed and includes insights and perspectives in relation to their work from the nurses involved in the film (Anderson, Priest & Seymour, 2007). The BCCDC nurses began touring the film across the country in schools of nursing and other venues in the fall of 2007 (Gold, personal communication, September, 2007).

The client-centered nursing contribution in supporting social justice for people who use drugs and the efficacy of harm reduction as a holistic public health approach is in evidence in a small body of nursing literature. Harm reduction remains a controversial approach for the problems of drug use and the influences and resulting polarities of opinion are acute. It is within an atmosphere of divergent global, national and local agendas surrounding illicit drug use belief systems and policies that nurses who work with people who use drugs in the DTES are making sense of nursing practice through the lens of a harm reduction approach. It would appear important, to better understand harm reduction in nursing practice, to shed some light on how nurses working in the foreground, have made sense of adopting the emerging harm reduction framework. By exploring the experiences and perceptions of nurses who are using a harm reduction framework in their nursing practices with people who use drugs, a gap in the harm reduction nursing literature is being addressed. The literature review in its entirety informs the study and underpins the rationale for exploring the problem identified in the thesis.

CHAPTER THREE

Research Design

In this chapter, I describe the research design that provided the direction for this study. I then provide an overview of the analytic framework, methodology, study design, research setting, sampling strategies, data collection methods and procedures, data analysis, ethical considerations, and measures that I took to address issues related to scientific rigor.

I chose to design this study using the interpretive descriptive method as described in the nursing literature by Thorne, Reimer Kirkham and MacDonald-Emes (1997). Developed by nurse scientists in response to an understanding of the uniqueness of a nursing orientation to knowledge development, the interpretive descriptive method allows for the creation of nursing knowledge relevant to how nurses understand particular aspects of practice. By capturing the patterns and themes within subjective perceptions and by then generating an interpretive description with the capacity to inform clinical understanding, nurse researchers utilizing the method in their study designs are able to help promote understanding of phenomena of interest to the larger discipline of nursing (Thorne, Reimer Kirkham & O'Flynn-Magee, 2004). The method is very well suited to my study purpose; to provide a description and interpretation of the experiences and perceptions of nurses in order to gain an understanding of how they make sense of using a harm reduction framework to guide their practice with people who use drugs. I will discuss the method more fully later in this chapter. I begin with a discussion of the analytic framework used in the study, the beginning point recommended by Thorne et al.

(1997), which serves to orientate the existing knowledge about harm reduction and nursing practice upon which the study findings will be constructed.

The Analytic Framework

Thorne et al. (1997) suggest that a study designed using interpretive description should be located within the existing knowledge so that the findings can be built on thoughtful linkages to others in the field. As described in Chapter Two, marginalization theory (Hall, 1999), the addiction habitus (Small et al., 2006), the strategic operating principles of harm reduction (Single, 2000), and the work of Marlatt (1998) represent a range of beliefs and values that inform attitudes, including those of nurses, related to drug use, the people who use drugs and the harm reduction approach. I believe that the above literature is particularly relevant to what is known about the harm reduction approach as it currently informs nursing practice. These writings are, therefore, pivotal to the foundation framing the analysis upon which new knowledge specifically relevant to the study objective is generated.

Further, Thorne et al. recommend that a study designed using the method should, at the beginning, foreground knowledge, assumption and biases about the subject of study interest, in order to orient the inquiry and to make explicit the design decisions. As part of the analytic framework for this study and in addition to the review of the literature, it was important that I explore my own personal process in adopting a harm reduction orientation in my nursing practice with people who use drugs. Attending to this at the outset of the research process was necessary in order to make as transparent as possible my own assumptions and biases and their potential influences, particularly in advance of

the interpretive phase of the study. My assumptions and biases in relation to adopting a harm reduction orientation in nursing practice are strong; measures I took to address the issue will be discussed later in this chapter.

The Analytic Framework and My Personal Influence

As evident in the preceding paragraph, a key assumption that I have made, based on my own experience and perceptions, is that a process of evaluating beliefs and attitudes about drugs and people who use them is required in order for nurses to make sense in adopting a harm reduction orientation in their nursing practice. This belief underscored my personal motivation for doing this study and influenced the questions that I asked of my study participants. My assumption is that the nursing tasks performed in using a harm reduction approach with people who use drugs are relatively simple ones. My personal experience has led me to believe that the challenge for nurses in using the framework is, therefore, not in what we do for our clients in terms of concrete actions, but in how we understand going about doing what we do. For me, this means exploring how nurses describe creating therapeutic nurse-client relationships, on a day in and day out basis, with people who are engaged in traditionally socially judged, high-risk behaviors. My personal belief is that the challenge in adopting a harm reduction approach in nursing is in gaining an understanding of how to remain therapeutically engaged, against a backdrop of what at times appears to be the all-consuming chaos of drug use, in order that we may find moments in which we are able to partner with people who use drugs to create opportunities for health.

I also believe that it is not easy to consistently adopt a harm reduction orientation in nursing practice; for me, a process in which I need to reflect on an ongoing basis on

my personal attitudes and beliefs related to drugs and drug use is required (Wood, A. et al., 2003). I have found myself struggling with issues surrounding the drug use culture (for example, petty crimes committed by people who use drugs to offset drug costs) and those struggles make me, at times, remember the sweeping judgments that I had been taught to believe, and had previously held, about people who use drugs. At the same time, I am very aware of the effects of drug prohibition, systematic marginalization and the culture of poverty that has been the result for people who use drugs. While immensely challenging for me personally, I also know this to be the most fulfilling work I have done as a nurse and a human being. These declared assumptions, on my part, underpin my personal rationale for undertaking the study and provide a broader understanding about what, I believe, is known about harm reduction at the nursing practice level. I am curious to learn about the experience and perceptions of other nurses who work with people who use drugs. In keeping with the interpretive descriptive method, advanced by Thorne et al (1997), declaring my assumptions apriori serves the purpose of broadening the foundation for the analytic framework upon which new understandings about the phenomena of interest can then be constructed.

Methodology

As previously mentioned, the study was designed using an interpretive descriptive approach (Thorne et al., 1997). Interpretive description is a qualitative method that acknowledges the constructed and contextual nature of human experience and at the same time acknowledges shared realities (Thorne et al., 2004). This method, as a form of naturalistic inquiry, is therefore suited to an exploration of the experiences and

perceptions of nurses who use a harm reduction framework in nursing practice with people who use drugs. The interpretive descriptive emphasis on examining the constructed and contextual nature of everyday life (Thorne et al., 1997) makes it a particularly good fit for the purpose of this study. The following key axioms of naturalistic enquiry underpin the design of an interpretive description study and were considered integral in the design of this study:

- 1) Multiple constructed realities that can only be studied holistically, therefore reality is complex, contextual, constructed and ultimately subjective
- 2) The inquirer and the subject of inquiry interact to influence one another, in fact they are inseparable
- 3) Theory must emerge from or be grounded in the data, no a priori theory could encompass all of the possible multiple realities

(Thorne et al., 2004)

Study Design

The study focuses on exploring the experiences and perceptions of nurses who use a harm reduction framework with people who use drugs. The ways in which nurses make meaning of their nursing work with people who use drugs is complex and rooted in a contextualized and constructed reality. Qualitative analysis focuses on uncovering knowledge about how and what individuals think and feel about the situations in which they find themselves (Thorne, 2000). It is oriented towards the understanding of cases as opposed to variables, and towards the discerning of the particulars presented by each piece of data (Sandelowski, 1995). The interpretive descriptive form of qualitative

methodology, that is capable of eliciting a rich description, is therefore particularly suited to this study.

The interpretive descriptive method is generally utilized for conducting a small study in which the focus is on obtaining a depth and richness of description about a particular phenomenon of clinical nursing interest (Thorne et al., 2004). Sandelowski (1995) asserts that developing deep understanding about information-rich cases is the focus of qualitative research. Further, the product "...is a coherent conceptual description that taps thematic patterns and commonalities believed to characterize the phenomenon being studied" (Thorne et al., p 7). The end result of an interpretive descriptive inquiry would be a 'tentative truth claim' about what is common within a clinical phenomenon (Thorne et al.).

Research Setting

The study focuses on examining the experiences and perceptions of nurses who work in a harm reduction-focused health care setting in the DTES of Vancouver, BC. Permission to sample from the available pool of nurses was received from their supervisor.

Sampling Strategy

Interpretive description, with its emphasis on eliciting the constructed and contextual nature of human experience and allowing for shared realities, is usually derived from relatively small samples (Thorne et al., 2004). In general, it is recommended that qualitative studies that are directed towards discerning the essence of experiences should include approximately six participants (Sandelowski). With this in mind, purposeful sampling methods were utilized to recruit eight participants.

Recruitment emails explaining the study were distributed to potential participants by the clinic coordinator (Appendix A). All the nurses working in the clinic were eligible for study inclusion and the nurses responding to the recruitment emails were sequentially entered into the study.

Data Collection Methods and Procedures

One of the axioms of naturalistic enquiry adopted by Thorne et al. (2004) to underpin the interpretive descriptive method espouses that the researcher and the research subject interact to influence one another and, in point of fact, are inseparable from each other. With this awareness, it must be stated clearly that as the researcher of the study, I currently work full-time in the same harm reduction nursing practice setting as the study participants. I have therefore been required to engage in a rigorous and ongoing process of critical reflection and reflexivity (to be discussed in greater detail later in this chapter). The fact that I have worked in a collegial relationship with all the potential study participants also required consideration in the design of the study.

Primarily for this reason, I designed the study using focus groups as the data collection method. It was important to minimize the impact of the collegial relationship between the participants and myself and using focus groups generally decreases the barriers to disclosure that may occur in one-on-one group interview settings (Streubert Speziale & Rinaldi Carpenter, 2003). In a focus group format, all participants know in advance that confidentiality is compromised in a group setting and decisions to disclose are made considering the whole group and not just the researcher. Data collection using groups with “shared experience upon which to build” (p.30) are “inexpensive, flexible, cumulative, elaborative, assistive in information recall, and capable of producing rich data” (Streubert

Speziale & Rinaldi Carpenter, 2003, citing Fontana & Fey, 1994 and MacDougall & Baum, 1997, p.29). Fern (2001), as cited by Curtis and Redmond, (2007), contends that experiential focus groups are important when the researcher has no interest in generalizing beyond the population of interest and a collectivist value orientation is present.

Curtis and Redmond also believe that in social science research, nursing included, a focus group "... uses guided, interactional discussion ... to generate the rich details of complex experiences and reasoning behind an individual's attitudes, beliefs, perceptions and actions ... particularly useful when current knowledge about a subject is inadequate and elaboration is important (p 27). For this reason the data collected in this manner is particularly suited to the stated purpose of the research study. The non-directive quality of a focus group allows the participants in the group to comment, explain, disagree and share experiences and attitudes (Curtis & Redmond). In keeping with an effective interpretive description in order to generate nursing practice knowledge it is necessary that one is able to distinguish commonalities and eccentricities and requires that participant's accounts be in some measure shared by others (Thorne et al., 1997). The use of focus groups as the data collection method is therefore suitable to achieving the product of an interpretive descriptive inquiry.

The use of focus groups can also be a limitation of the study as focus groups can at times generate "group think" in which the individual articulation of experiences and perceptions becomes lost within the dynamic of stronger group members (Carey & Smith, 1994 as cited by Struebert Speziale & Rinaldi Carpenter, 2003, p.30). This can be countered by a vigilant moderator, who in paying attention, draws out the less vocal members of the group by asking them if they agree with the point of views being

expressed. The moderator might also be required to play what could be considered the role of “devil’s advocate” and to rhetorically offer an opposing viewpoint in order to create opportunity for divergent opinions to surface.

The focus groups took place in my home in order to provide a quiet and relaxing environment conducive to “a non-judgmental and non-threatening setting” (Curtis & Redmond, 2007, p 27). It was also important to conduct the focus groups away from the workplace to protect the confidentiality of the participants. The participants were divided into two groups, the first four to respond to the recruitment email were placed in the first focus group; the second five were assigned to the second group. The relatively small size of the groups was important to the design of the study in ensuring the greatest accuracy in transcription; a potential concern inherent to taped focus group interviews.

I circulated potential meeting dates to both groups via email. The interviews were scheduled at a time convenient to the interview group members. The emails were individually addressed, so no participant knew in advance of the first group meeting who was in their particular focus group. The ninth nurse was ill the day her scheduled focus group was held and withdrew from the study. Both initial focus groups, each with four participants, were held one month after initial recruitment.

The first focus group interview guide was composed of broad-based trigger questions that were intended to stimulate group conversation (Appendix B). The goal was to encourage the participants to talk freely and to engage in a discussion of the overarching topic, their views of harm reduction and nursing. The participants’ responses were to be used to generate more in-depth exploration of a particular area of discussion and to challenge ideas and to explore beliefs and values. While my intent was to facilitate a semi-

structured interviews, both my inexperience in the role of facilitator and desire to ask all the questions that I had prepared led to quite a structured format in which I asked questions that the members of the focus group answered. My degree of involvement was therefore greater than I had anticipated and I was required to attend to my commitment to the process of reflexivity. I accomplished this by debriefing extensively by both talking into a tape recorder as soon as the interviews were over and through discussion with my thesis advisor after each focus group interview. Throughout the focus group interviews, I found it an ongoing challenge to limit my contributions within the discussions.

A second series of focus groups, each comprised of the same participants as the original, were held three months later in order to provide an overview of the initial findings to the participants, to clarify the preliminary findings with the groups and to continue the discussion. The second group interviews were conducted in the same manner as the first and were guided by a second set of trigger questions (Appendix C). These interviews, as well, were semi-structured in nature. In both focus groups, the participants were interested in answering all my drafted questions and wished to ensure that the questions that I had prepared were answered. In the second series of interviews I felt more comfortable in my role as a facilitator. I obtained group consent prior to both of the second interviews to probe responses with a greater intensity than used in the first in order to create an opportunity to maximize the depth, width and breadth of the data collected. The use of a clarifying interview is an important feature of interpretive description (Thorne et al., 2004).

Each group interview was scheduled to last no longer than two hours and all of the interviews ended prior to that time period at the request of the group (two instances) or when I sensed group fatigue and became aware no new information was being generated

(two instances).

Table 1 (below) provides some general descriptive information detailing the nursing experience background of the study cohort and the focus group number in which they were participants. The numbers, under the participant column, correspond sequentially to the order in which the participants were enrolled in the study.

Participant (n = 8)	Focus Group	Total Nursing Years (Mean = 12.4 years)	DTES Nursing Years (Mean = 6.1 years)
1	2	20	9
2	2	3	2
3	2	3	1.5
4	1	17	11
5	1	7 months	7 months
6	1	15	11
7	1	26	3.5
8	2	15	10

The interviews were audio taped and I made every attempt to transcribe them verbatim. Tape recorded and written field notes were done immediately after each of the four interviews and included descriptions of the setting, context and non-verbal behaviours of the participants. The notes were multi-purposeful: they served to describe the event and conversations and provided me with reminders for subsequent interviews and they also provided me with a theoretical starting place for the beginning interpretations. My reflexive tape recorded sessions contained comments about my own beliefs, biases, and performance

throughout the interviews process. All of these impressions served as important touchstones as the analytic process proceeded.

Data Analysis

Data collection, preparation, analysis and interpretation are processes that overlap “temporally and conceptually” in qualitative work. Qualitative analysis involves breaking the data apart while interpretation involves making something new up or out of the data (Sandelowski, 1995, p. 372). Thorne et al. (2004) describe the wide-range of “recipes” to guide the mechanics of the analytic process of qualitative research while making it explicit that it is the researcher not the recipe guiding the interpretation. Irregardless of recipe, the purpose of data analysis becomes “extracting meaning from the data set ... to then reconstruct, rebuild and present the processed data set in a thematic or conceptually relevant whole (Knafl & Webster, 1988, p.196). Data collection and analysis occur concurrently in this type of qualitative work. For that reason, as Thorne (2000) describes, a process of constant comparative analysis is appropriate to the interpretive descriptive methodology in that it allows for the development of new ways of understanding human phenomena within the context in which they are experienced. In the interpretive description method, data analysis involves moving beyond the ideas contained within the theoretical framework and from which the inquiry started towards an abstracted interpretation that illuminates the phenomenon that is being investigated in new and meaningful ways (Thorne et al., 2004).

At the completion of each interview the tape recording was listened to at least twice. I wrote field notes and the interviews were transcribed as soon as possible after each focus group interview. The notes were generated to convey non-verbals, climate and

nuances that were not captured by the spoken word. The process of transcription, while intense, allowed a protracted time in which I was afforded the luxury of immersion in the collected data. Repeated reading of the transcribed data followed. During this early stage of analysis, as I read the transcripts, I became increasingly aware of patterns and themes that were being repeatedly alluded to by the participants and I also became aware of particular stories which were shared by members of the group. The next thing that I did was to take the focus group transcripts from each set of interviews and to merge them into one document following the outline created by the question guide. I did this for ease of interpretation so that I was able to have one document for each of the two focus groups, which contained all the data (both interviews). I then assigned a meaning unit to each statement by summarizing each statement with actual words used by the participant and which I believe encapsulated the key elements of that particular statement. The meaning units were constantly compared to the other participant's responses and to the raw data as a whole through a process of re-reading and re-listening.

As a strategy to look at the raw data in as many ways a possible, I took all of the statements by each individual participant, de-contextualized their responses from the original and created one transcript for each participant. I did this in an attempt to discern the individual voices and perspectives within my sample, a difficulty within the dynamic of a focus group. I looked for commonalties and differences in values and beliefs across the entirety of each individual transcript for each participant in the cohort and then compared them across the cohort. The insights that this process generated permeated the entire analysis.

I compared answers and discussion on topics within each focus group and across both focus groups to identify similarities and differences. Discrepancies identified within the first series of focus groups were useful for clarifying and for use in developing the trigger questions for the second series of focus groups. The input of participants in the construction of meaning is a component of the interpretive descriptive approach (Thorne et al., 2004).

After the completion of the second focus groups, I repeated the same process of transcribing, thoughtful reading and listening, tape recording as my method of journaling, and again melded the transcripts into one document. I then deconstructed the whole into the individual and then reassembled the raw data again into one, and ascribed meaning units to each piece of the raw data. In reading the accounts I became aware of the similarities and the differences that the nurses expressed in the interviews in regard to their views of their practice. I began to cluster these insights and to attach meaning units to them that to me seemed to capture the essence of their accounts.

As the analytic process continued, I expanded or collapsed categories to acknowledge the developing conceptualizations. This was a non-linear, constantly evolving and flexible process, hallmarks of qualitative analysis (Sandelowski, 1995). Emerging patterns and themes were reviewed and compared in order to identify and delineate the major descriptive themes (Knafl & Webster, 1988) and to then move to a higher level of conceptualization in the interpretive phase.

Although current knowledge forms the basis for a preliminary analytic framework, it was important to maintain a position of curiosity and for me to continually restate the research question as alternate themes and patterns were identified. Maintaining

an objective distance was personally very challenging for me and I found that recording my own feelings, values, and perceptions about the findings was an invaluable tool that allowed me to reorient the analysis to focus on constructing the knowledge from the perspective of the participants. An example of this occurred when one participant described people who use heroin as “being better than” people who use cocaine because of the challenging behaviours that are more commonly associated with cocaine misuse. It was necessary for me to debrief this assertion by tape recording my reaction as I see personally believe there to be little difference in the particular drugs of misuse and do not agree with affixing yet another constructed hierarchy in which specific drugs are labeled as good or bad. It was of critical importance to the analytic process that I was vigilant in this regard because I have been immersed in the practice of harm reduction for the last seven years in my professional life and it has also been the focus of my academic area of interest. It would have been very easy to allow my strong assumptions and beliefs to subsume those of my participants.

Ethical Considerations

The proposal for the study was submitted to the UBC Behavioural Research Ethics Board and approval was received. An ethical consideration of paramount importance to the study design was the positioning of me, as a researcher, with co-workers who would be my study participants. It must be noted that I am not in a position of authority over them in our shared workplace so there was no official “power over” exerted to participate in the study. As already described in detail, the study was designed with awareness that we all knew each other collegially and this informed the data collection method.

The use of focus group interviews makes anonymity impossible to guarantee for the participants and I made sure that the participants were aware of that reality. For this reason, I made every effort to ensure that the identities of the participants remained confidential outside of each group. I also sought to make sure that no significant identifiers were included in the writing of this thesis. In order to not impede the conversational flow while the focus groups were transpiring, I allowed participants to freely refer to common workplace situations and to use each other's names. The transcripts were then stripped of all identifiers and a unique code number for each person (as previously stated based on the order of recruitment into the study) was substituted. The audiotapes, codebook and all transcribed interview data were maintained in a locked file cabinet. The computerized dataset was password protected. In accordance with University of British Columbia policy, it will be retained for at least five years after the conclusion of the study. If the data is disposed of after this time, all paperwork will be shredded and audiotapes erased.

Written consent was obtained from all the participants prior to beginning the first focus group (Appendix D). Each participant reviewed the consent form, and I was available to offer clarification and explanation as necessary. No participants indicated any concern about the study. Consent should be viewed as a process that encourages mutual consideration (Munhall, 1988 cited by Struebert Speziale & Rinaldi Carpenter, 2003) and therefore, consent was verified on an ongoing basis with participants throughout the focus group interviews.

Ensuring Scientific Quality

“Without rigor, research is worthless, becomes fiction and loses its utility” (Morse, Barret, Mayan, Olson & Spiers, 2002, p 2). There is general agreement that all research should be open to critique and evaluation in order to assess the quality of the product generated (Long & Johnson, 2000). The primary criteria for quantitative research critique are reliability and validity (Emden & Sandelowski, 1998). In the qualitative research literature there has been spirited debate over whether evaluative criteria should be standardized for assessing the rigor of the end products of research produced in this manner. Critiquing qualitative research by adapting criteria used in the positivist paradigm is problematic because of the interpretive nature of knowledge production through a qualitative inquiry (Emden & Sandelowski, 1998; Long & Johnson, 2000; Sandelowski, 1993). Thorne (1997), as cited by Emden & Sandelowski (1998), believes that a critique of qualitative research demands a balancing between art and science. Sandelowski (1993) also reminds us that in the “interpretive paradigm, reality is assumed to be multiple and constructed rather than singular and tangible and that ultimately the evaluation of a research project is a matter of judgement on the part of the researcher” (p 3).

In that light, evaluating scientific quality in qualitative research necessitates making a decision on the utilization of a set of established criteria. For the purposes of the study, I will use the criteria evaluation described by Guba and Lincoln in 1985 (accepted in some and debated in other qualitative evaluation circles). The operational terms to ensure rigor are: credibility, dependability, confirmability, and transferability.

Underpinning all of this is the concept of reflexivity, which is considered integral to excellence in qualitative studies (Sandelowski & Barroso, 2003).

Credibility

Guba and Lincoln (1985) defined credibility quite simply as the activities that are undertaken throughout the research process that increase the probability that credible results will be produced. To aid in ensuring this during the data collection phase, I employed some of the strategies recommended by Poland (2002) and made use of reflective questions, repeated back statements to the participants and asked for clarification when I was uncertain that I had heard accounts correctly. Credibility is further attained through a conscious effort to establish confidence in an accurate interpretation of the meaning of the data (Carboni, 1995).

I utilized a number of methods to enhance credibility in this study. Struebert Speziale & Rinaldi Carpenter (2003) state that one of the best ways in which to ensure credibility is prolonged engagement with the subject matter. I made the decision to transcribe the focus groups tape recordings myself and this intensive process provided me an opportunity to immerse myself in the data throughout the data collection period. The actual process of hearing the participant's words, as I transcribed them into written form, was invaluable in the co-creation of meaning.

The analysis strategy that I used in which I ascribed meaning units to all segments of the raw data by using phrases contained within each served to ensure that the recognizability of the original data was maintained. As well, because of this strategy, when copies of this thesis are made available to the participants, they will also be able to recognize how the findings are transparent in the representation of their experiences. I

used ongoing constant comparative analysis, which allowed me to continually check to see how the data was represented by the meaning units and also to be aware of emerging consistencies and discrepancies. The use of the second focus group interviews served to enhance and expand the construction of meaning by creating an opportunity for the nurses to delve more fully into their experiences and perceptions.

Sandelowski (2000) describes two tenets of validity; descriptive validity being when people recognize the descriptions and interpretations of a human experience as their own and interpretive validity happens on occasions when an accounting of the meaning of those events that participants would agree as accurate occurs. As a design strategy, I met with each focus group twice. At the beginning of each of the second focus groups, I presented a summary of my initial findings and described the emerging patterns and themes that I was seeing. Each of the groups validated that the beginning analysis accurately reflected their perceptions of the content of the initial focus group in which they had participated.

Dependability

Dependability, as a criterion for ensuring rigor in the tradition of Guba and Lincoln (1985), is predicated upon credibility and vice versa. Enhancing both the credibility and dependability of the study were the linkages to the literature review that framed the study, analysis and findings. An understanding of how nurses, who work with people who use drugs, make sense of their nursing work was created with an acknowledgment of the historical and current social context in which the larger focus for discussion, harm reduction, was situated. This was accomplished through the literature

review, which allowed a foundation from which the new understandings could clearly emerge.

Dependability was ensured in the study by a recognizable rendering of the finished product that was clearly linked to the data. The inclusion of negative cases served to highlight the individual from the group (participant within the larger entity that was the focus group) and the group from the individual (focus group and myself) and also served to ultimately enhance the dependability of the findings. Some of the quotes that I included served to act as negative cases and produced some of the most richly, descriptive moments and created a “flood gate” of opportunities for the emerging of deeper levels of understanding.

It was important to induce from the data and to not impose any a priori deductions upon it; at times the focus groups discussion and some of the stories shared were tangential and off topic. Rather than stopping the participants in mid-telling and imposing too much rigidity upon the data collection process and after initial analysis of the entire dataset, I made a decision to let some data go. Foremost in deciding what data to let go was, my decision that it lacked relevance to the purpose and objective of the study. For example, some data was let go because it referred directly to clinic operations where the participants work; while interesting to the participants, the discussion was not germane to the study aim. Sandelowski (1995) points out that it is a common misconception in qualitative research that every single piece of data must be included in the end product.

The focus group data clearly demonstrate the imposing of my own influence during data collection. Transparency in acknowledging how my point of view at times

shaped the focus group dynamics also increases the dependability of the findings; the differences in which the participants articulated their experiences and perceptions then became more clearly distinguishable from my own. After I finished transcribing the interviews, I sent them to my thesis advisor so that she could provide me with feedback on my influence on the data collection process and my style. She validated my perception that I was quite visible in my contributions in the earlier portion of each of the transcripts and she provided me with interviewing tips on how to maximize the potential responses of the participants to my questions. She was also instrumental in helping me to frame the question guide for the second set of focus group interviews. Her objective feedback validated my stance as the researcher and provided me important information that I was able to use for my subsequent interviews. Sandelowski and Barroso (2003) assert that a finding within a qualitative research study is the “sum of an irreplaceable socio-cultural performance involving researcher and subject” (p 215). Dependability of the study rests on a clear accounting of my own assumptions and biases and on my collegial relationship with the participants and I have attempted to attend to this in all areas of the study design.

Confirmability

Confirmability is a process criteria used to ensure an aspect of rigor; the process of developing a clear audit trail in the account of the findings is essential to meet this criterion. Access to audio tapes, transcribed data from the group interviews, journals (both written and tape recorded), field notes, memos etc are available so that a clearly auditable trail can be provided to confirm the study results (Sandelowski, 2000; Streubert Speciale & Rinaldi Carpenter, 2003; Thorne et al., 1997). The probability that the study findings will have meaning to others is increased and transferability or fittingness of the

study results is also enhanced. Decisions that I made throughout the data analysis are described as well as potential limitations to the study. Engagement, imagination and conceptual creativity are demanded by good qualitative analysis according to Thorne et al. (2004). While there is a back and forth synergy between the researcher and participants in the co-creation of meaning in a study done through an interpretive descriptive method, Thorne et al. call upon the researcher to ensure that the research product clearly demonstrates the interpretive lens of the researcher visibly and accessibly throughout the report.

The rationale for the decisions that were made about the data included in the analysis are available so the reader of the report can make a decision as to whether or not they are consistent with the stated research purpose and question. It is hoped that the thought processes that led to the development of the themes and patterns expressed in the findings also all lead the reader clearly back to the analysis of how nurses make meaning of their work with people who use drugs through the lens of harm reduction. The constructed and contextual nature of human experience and at the same time shared realities (Thorne et al., 2004) of the focus group participants is also clearly auditable in the decision trail of the findings.

Transferability

Transferability in rigor refers to the potential that the study findings have meaning for others in similar situations. The focus groups were a construct of a specific time, place and group dynamic. The ability for the participants to challenge, deepen, and enrich each other's understandings of the topic under discussion makes the data even more detailed. While this can in no way be replicated, the impressions, stories, patterns, and

themes created from them, are expected to resonate with others in similar situations. This is a hallmark of transferability according to Guba and Lincoln (1985).

Conversely, a potential limitation to the transferability of the results was the data collection method used in the study. The focus group is an acknowledged and powerful data collection method for providing an overview of understandings and for prompting rich recall and description of a particular topic. Lost in the method is the depth and detail that can be elicited from an unbiased individual recounting of personal experience and perceptions. In the study, the dynamics of the two focus groups were quite different from each other in the articulation of the issues and the expressions of personal beliefs. While both sets of focus groups were guided by the same two question guides, the energy, emphasis and articulations varied across the groups.

While some may claim the analysis was limited because of the nature of focus groups as a data collection, I anticipate that the utility of the study will be recognized and debated and be directly transferable to others engaged in the harm reduction debate.

Reflexivity

Reflexivity is considered a hallmark of excellent qualitative research and “implies the ability to reflect inward toward oneself as an enquirer; outward to the cultural, historical, linguistic, political, and other forces that shape everything about enquiry, and in between researcher and participant to the social interaction they share” (Sandelowski & Barroso, 2003, p.216). Researchers are usually interested in the objectives of their studies; occasionally they are vested in them. In all research enterprises, in particular those in which the researcher is personally vested, the researcher must exert conscious attention to appreciate his or her influence and to allow the participants to speak

authentically for themselves. I employed a number of strategies to address this criterion. I kept field notes, kept a written journal and tape-recorded my thoughts and ideas throughout the literature review, collection, and analysis phases. This afforded me the needed opportunity to reflect upon and respond to issues that arose as the study unfolded as well as to achieve a clearer understanding of how my positioning both impacted and influenced the study. The second series of focus groups and the feedback provided to me throughout the research process by my thesis advisor were critical not only in validating the findings but to ensuring that the voices of the participants, not mine, were heard and adequately portrayed.

Reflexivity, as described by Finley (2002), is a process of thoughtful, conscious self-awareness. I have been actively engaged as a nurse at the grass roots level in advancing a harm reduction orientation for nurses who work with people who use drugs. Harm reduction as the public health response to the problems of drugs use has informed much of the reading and writing within my graduate studies. I have also been engaged in a personal commitment to praxis-oriented enquiry and, as described at the beginning of the review of the literature, have become increasingly aware of how my own values and beliefs were informed and shaped and then ultimately changed and broadened by the wider social discourse related to addiction, marginalization and people who use drugs.

My personal process in coming to an understanding of the principles and interventions of harm reduction was at the genesis for my interest in how other nurses might articulate their own experiences in adopting harm reduction strategies with people who use drugs. I am acutely aware of the privilege attendant in my ability to engage in studies at the postgraduate level and of the influence that my perspective has on the

findings. And in applying the same worldview, I am also aware of the perception of power that may be associated with my knowledge acquisition in specific regard to my area of nursing interest. For that reason it was particularly important that my thesis advisor was available to both provide focus and to challenge my assumptions about harm reduction and nursing practice.

“The pot carries its maker’s thoughts, feelings and spirit. To overlook this fact is to miss a crucial truth, whether in clay, story or science” (Krieger, 1991, quoted by Finlay, 2002, p.531). The ultimate goal of reflexivity is to capture the connections and influences that the researcher and the participants have on each other with an awareness of how meaning is constructed within this context. In the naturalist paradigm it is accepted that the inquirer and the subject of inquiry interact to influence one another, in fact they are inseparable (Thorne et al., 2004, citing Lincoln & Guba, 1985). Yet it is incumbent that as much as possible the researcher be both truthful and transparent in their positioning. I attended to reflexivity in the study throughout the development of the review of the literature and the process of data collection and analysis by using field notes and tape recording my thoughts, assumptions and ideas. I also made a personal commitment, supported by my thesis advisor, to engage in ongoing praxis-orientated inquiry.

In this chapter, I have provided an overview of the analytic framework, methodology, study design, research setting, sampling strategies, data collection methods and procedures, data analysis, ethical considerations, and the measures that I took to address issues related to scientific rigor for the study. Included in the latter was an attempt to declare apriori some of my personal biases and assumptions related to harm

reduction and to describe the process of reflexivity in which I engaged throughout the research process. In the next chapter, I will provide a review of the findings based upon my interpretation after analysis of the interviews with the study participants.

CHAPTER FOUR

Findings

Providing an opportunity for people to share their stories, be listened to and explain how they understand a given phenomena, lies at the heart of a qualitative inquiry. The purpose of this research project was to gain an understanding of how nurses who work with people who use drugs make sense of adopting a harm reduction framework in their nursing practice. The chapter begins with a discussion of the questions that I asked and my rationale for asking them. I then move to a brief overview of the group dynamics during the interview process and discuss, in general, the participants involved in the focus groups. Next, a discussion of the interviews follows in which I describe the specific questions that I asked and the participants' responses. I include supporting literature and my interpretation of the meaning that I have attached to the participants' responses. The chapter concludes with an identification of one broad theme that I identified through the interpretative process.

The Interview Questions

In drafting the interview guide (Appendix B and C) for the focus groups, I was most particularly interested in exploring, with a group of nurses already practicing in a harm reduction context, their thoughts and feelings in regard to how using a harm reduction framework with people who use drugs has utility for nursing practice. In that light, I wished to ask questions in order to gain understanding, from the study nurses' perspective, into how "we do what we do" as nurses who work with people who use drugs. In order that other nurses might better understand adopting a harm reduction

framework for their own practices, I was interested in framing questions which provided opportunity to explore, with the study nurses, the personal and professional process (and indeed, if they believed they had engaged in a process) in which they engage in using the framework in their practice. I wished to discuss, with the study nurses, their personal understanding of addiction and the controversial nature of adopting harm reduction as one response to the issues of addiction. I was interested in learning about how the nurses in the study described their own values and beliefs in relation to people who use drugs. In order to ascertain how the participants understood the influences of the predominate cultural values and beliefs related to drugs and drugs use on themselves, I asked questions in order to elicit understandings about their historic attitudes towards drugs and drug use. I asked them to share their personal beliefs related to people who used drugs. As the nature of this work is so challenging, I also wished to explore with them any ambivalence or concerns they may have with regard to using a harm reduction framework. I asked questions to discover when the study participants first heard about harm reduction and in what particular context. I wished to understand what motivated the nurses to adopt harm reduction into their own nursing practice and what drew them to seek nursing employment in harm reduction focused health care facilities. It was with these objectives in mind, that I drafted the questions that I did in developing the interview question guides.

The Study Participants

The eight nurses who together comprised the project's sample were unique in how they articulated their experiences and perceptions in regard to their nursing practice and

in how they understood using harm reduction with people who use drugs. In general, they were both passionate and realistic about the nature of their nursing specialty and they were generous with their time commitment to the project. The nurses appeared to really enjoy being able to come together in a group to share their joys and struggles in their area of nursing work. They were respectful in listening and were considerate with each other. Murmurs of agreement can be heard throughout the taped transcripts. Some of the nurses had strongly held opinions and they appeared to be comfortable in defending their, at times, divergent positions within the group setting. There was also a lot of laughter, some good-natured ribbing and the nurses frequently used humour to describe aspects of their nursing work. At times they were sad, even angry, about circumstances they saw as negatively impacting the lives of their clients and their ability to do their jobs better.

The two focus groups, as separate entities, were both similar and divergent in the understandings that were shared when I compared them with each other. I think the most striking difference was that the members of focus group #2 more closely answered the questions; in general the nurses in the group all answered each question and then waited for the next question. The members of focus group #1, while also answering the questions, also talked more amongst themselves and their interviews, therefore, took on a more conversationally meandering nature. Despite these differences, both groups very clearly waited for, at times asked for, and then answered the questions I posed. They requested clarity and rephrasing of the questions when they found it necessary. The members of both focus groups were vested in exploring the questions that I had drafted and, perhaps because they knew me, were interested in “helping” me to accomplish my research objectives. I was asked if I was getting the information that I needed and if they

were adequately answering my questions. In my attempts to rephrase questions both to illicit more understandings from the study nurses and in an attempt to foster the expression of various viewpoints, I found myself at times to be too visible within the interviews. When I became aware of this, I would disengage. I believe that this was the ultimate dynamic that served to create the back and forth of responses and interaction that occurred between the participants and me throughout the focus group interviews.

Despite the study design decision to assign the nurses to focus groups based on time of enrollment into the study, I found that each group had a blend of experienced and nurses newer to the profession and also of nurses who were experienced in public health nursing in the DTES and those newer to the subspecialty. The individual participants within each group also expressed themselves quite differently from each other. All of the data has been stripped of significant identifiers to protect the anonymity of the participants. The participants were informed that their names would be changed in the write-up of the findings; I arbitrarily assigned the names used.

I began the first focus groups by reading a prepared statement in which I described why I was interested in doing this particular research project, what my research question was and I explained that I was particularly interested in gaining understanding of how “we do what we do” as nurses who work with people who use drugs. I also acknowledged that I knew each of them, welcomed them, encouraged them to relax, and to enjoy the process. Next, I asked each participant to share two things: how long they have been nurses and the number of years that they have worked in inner city community health settings (Table 1, Chapter 3, p. 60). I also asked them if there was anything in their nursing education that prepared them for their work in an inner city health setting.

The participants' responses to these introductory questions served to provide a general overview and to introduce the nurses to each other by sharing some information that they may not have known about each other. The responses, to the question about preparedness in their nursing education for working in an inner city community health setting, appeared to be evenly split across the participants. Valerie and Diane felt well prepared, through their educational practical experiences, to work in inner city urban health. Lori and Jane also felt that their nursing programs gave them a foundation that prepared them for their work in inner city community health settings. The other four participants reported feeling unprepared by their nursing education for work in addictions; they also all agreed that their addictions' education occurred within their psychiatric rotation in nursing school.

The remainder of this chapter will be organized to include the questions that I asked, followed by how the participants responded and what the particular question prompted in relation to other discussion. I have titled each section; usually contained within one of the participant's quotes and begin each with an explanation of why I chose that particular phrase to describe the section. Woven throughout are descriptions of the focus group dynamic that I may have found germane and my interpretations, supported by the literature, of what the nurses have described. I begin with the discussion that immediately followed the broad, first question that I asked of each focus group.

The Interviews

The First Focus Group Interviews

A different way of being

I chose this title to describe this section because in the following group of quotes the nurses described a multiplicity of ways in which they perceived themselves as being different as nurses. While understanding the complexities of acute care nursing settings, they described being unable to practice nursing in the way they envisioned while working in hospital settings. They described themselves as valuing the development of therapeutic relationships and being limited in their ability to do so in hospital practice environments. They described having to learn new skills in order that they might practice in a different way as nurses in the community. They described feeling personally constrained as nurses in hospital settings and they recognized the paralleling constraints that people who use drugs struggled with as in-hospital patients. The nurses appeared to me to be describing an understanding of those struggles and were interested in seeking creative ways to address the challenges they personally experienced and saw people who use drugs as experiencing in hospital. The nurses also described people who used drugs as being treated differently than other patients in hospital. In the following paragraphs, I provide examples in which the notion of being, wishing or learning to be different is expressed both to describe the nurses' perceptions of their own nursing experiences and what they wished the health care experience for people who use drugs to be.

In response to my initial question inquiring about their educational preparedness for nursing work in the DTES, Kelly said, "even when I went back and got my degree, nothing in addictions. I mean, I did have some exposure from working in the hospital, but

I hate, I really disagreed with how they were treated in the hospital”. I probed her response and asked her what she disagreed with and what she saw that was not working well for her in regard to people who use drugs when they are in hospital. She responded by saying “just the whole hospital approach, ok, you have to get up at this time and you need to do this at this time and it so obviously wasn’t working” and she stated that she believed that it was really challenging for hospital staff to “try to do things differently”. She further added “you would always hear the term; they’re so manipulative instead of, kind of, looking at what they could be doing different to work with addicts and sex workers”. It may be inferred from her statement, that because of the demands of addiction, Kelly believes that conforming to the regimented environment of acute care facilities is difficult for people who use drugs. Although she offered no alternatives, Kelly seems to be saying that both different approaches and attitudes in caring for people who use drugs are necessary. Jack agreed with Kelly and described what he experienced, “people were stigmatized immediately, big stars, IV drug user, caution, body fluids and that sort of stuff and pretty well thrown on Methadone right away and just treated differently. Doris also agreed and recalled feeling that hospital staff treated people who use drugs “very judgmentally”. In the addiction habitus (Small et al., 2006), the operational cultural narrative described by the nurses above would appear to be rooted in the belief that people who use drugs should be made more uncomfortable to prevent and not enable addiction; unfortunately the acute care experience of some people who use drugs continues to validate the veracity of the narrative (Wood et al., 2003; Zrinyi & Balogh, 2004).

The nurses' perception that people who use drugs are treated differently in hospital settings is supported within the nursing literature (Griffiths, 2002; Wood et al., 2003). There is a long history of labelling patients within the culture of nursing. In 1982, nurse researchers, Kelly and May, explored the notion of labelling by nurses and the processes of categorization that resulted in the designation of good and bad patients. They postulated that nurses symbolically take on the role of the patient to make sense of their own nursing role and that during the course of this process patients are labelled. The good patient confirms the role of the nurse; the bad patient denies the nurse that legitimation. It is not surprising then, that a client group that has collectively been described by nurses as "dangerous, disruptive, threatening, demanding, controlling, angry, manipulative, troublesome, impulsive, complaining, suspicious and non-complaint", may be considered bad patients and peripheralized in the nurse-patient relationship (Mattinson & Hawthorne, 1996, p.23).

The experience of the participants in focus group #2 appears to be that people who used drugs were perceived to be different from other patients in acute care and as a result were stigmatized and set apart. The sensitivity of these nurses to the peripheralizing experience of being treated differently, or the notion of just being different, also appears to identify how they themselves felt, as nurses, working within acute care settings. Valerie simply said that she believed it was because of, "the way large hospitals are run". Kelly expressed her perception of feeling that she was different from other nurses working in acute care, "I was dissatisfied working in the hospital and working in that structure and doing shift work and also working with the colleagues that I was working with. I just felt like I was this freak, this person that would speak out and people would be

like, what she is talking about?" Doris, was pragmatic in outlining the differences she experienced in community and acute care practice settings, "you are not bound in any way by having to stay within a protocol, like I found working in the hospital" and she added, "you could think of these really great ways to help people and you wanted to do it but your hands are tied by the stuff you have to get done in a day".

The nurses appear to have a shared perception that nursing in acute care required that they be in some way conforming and that it restricted how they wished to practice. Job dissatisfaction has been repeatedly demonstrated to be the single biggest reason that nurses leave their jobs (Lum, Kervin, Clark, Reid & Sirola, 1994). The demands on nurses working within acute care settings are well documented (Dunn, Williams & Esterman, 2005). The increasing illness acuity of in-hospital clients, nursing shortages and the lack of mentorship for new nursing graduates have all been cited as influencing the climate and job satisfaction of nurses working in acute care (Buerhaus, Donelan, Ulrich, DesRoches & Dittus, 2007).

Perhaps the nurses' feelings of being different are understood by an increasing body of nursing literature exploring person-environment fit theories. Takese, Maude & Manias (2005) pioneered work that explored the relationship, or fit, between both the person-environment and person-occupation in the nursing profession. The person-environment relationship refers to nurses' perceived compatibility between their work values and their perception of their environmental attributes; work values being defined as the outcomes that the nurses would like to achieve in their work. The second relationship is between the nurse and the actual nursing job. Involved is the nurse's desire to engage in particular roles and the actual opportunities that they have to do so. The

ultimate goal is finding synchronicity between the person-occupation and person-environment in a nursing job. The search to find a nursing environment that fit them was held in common amongst the participants.

The participants shared an understanding of what they perceived to be the differences in their practice experiences in acute and community health care practice settings. Lori, in speaking about her educational preparedness for her eventual work in the DTES, was eloquent in describing what, for her, were the differences that she saw in the two practice environments,

I just felt so inadequate. I just felt like I didn't have, I didn't have counselling skills, so addiction counselling, I mean, I had to learn about people's lifestyle, I had to learn about community resources, I had to learn about injection practices, you know, and how that fit into people lives. I had to learn quite a different way of being in relation to people in the community than in the hospital. In the hospital, you know, there is a sense that you are part of the team that runs the institution, you know, you are part of the walls, you are part of that. In the community, it is a very different ballgame. You're on people's turf, you know, when you go into a person's hotel room you are in people's living space where as if you go into a patient's room in the hospital you still feel this weird sense of ownership. It's like, part of the institution, so that was really different. I found I had to, you know, I found I had to learn a different way of nursing and a different way of being.

Jane echoed Lori's perceptions; "it is about being in a different way with your clients, practicing in a different way than you would inside the hospital". Mary provided an example of what she experienced with nurses working in acute care settings with people who use drugs. She described her work as a member of a mental health on-call team,

We were a resource to a hospital and any time somebody came in for detoxing, with some sort of a drug psychosis, with a medical problem but was addicted to drugs or alcohol they would call us right away and then we would have to come in, they would say, 'I don't know what to do, I don't know how to, you know, I can deal with their broken leg but the rest of it, I don't know how to deal with'.

In response to my question probing what she believed the nurses were having problems dealing with in those circumstances, Mary answered that she felt that “ maybe it’s a way of communicating, the person might be angry and quite vocal and it was a communication thing that, that I think the nurses had a problem with. ‘I don’t know what to say to this person, I don’t know how to respond this person’, it wasn’t really a nursing thing, it was more a communications thing”. Lori agreed with Mary, she said, “people who use drugs, I think, get really stressed when they come into hospital, and I think, there is a lot of acting out, you know, a lot of anger and, I think people go, that person is just too difficult to deal with and I’m not going to be able to sit down and communicate with them. There is just too much going on”.

The nurses in both focus groups acknowledged the challenges that people who use drugs may present within traditional health care settings. Within a busy practice environment where nurses feel time constraints in meeting their daily responsibilities, it is not difficult to imagine that a group so historically labelled may not receive the attention given others not labelled in the same manner. The perceptions of stigma experienced by people who use drugs has been described in the nursing literature as reasons why they avoid needed hospital admission or leave hospital against medical advice (Griffiths, 2002; Wood et al, 2003). Martinez and Murphy-Parker (2003) also report that nurses are no exception when it comes to negative attitudes associated with people who “abuse substances” (p.157). They found that nurses and nursing students had stereotypic, moralistic and pessimistic attitudes and that inadequate knowledge of drug and alcohol related health problems were the primary reason for their negative attitudes in working with the population.

Diane expressed similar thoughts to those of Doris about acute care in describing her experience as a nurse, who works in both settings,

In the hospital everything is very task orientated and, you know, you get so busy with tasks and its all about filling out your check sheets and doing your documentation and making sure you've done your dressing changes and set up your IVs and it's very, very tangible. Where as I in the community, I think, you are acknowledging the person more and their lives, especially in harm reduction, you are really, you're acknowledging where they are coming from and why they are in the situation they are in and how you can best help them given their life circumstances. Most of the time I am finding, in my job at the hospital, you don't even really get to know people at all and they have to deal with their lives when they leave the hospital and it is not really your problem.

Jane agreed with Diane and also with a perception shared by Kelly when she said, "I went into nursing because I enjoy working with people and I felt I had an affinity with people. And then I got into the hospital and I was like, the worst, like no one wanted me on their team because I was busy talking to people and I wasn't supposed to be doing that". Again, there appears to be a strongly identified feeling that the nurses in both groups enjoy community health nursing more because they believe that they are able to develop relationships with people in a different way than in acute care settings.

The participants appear to particularly value the relational aspects of their profession. This is re-enforced by the sense of being more comfortable and understood in inner city community health nursing which permeates the following two comments made by Jack and Kelly. Jack said, "there is a group of your peers who are in the same head space as you and, I think that is, a big, I think if you looked at all of us nurses in the DTES, we are all different but all have a similar desire or mind frame for people and people's issues". Kelly said, "It's such a great fit for me" and "I work with an amazing group of people who are all on the same wave length, you know, we all really care about the people in the DTES. It is perhaps apropos that Kelly actually uses the word, fit, to

describe the sense of congruence she feels between her practice environment and nursing work.

This saving thing

I chose this quote excerpt for the following section because it best captured the complicated and challenging process the nurses described in trying to understand the daily life experience of people who use drugs. As well as gaining an understanding of their client population, the nurses also described how they went about reconceptualizing their understanding of their nursing work and creating opportunity for therapeutic relationships within the complex reality imposed by ongoing drug use. The nurses did not appear to view this process as linear. In particular through Doris' words, evidence of her evolution in trying to understand the client population and how she is learning to meet their nursing service needs demonstrated elements of this process. I understand the notion contained in the section heading to encapsulate one of the many struggles and challenges the nurses face in learning how to deliver nursing services through the lens of harm reduction with people who use drugs.

I had asked both the focus groups what their first experiences were like, as nurses, working with people who use drugs. I asked this particular question because I was interested in ascertaining whether or not the nurses identified any process of changing attitudes. Kelly began by saying,

I was incredibly green and it really took me awhile to get the population and to figure out how to work with them and I used to just go out of my way, to get people food and clothes. I think for me, the light bulb went on when I realized that I didn't need to fix things for people. They're on this journey for whatever reason and for me, as a nurse, I can be there to support them and to provide care but it wasn't my role to fix them or make life better for them and so for me that was just like a huge relief.

She also added, “oftentimes I was like, why am I working with this population, you know, cause they’re nutty, they can be really nutty and they can be crazy and they can tell you to fuck-off and they can throw things at you and they can also be really great, so there was definitely a lot of mixed feelings. It took me a long time to feel at ease in the DTES”. It appears that by the choice of the words, “fix them”, Kelly may have assimilated some of the influence of the medical/cure model of addictions. As she continues to talk, it appears that she may have come to embrace a more holistic approach in her work with people who use drugs. The fact that she now laughs at herself and at how much she used to try to do for her clients may be indicative of how she has evolved in her understanding of the issues associated with people who use drugs. She also acknowledges the challenges and ambivalence she feels both in working with a population who can demonstrate behaviours that are at times quite off-putting and in becoming at ease in the DTES. Doris, also felt that she had a lot to learn when she first began working with people who use drugs, she described her journey in the following way,

You learn a different culture, you learn to accept the fact that it is two totally different cultures and if you accept, or if you take a lot of what they give you within the context of our culture, it can be very offensive or very hurtful. Like you said [looking at Kelly] they will tell you to fuck-off or they will tell you whatever. Once you are down there for a little while, and you kinda learn, learn the norms, you learn how to work within the population and it is very satisfying, you learn that you can’t go in there with the intention of completely changing around someone’s lives or quote, unquote ‘saving someone’. You need to go in, think about who they are in their social context and work with that.

The exteriorizing notion of “other” appears to be woven throughout this comment made by Doris; she is articulating the way that she has learned to understand people who use drugs. In the process she creates a dichotomy of them and us and in so doing may be

revealing a belief that people who use drugs are in some intrinsic way different from people who do not use drugs. Doris expresses her understanding that a different approach is required to be effective with people who use drugs; she appears to be discarding the notion of saving someone from drug use, which arises from the moral model of addictions. I asked Doris to further explain what she meant when she referred to two cultures. This is her response,

I think different priorities with an injection drug user. Now that I have worked a little bit down there you see someone, you know, you see these unbelievable things like someone prioritizing the need for their next fix over feeding themselves or feeding their children or self care in some way or another and in our culture that would be absolutely unheard of. But if you go in there and judge them like that then you are not going to get anywhere because they are so used to being judged, that they'll just and they know exactly when you are judging them, and you, you won't form a relationship that you need to form. You need to throw away all judgments and you need to work with them within a context that, that's suited to them or that's from their point of view, I guess, you need to understand their priorities.

With this explanation, Doris appears to both affirm her belief that people who use drugs are different from "our culture"; at the same time she verbalizes her realization that to achieve a therapeutic relationship, requires a tempering of those ideas. A nurse new to the DTES, Doris may very well be in the process of reconceptualizing her worldview of people who use drugs. She appeared, to me, to be actively engaged in trying to understand people who use drugs. Disentangling and trying to make sense of deeply engrained beliefs related to people who use drugs is a difficult process for nurses and involves ongoing praxis (Wood et al, 2003). Valerie shared her process by describing the evolution she went through in developing therapeutic relationships with people who use drugs,

I have gone through like a few phases of understanding and I think at the very beginning, it was almost, when it was the easiest for me. I think, I was just

more into, because I didn't know much about injection drug use, I saw them as the expert. I was very open to everything that clients had to say and I asked a lot of questions and I think that was a good way for me to actually form relationships. They just saw it as, 'I am the expert and whatever, and you have got a professional asking me these questions and learning from me' and so that was the beginning. Then once I got to learn more about the DTES and the services and all the rest and to get to actually form relationships and to know people and hear their struggles and their personal problems then I think I went more through a phase of, you get to care about people. Like you see them all the time, you see them on good days and on bad days and want to go through this, like this saving thing, like we talked about. I think I really went through a phase of that as well and then I think more just an understanding of, just as Kelly was saying, about you can't be everything for everybody and just really realizing again what is your priority and working to help them achieve their priorities in terms of their health and well-being.

Valerie's articulation of her experience resonates with that of Kelly's yet her focus on the nuances of relationship building and the subsequent challenges that resulted, on a very human level, is both particularly compelling and poignant. She, too, speaks to her desire to save people and to then moving to a place of working with her clients based upon their self-identified priorities. It would seem that her belief system may have shifted from an understanding of addictions from the medical/moral model to a more holistic model. Jack recalls what he found particularly challenging when he first began working with people who use drugs; "when I was first down there it was, you know, over the years you get a little bit jaded out by it, at first I remember being upset many, many times at hearing horrible, horrible things that people have gone through to get there; whether its the deaths, the abuse, whatever it was that has so affected them".

Jack's expression of being initially very shocked and now less shocked upon hearing tragic stories over the years, led me to ask if his views of people who use drugs have changed over the years. He said, "I mean, I was very tolerant and I think, I was more idealistic about things back then, but even now, I am more compassionate for it

then I was before”. He too, speaks to a process of coming to understand his work with people who use drugs. Jack used the expression “jaded out” to describe how he feels after hearing traumatic stories for years. It would seem important that nurses who are working with people who use drugs are cognizant of the psychological impact of this type of nursing work and the potential for burnout. The vicarious trauma literature speaks to “distancing” as a mechanism that nurses use to prevent the full impact of their client’s trauma stories from affecting them (Clark & Gioro, 1998, p.2). Strategies aimed at minimizing these occurrences such as effective nursing management teams and the availability of colleagues for debriefing are critically important. Jack, in clarifying his explanation, describes his ongoing compassion. One could assume that his ability to continue to feel compassion might demonstrate his commitment to utilizing the strategies identified above.

In this part of the discussion, the nurses appear to be saying that there is a large learning curve, both personally and professionally, required to understand the complexities involved in nursing practice with people who use drugs. After Jack’s comment, Doris replied with the following,

Through working with the population what we get to learn, that I think a lot of other people ignore or perhaps don’t want to come to terms with, is that a lot of the people who are down there we’re not so far removed from where they were at. You know it came down to maybe one moment in their lives where they had to make a choice and they made a choice one way and maybe up to that point their life was exactly the same as mine or as yours and we made a different, I made a different, choice when I was at that point. When you learn that all of a sudden, you feel, I think definitely the compassion; it really changes things for you. You learn that everyone isn’t just, and I mean definitely some people were, I don’t want to say destined, to become injection drug users from the beginning but, you know, brought up in abusive households and both parents were using. A lot of people weren’t, a lot of people were brought up in white-collar, blue-collar, and you know, so-called normal households.

In contrast to her previous comment, when she described her process as learning to know two different cultures, Doris is now saying that people who use drugs are exactly the same as her but just made a different choice at a pivotal moment in their life. Again it appears that Doris may be actively engaged in a process of deconstructing previously held beliefs and that she is beginning to integrate new ideas about people who use drugs. At the end of her comment, Jack interjected and said, “the difference was, at that time, we all had some kind of support system”. Doris agreed with him and Jack continued “those folks had, when that was going on; their support system had already failed them previously”. Doris again agreed that this was a good point and Jack concluded by saying “because that would make a total difference to what road you go down and it would make a night and day difference in terms of their childhoods”. The entire group murmured in agreement. A pattern of different attitudes, evolving personal views and changing realizations about drugs and people who use them was expressed throughout this dialogue amongst the nurses. An element of social control amongst the nurses in articulating a “correct” viewpoint of harm reduction might also appear to be evident. Jane, humorously, described the process, as she saw it for nurses, as one of “moving along in their worldview”.

In response to the same question, a discussion of why the nurses felt they wanted to work with people who use drugs occurred. Mary said, “I sort of saw it as a population that had a lot of people that weren’t interested in working with them and needed someone that cared to work with them”. Lori added “I had seen a lot of physical pain, you know a lot, people in a lot of pain with cancers or leukemia’s or, god knows what, but I had never seen people as tortured as people that were using drugs and I think that is really what

drew me to them”. Mary and Lori appear to be echoing sharing a sense of deep compassion for the life circumstances that challenge the population with whom they work on a daily basis. Compassion is described as one of the central components inherent to a harm reduction philosophy (Stimson, 2007).

It’s like knowing the bird

In the following paragraphs, the nurses are describing what harm reduction means to them. For some of the nurses, the concept of harm reduction was something they found to be initially challenging. They described trying situations in which they found themselves and their struggles in applying the strategy with some people, especially young adults, who use drugs. While many of the nurses felt ambivalence on personal and professional levels, they also described understanding the need for harm reduction interventions. They believed that the philosophy contained within the approach paralleled how they understood the art of nursing; this section’s heading encompasses how one of the nurses, Lori, described her recognition of what she believed to be those similarities.

I had asked the nurses in both focus groups when they first recalled hearing the term and I asked them to describe their understanding of harm reduction as a public health strategy for addressing problematic drug use. Kelly admitted that “it’s taken me awhile to kind of really grasp the concept” but she now believes “it just makes so much sense, I mean in so much of life” and Lori realized that “it wasn’t really until we started, really working towards the safe injection site that I started hearing about harm reduction, harm reduction, OK, and then kind of getting my head around it”. Doris described her experience in coming to understand harm reduction as both a set of interventions and a framework to guide practice with people who use drugs,

You hear the things that are associated with it: needle exchange, safe injection site and you get those in your head. But I don't think I really understood it for quite awhile.... you know, it is not an institution, is I guess what I am trying to say, its not just a harm reduction site, its not just a needle exchange. It's actually an entity in and of itself that can be applied to many, many different situations.

Lori, in sharing that harm reduction only really jelled for her as a strategy directed specifically towards drug users at the time of the discussions around the opening of InSite, lends credence to the notion that the nurses may have been personally integrating the philosophy of harm reduction at the same time as the shift in the city's public policy. The nurses appear to be saying that they required a process of concept integration to understand harm reduction as a strategy to address the problems associated with drug use. A number of examples follow in which the nurses describe how they have come to understand harm reduction. In the first, Kelly discussed how she came to understand the utility, for her, in adopting a harm reduction approach and applying it along the entire continuum of addiction services,

To work with people to reduce their harm, no matter where they're at in their addiction phase, I think for me was where harm reduction really sank in for me. They can be actively using and harm reduction works or they can be on the other end of the spectrum and they can be in detox or in, you know a treatment centre and that's also harm reduction. Being down there for a while you see that people go off and on the streets, stop using and then they start using again. Just kind of seeing that reoccurring theme helps me understand harm reduction as well.

Marlatt's (1998) call to meet people where they are at would appear to underpin how Kelly understands harm reduction philosophy. Jane, as well, described finding the pragmatism of a harm reduction approach very congruent with how she understood the practice of nursing,

Harm reduction just makes sense. It fits in that paradigm of social justice. I think I incorporated it into my nursing practice because it made sense. I didn't have any clue about injection drugs; my clients did. That idea that they have a better idea

on their life than I am going to, and that they are going to teach me, like all of that, that's just how it should be.

Elements of the philosophy of harm reduction are evident in the language the nurses have adopted. In addition to compassion, pragmatism is described as the other central component inherent to a harm reduction philosophy (Stimson, 2007). Some of the nurses believe that a harm reduction orientation, although not explicitly named as such, has always been a part of the nursing role. Lori describes this by using the analogy of suddenly recognizing the species of a bird,

Harm reduction is something you practice in nursing and then all of a sudden, it's like knowing the bird. You know a bird that's like red and black and it sings a certain way and you know that bird and then all of a sudden somebody comes along and says: 'it's a black-tailed American warbler'! I don't know my birds but it's the same thing, it's just kind of a label that gets dropped onto something. I think it is inherent in nursing practice, it's about caring because, you know, when you care about somebody you say, 'OK, what can I do to help this person feel better, what can I do to help this society feel better, this community feel better' and, I mean, I think that's what nurses do and that's harm reduction.

Falk Rafael (2000) discussed adopting Watson's' philosophy, science and theory of human caring as a guide to community health nursing practice. She suggests that Watson's theory, in which an aspect of health is harmony with the world and or environment, is particularly relevant to contemporary public health nurses as they examine and address social, political, economic and other determinants of health as impacting the individual and the community. Jack expressed a similar understanding of harm reduction in nursing practice to Lori,

We were actually doing the harm reduction before it was a catch phrase, before it became more a part of our vocabulary. So we were doing all this educating and teaching and things that were harm reduction. Initiating a conversation with somebody as a nurse was harm reduction. Put a Band-Aid on that; do wound care, that's harm reduction. The scope of harm reduction, until it becomes this drug-using related term, we've been doing harm reduction since the beginning of

nursing. Now it's this injection drug using, it's a great slogan, I love it because I believe in harm reduction tremendously, but I think we've always done it.

Strategies aimed at harm minimization first appeared in the public health literature over twenty years ago; it was then that it narrowed in application to a response to the problems associated with problematic drug use (Wodak, 1999). The conceptualizations of harm reduction expressed by the nurses have a large body of support within the nursing literature (Griffiths, 2003; Gold, 2003; Hilton et al., 2000; Hilton, Thompson, Moore-Dempsey & Hutchinson, 2001; Hilton, Thompson, Moore-Dempsey & Janzen, 2001; Thompson et al., 2000; Wood et al., 2003). Once the nurses understood harm reduction conceptually they appeared to recognize it as not only intrinsic to how they understood nursing but they also expressed that it seemed to them to be quite a natural extension of how they understood the nursing role. Mary shared the experience that led her to explore extending her nursing practice to include a harm reduction framework,

I think when you mention that first thing of harm reduction, where it sort of clicks for you, I think, for me working in the in the jail, one of the doctors was very interested in cervical cancer and our high risk population for abnormal pap tests so she was keeping stats. We had this book where we wrote down everybody's name that had a pap test and what the outcome was. I remember going through the book once, and I'm going 'died, OD, died, OD, died, HIV'. I'm going, wait a minute, the women here are not dying of cervical cancer and we are all concerned about abnormal pap tests? They are dying of ODs and HIV and ... it's like, OK, what's going on here? The pap test isn't saving lives, there is something else and it's the harm reduction side of it, I think that, OK, what can I do to help these people because the pap test isn't helping people.

As previously stated, practicing from a harm reduction framework is not without very real challenges for the nurses. Kelly and Jane both recounted a similar experience in using harm reduction in their practice with street youth. This was Kelly's experience,

There was like a fifteen year old boy who wanted to learn how to inject and how to inject drugs. I think he had injected a couple of times and I had a hard time with that. And yet I knew that, unless, if he didn't know how to do it properly then he would cause more harm than if he did it safer so I went, you know, through the whole teaching with him and then I kinda had to walk away from that. And then, of course, I talked about the possibility of not using and resources where he could connect with people and, all that kinda of stuff but you know, it was hard, it's not easy, he was fifteen.

The other participants in her focus group were very supportive in acknowledging how difficult it can be to, at times, witness the choices made by their clients. Single (2000), identified respect for the basic human dignity of people who use drugs as one of the five principles of a harm reduction philosophy; while personally challenging, Kelly demonstrates that she has integrated key concepts underpinning nursing practice from a harm reduction orientation. Her peer group response also demonstrates the importance of avenues in which nurses working with this population may debrief situations in which they may find themselves conflicted. Diane had no specific recollection of her first experience working with a person who used drugs. She said,

I don't remember any specific incident. I think, even though, it was only, you know, not that long ago that I graduated but just because of how I was raised and, you know, the time in which I went to school, I think that addictions was never, like this, taboo subject and drug use or any of those topics. So it never really came and hit me in the face: 'ohhh, there is an injection drug user'!

For Diane, the role of her family of origin and other socio-cultural influences appears to have perhaps contributed to the less stigmatized lens through which she views people who use drugs. Diane's response above segued directly into the next question that I asked of both focus groups.

My mom said

In the following section, the included quotes focused on discussion in which the nurses shared how they had been taught by their families of origin to understand the

issues related to drugs and people who use drugs. The nurses believed that it was both their connection to their families and their exposure to particular social contexts in childhood which most informed their belief systems surrounding drugs. The study nurses discussed feeling supported by their families with regard to their current practice focus while at the same time they disclosed that their loved ones were worried for their personal safety. The knowledge that they were supported while simultaneously the subjects of concern served to underscore one of many ambiguities that the nurses appeared to negotiate in doing this nursing work.

I began by asking the groups what their family and friends said when they told them what kind of nursing work they were going to be doing. Given Diane's last statement, it is perhaps not surprising that her family and friends did not see the area in which she chose to work as extraordinary. She said, "my mom volunteers at a shelter every Tuesday morning and serves breakfast to the homeless, empties her wallet when she walks downtown and sees people asking for change, that is just personally, how I have been shown to see those people, as people". Mary said the people who knew her did also not see it as extraordinary. When she began to work in the inner city community harm reduction facility, she recalls people coming up to her and saying "as soon as I knew it would be opening, I thought of you and I figured you would be down there". I asked her to try to describe what she thinks she must have as a nurse and as a person in order for people to say that. She believes they see her as an "advocate, again with the poverty, with the drug addiction, I think whenever conversations come up with friends or family, I think I end up being the advocate". Jane's transition as a nurse to DTES was

also seen as less than extraordinary; she describes her choice of nursing work as almost a familial expectation,

My parents are, have always been fighting, fighting a social justice cause, an issue, and that's how I understand the world. I think there was even this sense that if you weren't involved in something like that then you were, you were frittering away your time and I guess my family values are, is that Scottish, you work and you work at something that's meaningful and you need to be involved.

Jack recalls what his mother said when she realized where he was going to work” my mom thought it was fabulous, ‘I’ve read something in the paper about your group down there’, she’s always thought it was great”. Valerie believes “my mom also is like, loves it, she’s a nurse, she gets it”. Doris was exposed to different family values in relation to drugs, “my mom is a sixty-five year old conservative British woman who totally had, was brought up on the attitude that drugs are bad”. All of the nurses who answered this question described feeling well supported in their choice of nursing specialty. Yet when they spoke about some of the responses they heard that were specifically related to the DTES other attitudes were revealed.

Lori said, “my family and friends were scared; they said are you safe down there? Are you sure it’s OK? I remember my dad reading stuff in the paper and going are you alright down there?” Jack shared some of the assumptions he knows to be associated with personal safety in the DTES; “people they roll up, they lock their doors, see that man there? It's that place, you know, that bad place”. Valerie said, “I think a lot of my friends are that really don’t know anything except for the media, are you, like, safe there?” Kelly described her initial and current thoughts about the neighbourhood in which she works; “I had always thought the DTES was really scary, now I think it is the friendliest part of the city”.

The media perpetuates the dominant social discourse related to people who use drugs (Alexander, 1990). So in addition to weighing the larger beliefs and attitudes about drugs and drug users, it appears the nurses must also make meaning of the assumptions associated with the DTES community in which they work. The cultural narrative of the addiction habitus in which drugs are seen to promote violence appears to underlie the belief that the DTES, a place where there is known to be drugs and drug users, is dangerous (Small et al., 2006). The ability of the nurses to recognize and question the influence of the predominant values and beliefs would appear to be an important foundation for their ability to do the work that they do.

It might be assumed that family values (Diane, Jane, Jack) may have influenced the worldview of how some of the nurses see the issues of problematic drug use and their choice of nursing practice interest. Both Diane and Jane seem to be saying that they were orientated to issues of social justice since childhood. Of note, two of the nurses (Doris, Valerie) revealed some interesting assumptions with regard to attitudes about drugs. While the implicit assumption is that Valerie's mother does indeed "get it", it cannot be inferred that she gets it because she is a nurse she understands the issues of problematic drug use. In the same light, while Doris' mother may "not get it", it cannot be assumed she does not get it simply because she is a sixty-five year old British woman.

Sense of having different values

The idea of being "different from" again appeared to permeate the following section of the discussion. While the influence of values similar to their families of origin with regard to people who use drugs might have informed the decision to work where they do for some, other nurses discussed feeling that they had a different social view of

the drug issue than did their families. Following Jane's comment about being taught by her parents that it was important to do meaningful work, Mary and Lori discussed having a sense that they were different than others in their families. Lori said, "I've always been the black sheep in the family, you know, I've always been the one that, who started doing things a little differently and everybody, kind of goes, yeah, that's Lori, you know". Mary agreed; "that was a very similar experience with me". Lori then said, "I am convinced that it is that element, you know, that sort of separateness or that sense of feeling different or that sense of having different values that also makes me identify with people who, who are a bit disenfranchised from society or who, who feel isolated or marginalized". I asked her to describe what she thought those different values were. Lori replied "yeah, different values, I guess, you know, I came from sort of a middle, middle-class, white, you know, fairly well-to-do family and I just had this identification with people that didn't who weren't doing so well. Diane said, "Marginalized?" and Lori agreed saying,

I mean, it's difficult to see where those kind of things come from, you know, I think there is something character-logical going on, you know, in your personality, if you chose to work in certain situations and I think, it was a sense of isolation, a sense of loneliness in the, in the surroundings I was in.

She has a strong sense of "belonging" with the community with whom she has chosen to work and believes that her choice to do so was "formed by a lot of early stuff". The other members of the focus group were unanimous in their murmurs of agreement. It is perhaps obvious that families of origin may have influenced the nature of the nurses' work. For some nurses their current choice of workplace appears congruent with their family values while, interestingly, for others their differing worldview appears to have brought them to exactly the same practice area.

I saw a little bit of change in people's attitudes

The rationale for a harm reduction approach to problematic drug use is not only complex for nurses and their families to integrate but for the larger community as well. It is controversial because it is so drastically different from conventional addictions treatment approaches. Harm reduction provokes ambiguity and skepticism and the nurses discussed finding themselves in situations where they felt the need to defend or champion the philosophy. The quote that titles this section encompasses the incremental change the nurses shared seeing in others' attitudes when they explained their work in greater detail. It also, I believe, might serve to echo the processes shared by the nurses as they themselves became more immersed in the daily practice of harm reduction.

Jack said that people in his life want to know if things are changing in the DTES and he feels that "you are the voice of the place because you are talking to a group of people who might want to argue or something, who have no clue about it". Doris said that "people really want to talk about it, they have so many questions" and that she feels that it is good for others because "you can read about it in the paper all the time, but to actually have someone to interact with" is important. Valerie, discussed having lots of friends and family in the States and said, "so I get a lot of different attitudes from there" and in terms of understanding her work," for the guys in the States it is still a really big jump". She also works in a smaller community hospital; she had this to say about her belief that her advocacy of a harm reduction orientation to practice has changed attitudes,

We weren't seeing injecting drug use so much as alcohol, but, it's the same, stigmatizing attitude and, we used to get into a lot of heated debates over attitudes and treatment, it would be the one thing I would just be calling people on left and right. I did a presentation, and it was just a stigma, it was just a lack of knowledge around addiction, you know. 'They are choosing to be this way, they are choosing to be difficult and non-compliant even when they are not, they don't care about

their kids or they wouldn't be doing this or whatever, right'. I think I saw a little bit of change in people's attitudes and, when they talked about what addiction is and, the situations that could possibly lead someone to be in, in that place, and I think that just by thinking a little bit more; they are human beings who have issues, they are people who happen to use drugs, right.

In the nursing literature, Martinez and Murphy-Parker (2003) described finding that the frequently negative and inaccurate initial perceptions that nurses and nursing students held about people with substance use issues could be changed. They also found that developing a more positive attitude might be partly related to education. Valerie's personal experience would appear to substantiate their findings. Kelly then had this to add,

I kinda feel like, that's my role, to be an activist, in the mainstream population, and to humanize people in the DTES and most of my friends, you know, they understand me and why I work down there. I've had a couple of comments from my brother about crack heads and I have a really hard time with that, you know, and I, there is always lots of teaching moments and I do think, you know, the general public just doesn't know because they are misinformed. The media paints this really untrue picture of addicts and how they feel and how they are bad and which keeps them even more marginalized from society. I feel like I need to be a voice for them...

Doris discussed what she saw as particularly important for her in telling stories about her work to her mother,

Having conversations with her and the first step is to kinda, normalize it and just to get people comfortable talking about it, even with friends or family as they get a little more comfortable with it, every time you have a conversation you pick-up where you left off and add a little bit more every time and attitudes do change over time. I mean, my mom now knows a little bit about harm reduction.

The controversial nature of their work in harm reduction practice settings might be one explanation why the nurses appear to have assumed the mantle of advocate both for the issues of the DTES and people who use drugs. The nurses appear to believe that through

their formal and informal discussions they are seeing changes in attitudes about both people who use drugs and harm reduction.

It was just a lot of connecting with people

In this section, the nurses unanimously described what I understood them to view as a core value in their work with people who use drugs as practiced through the lens of harm reduction. The title quote summed up the essence of their expressed value in the word “connection”.

I began by asking both focus groups to describe for me what they believed constituted a good day at work. I asked this question in an attempt to ascertain what the nurses may value in their particular area of practice. The answers were very similar across both focus groups; the time to form, or build upon pre-existing, therapeutic relationships was discussed extensively by the nurses in both groups. Jane said, “You feel one way if you were able to bang off ten paps in a day but there is a whole other feeling, I think, if you really made a connection with someone and, you know, that something happened there”. Valerie said, “It was connecting, it was just a lot of connecting with people, is the days that I, find really good, when you know that you have actually got through to them or hooked them up with some kind of service that is actually going to make a difference to their life”. Mary shared,

An ‘ah ha’ moment, when you are doing some teaching, or some real connection, it’s just something that, you know that for that instant you just made something a little bit easier in somebody’s life and it’s reflected in their eyes. I think that in the work we do, our successes are measured in really, really small steps. So if sometimes, you sort of, think, you get really excited to see somebody actually release the tie before they inject and it is like, it is such a small step, such a small step, and yet it feels so good when you actually see them.

Making connections with clients was consistently expressed as contributing to the satisfaction that nurses had in doing their nursing work and appears to be highly valued by them. The nurses identified being able to connect with clients when they described having a good day at work; not surprisingly when they had a bad day the opposite was also true.

It really shakes you; it hurts

One of the most distressing challenges faced by the nurses in their daily work was described as the potential volatility to which they could be subjected by their clients. While the nurses went to great lengths to understand the motivations behind troublesome behaviours and displays of anger, the toll it took on the nurses was apparent in their descriptions. The quote that is used to identify this section exemplifies this reality for the nurses.

I asked the nurses to describe what they considered to be a bad day at work. In addition to not having time to make connections with clients, Jane, Mary and Jack all mentioned the death of clients as difficult to endure and as constituting really bad work days. Many of the nurses also shared the experience of being the focus of client anger. Mary was generous in her analysis of anger when it was directed towards her; “the way that I cope with that though, I realize it is not me, it is about them, they are mad about something, things are not going good in their life but it’s really got nothing to do with me, it’s about them”. Closely paralleling Mary’s description, Diane said, “once you shift that way of thinking then its like, ok, now I know why its not about me, this has nothing to do about, with me, this has to do with their history and their situation in life at this time”.

While the nurses expressed understanding that the anger was not “about them” Kelly, Doris, Jane and Jack all discussed how disconcerting, hurtful and shocking it is to be the focus of verbal assaults. Jane, to murmurs of agreement from her focus group, discussed requiring recovery time and the need for her to have colleagues with whom she could go to in order to debrief after experiencing verbal assaults. A number of nurses also spoke of the importance in having a balanced work and personal life in order to work effectively with people who use drugs (Kelly, Valerie, Jane, Jack). Jack expressed his experience with anger,

I’ve been at [harm reduction-focused health care setting] and just screamed at by somebody before and it has just set me off for the rest of the shift. It really shakes you, it hurts when it comes out of the blue and somebody is all over you. It’s a violent attack to your senses and you are just messed with for the rest of the shift. I have a really great external social circle, you just go back to work, that’s what you do. For me, old school or not, I don’t know, you just go back to work and it’s another day and that person had a, as much as you had a shitty day, that person who got under your skin there had a shitty day, too. And they might still be having a shitty night when I wasn’t.

Based on the above comments, it would be surprising if any of the nurses disagreed that their clients’ anger issues “come with the territory” in working with this population. It may warrant closer scrutiny to understand whether or not an element of social control is being exerted in which verbal assaults to which nurses may be subjected are being sanctioned as a cultural norm by nurses, or others, who work through the lens of harm reduction. The need to debrief situations in which nurses are verbally assaulted and to be supported by nurse colleagues and managers appears evident. Verbal assaults on nurses by clients who use drugs was the subject of a recent Irish study, where it was demonstrated that nurses who worked in a Drug Treatment Centre Board, were “more likely to be the victims of verbal assault because of their role within the clinic which at

times can involve limit settings and warnings” (Whitty, 2006, p.91). As identified by the study participants, it is important as well to maintain a balance in personal and professional life. This helps to ensure that they “are in the best position to bring themselves and their clients through the many hazards of trauma work” (Clark & Gioro, 1998, p.1).

To get beyond the addiction

The quote heading this section refers to what, I believe, the nurses experience as one of the relational benefits that is afforded to them by working in harm reduction practice settings. By stripping away the veneer and actually seeing people injecting drugs time and time again, the nurses believed themselves to be well-placed to develop authentic therapeutic relationships. At the same time, the nurses also felt that constant exposure to a very troubled set of behaviours normalized and contributed to desensitization. This led them to other very real and visceral human responses. The nurses poignantly described the struggles and ambivalences they at times felt working in these types of practice environments.

I asked the nurses what their perception of the experience of working in an environment which required them to bear witness to the daily reality of ongoing drug use was like. Jack said, “I think it helps normalize it a bit, you get, you’re surrounded by it, bombarded by it, after your initial shock of getting through it and learning things about it, it becomes normalized behaviour for folks who are addicted or who are injection drug using” and he concluded with “you get more chance to feel, to get beyond the addiction and into the actual using of drugs to deal with other issues”. Valerie agreed and felt that it normalized it not only for the nurses but “I think with, having that attitude and being able

to get past it, you also have got the opportunity for clients, they see that you have got passed that and, I think, it normalizes for them. She believes this is important because, “it lets you build a real relationship because they realize, you do see those other things about them”. Diane said,

For me, the biggest thing about working in [the harm reduction focused-health care setting] is hearing people’s stories about their childhood and about their life and just realizing that, given what they have been through, like, they have no choice but to be where they are. They are doing the best that they can and often when I meet people who are, against giving people free heroin, you know, I’ll bring up a story. It kind of puts a face on the reasons why we are doing what we are doing. I think that brings understanding to just, you know, to tell those stories and, for people to know that, it’s not, we’re not helping people destroy their lives we’re helping them maintain a level of sanity in their lives and so, yeah, that’s the way it happens.

The nurses appear to be saying that their ability to be with people who use drugs in an environment that acknowledges the reality of drug use allows them to breakdown barriers that may have traditionally stood in the way of their ability to develop more authentic therapeutic relationships. They believe both clients and nurses are able to then get past the actual drug use to other issues. Jack also reinforces just how shocking it can be to witness. Lori, had this to say about problematic drug use, “I would say as a person, do I accept it, no, I don’t, deep down, I have a, I hate it’. She elaborated,

There is a real deep acknowledgement that it fucks people up royally, you know, the drug use screws people up. The things people do when they are stoned, and it’s difficult because you see a person’s potential, you know. For example, when you see them in prison, what they are like when you see them straight, but I understand why they are using. I completely understand why they are using and I would hopefully never be judgmental about their drug use but do I accept their drug use, no, you know, deep down.

Jane, also a member of Lori’s focus group, interjected and said, “it represents pain”.

There were murmurs of consensus amongst the other participants in the group. Lori continued,

It's difficult for people, I think to move their life in any other direction because they are so preoccupied with the actual drug use and that's an incredible loss of human potential. I personally have just a really big, deep rebellion against that but I completely understand why people use. I mean, I understand the pain, I well, how do I understand? I will probably never really understand but, you know, I think as a nurse, I have come to a place to realize that these are their choices, maybe not always their choices, you know, and maybe it's life that has kind of taken them in that direction.

While Lori's deep abhorrence of what she sees drug use doing to people and to their lives is obvious, her compassion for the people themselves is palpable. There is extensive literature, for example, as noted previously the work of Alexander (2001), which explores the roots of addiction. The nurses are acknowledging the simple reality of addiction while at the same time they are expressing a very human desire that the lives of those people be different. The focus on the person, as opposed to the drugs, is again in keeping with one of Single's (2000) principles of harm reduction, which asks that practitioners focus on the harms associated with drug use rather than the drug use per se. Mary provided a vivid example of the challenges that drug use can pose to nurses who are trying to get clients to see beyond the demands of their addiction. She shared the following experience,

I remember ... somebody came in and had got hit over the head with a beer bottle and he had a huge, great, big, gash above his eyebrow and I looked under the bandage and it's, like, you know, almost like his brains are coming out. And it's like, 'you need to go and get some sutures, either go to the hospital, or go to a clinic' and he said, 'I can't right now, I need to do my fix'. OK, I watched him, waited until he was finished fixing, 'you've got about three to four hours, so why don't you go to the hospital right now, I'll call you a cab to go the hospital and get sutured up'. He said, 'you don't understand, I have three hours to come up with the money for my next fix, how can I go to the hospital'? That's what, sort of, showed what it was like for me.

In order to "meet people where they are at" the nurses appear to go through a process of letting go of traditional ideas about their nursing role (Marlatt, 1998, book jacket). In both focus groups the nurses discussed how they had to re-create their classic

understandings of being a nurse; of fixing people, taking away the pain or helping people to access services they believe their clients require. Also, according to the nurses, their increased exposure to the lived experience of people who use drugs may, on the one hand, afford them the opportunity to decrease the marginalization brought about by drug use. In so doing, they are allowed to maximize the opportunity for other interventions, yet another principle of harm reduction (Single, 2000). On the other hand, the drug use can become the proverbial “elephant in the room” which requires creativity for the nurses to circumvent. The nurses are, at times, seemingly engaged in a dynamic tension. They appear to continually negotiate their desire that clients access, what they believe to be, needed health care services on balance with the respect that the nurses have for their client’s right to choose differently for themselves.

You learn to let the little things go

In the quotes contained in the following paragraphs, the nurses discussed the changes they believed themselves to have undergone since beginning to work with people who use drugs. There was a sense, which I believe is captured by the quote that titles this section, that the nature of this specific work contributed to a greater individual awareness and understanding of the larger social and healthcare issues.

Jane said she had changed and credited it to her relationship with her colleagues “as far as looking at different understandings and meanings of things, yeah”. Mary said, to group laughter,

I have changed an awful lot since working in [the harm reduction focused-health care setting] like, since being right in the centre. I’ve learned an awful lot about communication skills and an awful lot about people and I think, because of my experience with engaging with so hard to engage people, I don’t have a problem on the bus, at the bus station, or a train. I can engage with anyone!

Lori felt that she had changed as well, she said,

I would agree with that, as well. I think it has changed me on a personal level and as I've, you know, watched things, sort of interactions with clients, it has made me also really think about systems. And it's made me think about health care systems and access to health care and it's made me think of bigger policy changes that need to happen to affect change for marginalized populations or populations at risk for HIV or, you know, sexually transmitted diseases because that's what we do. But its, its made me think, you know, a lot of the very personal interactions I think have also led to, I think, the macro picture.

Valerie said, that she felt her work with people who used drugs made her feel more "tolerance or accepting-ness, or whatever, of lifestyles that aren't the same as mine" She also felt that, as a nurse who also works in acute care, "it improved my thinking about what it is going to be like for them when they do leave acute, so just hooking people up with other resources" and she feels "I do a much better job of it". Doris felt she was "a lot more laid back" and she believes that working in the DTES "really improves you as a nurse, you learn to let the little things go". Kelly finds much greater personal job satisfaction, working in the DTES, "its way less top down and I just feel my job satisfaction is just so much better. I mean, I don't want to take a day off". The nurses' generally had a perception that the ways in which they had changed as nurses were positive; they appear to be identifying shifts in priority and to valuing those shifts both personally and professionally.

The Second Focus Group Interviews

The second focus group interviews took place three months after the first. The setting was again my home and the same nurses comprised both of the focus groups. I began the interviews by describing aspects of the first interviews, my impressions and my beginning interpretations after my initial analysis. I told them that I was interested in

probing a bit deeper in this interview in order to continue to try to describe how “we do what we do” in order to better understand how we make meaning of adopting a harm reduction framework in nursing practice with people who use drugs. They all agreed that it would be ok for me to do so. When the prearranged time came to start the interviews, Lori, was absent; out of respect for the other participants in her group we decided to begin without her.

The second interview for both focus groups began with a follow-up to the last question that I had asked. I had asked both groups to tell me what advice they would give to a nurse new to harm reduction and to working with people who use drugs. At that time, Jack supported by Kelly, had advised new nurses to “watch and learn” and to be aware that “you are getting involved in people’s lives, they are not just a pneumonia case”. Lori had said that new nurses should be aware that they “have a voice, have power”; Jane advised that new nurses needed to be patient and Mary felt that mentorship was fundamental. There is, not surprising, a large body of literature that supports the importance of mentoring to the successful integration of new staff into healthcare organizations (Stewart, 2006).

People going in thinking save, save, save

The idea contained in “saving people” was again prevalent in this section of quotes. I used it again to headline the following paragraphs for a number of reasons. The notions of “saving” and “curing” are concepts with which I understand the nurses to struggle in a harm reduction practice context. They appeared to feel that it was necessary that they quickly integrate, into their practice awareness, the knowledge that some people may never stop using drugs and to then sublimate their own aspirations for their clients’

recovery. The nurses also appeared to shift their nursing focus away from the traditional focus of the goal of the medical model (a “cure”). The resulting juxtaposition served to position the nurses in a place where their own notions of “hope” for recovery or for better lives for their clients were quelled. Perhaps as a self-protective mechanism in order to stay engaged in the daily reality of their workplaces, the idea of “saving” then becomes something almost distained within the culture of these nurses. The nurses are also sensitive to the issue of othering and skeptical of nurses who they perceive as afraid of people who use drugs. All are discussed by the nurses in the following.

To provide context for this section, I was very interested in continuing to explore with the nurses what attributes they believed it was important for nurses to have to do their particular work and so I reconfigured the question that I asked in ending the first interviews. I now began by asking the participants what they saw in a new nurse coming to work in the DTES which caused them to be concerned. In both focus groups, this question garnered one of the most energetic discussions that occurred during the entire data collection process. The nurses were forthright and had strong ideas about the attitudes, beliefs or characteristics that they believed a nurse interested in working with people who use drugs should or should not have.

Fear, both of people who used drugs and the behaviours associated with drug use, was the single biggest attitude identified as a cause of concern for the nurses; each nurse in both of the focus groups was in agreement. Nurses, new to working with people who use drugs and who were also perceived to be afraid, were viewed differently, although, by the two groups. Some of the nurses saw fear of the DTES and people who use drugs drug users as an expected trait in a nurse new to the area. They did not believe that being

afraid meant the nurse would not succeed; they saw it as normal, almost a right of passage, but only up to a point. In the early stages, they believed that it was healthy in helping the new nurse to establish appropriate professional boundaries. Kelly and Jack identified fear as a function of “being green” to the issues of drug use and the DTES. Jack, supported by the other participants in his focus group, further believes that there is a lot for a new nurse to consider with regard to what they had been taught about drugs and people who use them. He said, “as a society we are indoctrinated; drugs are bad, drugs are evil, you do drugs you are bad and now you are in this bad area in a bad part of town” and he added “when you first enter that area, it is a bad area and all you know is that compassionate thing, but you are still struggling breaking down this society teaching of, you know, what you see”.

Other nurses were less accepting of nurses they identified as afraid. As described by Jane, fear was believed representative of judgment; “doesn't like them, don't want to touch them, don't want to talk to them, fear about drugs!” She was supported by the other members of her group in her belief that fear was seen to translate into “continuing to ‘other’, they are looking into the goldfish bowl going, ‘ohhh, look at that, look at that, ohhh!’ and having the shock and the little adrenalin rush”. In Jane’s analogy, the DTES is the goldfish bowl; people who use drugs are the fish.

The following are descriptors of traits that the nurses believe would create challenges for new nurses to have and were combined with responses from both focus groups: not open, unwilling to engage, using power-over, rigid, accustomed to following policies and procedures, intolerant and controlling. Valerie felt that nurses who had a

strong sense of “us and them ... superior and condescending, just not respectful towards those people” would have difficulties.

The nurses appear to be quite sensitive to the systematic process of “othering” that occurs with marginalized groups, including people who use drugs (Reimer Kirkham & Browne, 2006). The process of “othering” is rooted in a belief that some people are not the same. Those not understood or recognized as similar are feared and as a result, they are peripheralized and exteriorized. The attitudes that the participants identified as desirable for a nurse working with people who use drugs to have are consistent with those expressed by Brennan and Giles (1996) in the nursing literature and by the nurses interviewed in the BCCDC Street Nurse Film, teaching film “Bevel-Up (2007). Again, Marlatt’s (1998) call to meet people where they are at would appear to underpin the visible elements of pragmatism and compassion underscoring the participants’ awareness of harm reduction philosophy. Also, infused throughout the discussion was an understanding of Single’s (2000) principles of harm reduction (most especially in regard to respecting the basic human dignity of people who use drugs).

The nurses were wary of people that they considered to have a “saviour” agenda. Jack cautioned about “people going in thinking save, save, save”. Interacting with, being willing to learn from and getting to know a client were described as very important to both focus groups. Doris, Valerie, Jane, and Jack discussed being concerned about nurses who they suspected of coming to inner city community health harm reduction settings with an attitude of having “the cure” for addiction and being able to “love them into recovery” (Jane). Perhaps as a result, in both focus groups, nurses also clearly identified the importance of negotiating appropriate boundaries in their work. Lori (now present

after arriving late) explained what would concern her, “maybe being inappropriate, in comments, in judgments, in safety calls, there is a lack of professionalism; you are dealing with a client population that is much more on edge, much more vulnerable to power dynamics, to exploitation physically but also mental health wise”.

Kelly felt that being “reflective” and willing “at the end of the shift” to ask, “What worked? Didn’t work? How did you feel? What came up for you?” were important attributes for a nurse wishing to work well in the DTES. Kelly, Jane and Jack also discussed the allure in working in a cutting-edge and unpredictable environment like the DTES; Jane expressed that particular personality type as “someone who likes to be on the edge, someone who can break a few rules, not be too hung up on certain things and can be creative”.

Some of the participants expressed their belief that working with people who use drugs was not for everyone and they also shared the view that they believed most nurses realized that for themselves early on. The participants, again across both focus groups, expressed a sense that new nurses who come to the DTES should be interested in the issues of both the community and of people who use drugs. Kelly believed a “sense of social justice and compassion” was important and Diane described it as having a sense of being “counter-culture with a social justice want”. Jane, again supported by her focus group members, believed it was necessary for nurses to have insight into “the social determinants of health and the inequities in health and economy in our world, that political view, that philosophical view of compassion towards all people when you are working with disenfranchised people.”

The discussion in both focus groups generated by this question served to highlight and, at the same time, reinforce some patterns interwoven throughout the first interview. The value that the nurses place on connection and therapeutic relationship is again apparent; the capacity for compassion is also valued. Also identified is respect for the vulnerabilities of people who use drugs and the attendant need to establish appropriate boundaries. It would also appear that the health of the DTES community, as well as the individuals, is of importance in how the nurses understand their work.

Give them a little more peace in their addiction

I used this quote as it illustrates the benefits, described by the nurses in this section, of nursing within an expanded range of harm reduction interventions. I asked the nurses to describe what they believe makes them good at their particular jobs in an attempt to ascertain what is valued about the nurses in their area of practice specialty. Valerie and Doris both felt that “openness to listening to people and learning from clients” was something they believed they were good at. For Kelly, it was more introspective; she again talked about her realization that it was not her responsibility to “change” people, she described being on her “journey and that they were on theirs” and to “really learning about addiction and that some people will never get off of drugs and it’s all ok”. I asked her to clarify what change meant for her in this context, and she explained that she was referring to the behavioural change model (described in Chapter 2). It is her belief that some people will live their lives in the pre-contemplative phase. Jack also felt that realizing that some people will never stop using drugs made him better at his job. He felt that it allowed “meeting people on their own turf, on their own terms, wired or not wired, that whole is addiction a medical issue or not or will they get better,

addiction is addiction”. The tenets of Marlatt’s (1998) philosophy of harm reduction are clearly visible in Jack’s response. He also talked, in a very similar way to how Mary had, in the first interview, about what value developing relationships with people who used drugs provided for him,

I think the gain for us, for me, is to see people get over small hurdles in their life, larger is better, but small hurdles in their life. To give them a little more peace in their addiction, you can’t just cure the addiction; you can take some of the historical pain through dialogue and counselling.

For the nurses, the knowledge of the chronicity of addiction in some people’s lives appears to foster an ability to engage in relationship building in a realistic way; not previously possible when engagement was contingent on eventual abstinence. The respect for the autonomy of individual choice imbues the participants’ descriptions.

The nurses agreed that an understanding of the impact of addiction on their client’s lives and counselling and teaching skills were what they had most developed and could share with other nurses after practicing in front-line harm reduction facilities. They also agreed that an understanding of client-centered care was required and made them good at their jobs; Valerie said it was necessary to ascertain the “client’s goal because that will determine what is possible”.

Missionary work

Some of the nurses had compared their DTES harm reduction work to be like working in a third world country. This caused me to consider whether the nurses believed that their nursing work was in any way akin to doing missionary work. I asked the nurses about that and was privileged to hear a very contemplative conversation between Diane, Jane and Mary in which they discussed the concepts of worth, compassion and spirituality. Diane specifically talked about the Hindu concept of “namus dei” which she

describes as the ability to look someone in the eye with an attitude that says that people are equal and valuable. I asked them if they felt their work with people who use drugs is in anyway like doing missionary work. I asked this question because I was very curious to discuss as many underlying influences as possible that may have driven their choice of nursing practice. While they did not believe that it was, the three nurses ultimately agreed that they particularly valued the concepts of compassion in their nursing work. They believed that the ability to communicate a sensibility that encapsulated compassion had the potential to make a difference in the lives of the people with whom they worked. Jane, talking about people who use drugs and, with murmurs of group agreement, said, "They are working it out as best as they can and I have no sort of illusions ... I am there beside them. I'm there beside them. I want to be, I want to hear them, I want to witness to them but I don't have any sense that they need to do anything different ... than that they need for themselves". Marlatt's (1998) exhortation, repeated by harm reduction practitioners, to meet people where they are at is also obvious in Jane's responses. The nurses are again endorsing the importance of client-centered care, their valuing of compassion and their respect for personal autonomy. Stimson's (2007) central components of a harm reduction philosophy are obvious.

Other nurses were much more light-hearted in responding to my question asking if they believed themselves to be missionaries; they definitely did not believe that they were. They expressed themselves colorfully and with awareness that their nursing work placed them in a context they knew to be unique. Jack said, he thinks they are adventurers, Doris felt that they were travelers, Kelly said, "it's a different planet". They all agreed strongly when Valerie said that doing a "reality check-in" was important for

her in acknowledging that where they worked is not the “reality for most of the world”. In the context in which she is saying this, I interpret this to simply mean the work environment for most nurses in Canada, and that the participants are again endorsing the need for a balance between their work and personal lives.

Just trying to make do

This section includes discussion about life lessons that the nurses shared which influenced their understanding of the experience of some people who use drugs. The quote excerpt comprising the title encompasses elements of compassion which was so prevalent in how the nurses collectively expressed themselves in the following paragraphs.

I had asked the nurses if they saw any similarities in themselves and the people with whom they worked in the DTES. Lori had a strong sense of identification with what she saw as one aspect affecting the lives of people who use drugs. She said that she felt she “identified with isolation, with people who are disengaged from the rest of society” and she said that she “feels ok with them there”. This triggered a memory of what, for Jane, has become a life lesson. She shared,

I was probably eleven and this guy gets on the bus and he is all over the place. I act like a pre-pubescent kid to this guy and my father says to me, ‘he is just trying to make do’ and I never forgot it. People, they feel pain, they get hungry, they get lonely and they have different worries on different days. Your worries might change your priority a little bit but, it’s like, you strip away everything and we are the same, we’re all trying to make do with what we’ve been given and with what we’ve been got. We’re just trying to make do and some people have less than others so it looks different, but really, we are all just people making do.

Mary felt that if it wasn’t for some decisions that she made relatively early in her life she didn’t “really know where she would be now” and she also felt that “maybe I would be down there as well”. Doris shared that she was bullied in elementary school and that

when she sees people who use drugs treated in certain ways, she remembers how she felt during those times. She also said that she “never felt really alone in that way, I always felt very strongly supported by my family”. Lori, much like Doris, recounted an experience that she had during elementary school that she believes in some ways helps her to understand the experience of marginalization. Her mother was German and they used to play Second World War games during recess; she and one other child were the Germans and everyone else were the British. She still believes that “it’s amazing the impact” her perception of feeling different during those games had on her. Jack believes “we all have had times when we did drugs, but I think what we had was more support, family, community, friends, I think, that were lost for a lot of folks, I think they lost out over the years” and he also believes that “we’ve also all had internal checks that pulled us back, I think for some people there are no supports” to put that “into place in youth”. The nurses clearly identify with certain aspects of what they understand to be the lived experience of people who use drugs.

Interestingly, in the above response by Jack, addiction is now explained as arising out of the disease model; this was supported by the other members of his focus group. During the course of the focus group interviews, seemingly divergent influences were at times accepted, rejected and interwoven together by the nurses as they appeared to collectively construct an understanding of particular issues associated with drug use.

When you have adults that believe in you

This quote aptly encapsulated what the nurses experienced as contributing to their understanding of the cause of some people’s problematic drug use. While they knew there to be exceptions, I understood them to believe that strong family and adult support

systems were fundamental to the development of self esteem and contributed to healthier lifestyle choices.

I had asked the nurses what they understood to be the reasons why they were nurses working with people who used drugs instead of being one of them. To a person, the nurses articulated the importance of supportive persons; especially those who were present during their young adult years, in their understanding of why they do not personally have issues with drug use.

Kelly said, “having really good friendships for me, I mean the family situation wasn't that great but having good support outside of my family and going to nursing school, like getting to nursing school and away from family”. Lori said, “it’s not like I didn't go through difficult times in my life or anything but I think, it’s because of how I was raised, the people I had around me that gave me the skills to navigate difficult stuff”. Valerie remembered the education she received as a young child in school programs; “Grade 1, when I was in the States and there was this big huge ‘say no to drugs’, it was just a huge program down there, and I really took it to heart. I just remember not wanting to go down that path”.

Valerie also discussed the importance of supportive people in her life, in addition she identified being strongly influenced by the cultural narratives surrounding drugs and drug use, “my family was supportive and all the rest, but I think the opportunities were definitely there, whatever reason, it was just really internalized, like drugs are bad, I’m not a bad person so I’m not going to do them. I just remember really like, I’m not ever going to do that”. For Diane, it was the “opportunities I have been given in life and the family that raised me, I think a lot of the clients that we have, had a rough start on life

and I was given everything as a child and honestly, I think that's the biggest part of it". Jane disclosed that she personally "came really close, I was on the street when I was a kid, a teenager, I mean, there were different ways I could have gone, for sure, but when you have adults that believe in you it is a bit different". She felt that having people who provide you with opportunity and "believe in you when things are hard" gives you "another alternative". Mary also felt that there were "decisions that I had made when I, sort of, saw which roads I could have been going down but I think it was my background which gave me that opportunity to make that decision; the family that I grew up in".

The nurse's belief that supportive persons and families are an important component in whether or not someone becomes engaged in problematic drug use finds some support in the literature. Carstairs (2006) reports, that in an extensive study of drug use done by Canadian psychiatrist, George Stevens, on inmates in the Oakalla Prison Farm during the 1950s, that 40% of the respondents reported coming from families with problems. Alexander (2001) advances this belief and theorizes that dislocation from the intimate ties that join people and communities is a precursor for addiction. The nurses appear very aware of the complex determinants which may lead to the problems associated with addiction.

Heroin is the devil

Harm reduction is controversial because it requires that strongly held assumptions about drugs be reconfigured. Not only are certain drugs illegal in contemporary societies but an entire social construct has been built which vilifies those same drugs and the people who use them. Understandably this contributed to personal ambivalences and unease for nurses now working in environments in which drug use is normalized and

even sanctioned. The study nurses discussed the various influences affecting their own evolving reconceptualizations.

Jack believes that said it was a particular “era of society” that taught that “heroin was the devil” and it would lead to “damnation” and that has changed leading to the acceptance of different attitudes and approaches towards drugs. Valerie said that her attitude only changed about drugs after she graduated from nursing school and took an HIV course taught by Irene Goldstone. She said she learned “where our perceptions about drugs come from” and that in this particular course she was asked to consider for the first time “just why you think this, like what are your feelings about this? You know it really challenged my thoughts on, on why do I think that heroin is the devil but, like you know, alcohol is ok?” This was met by much group agreement. She continued,

I'm ok with seeing my friends drink alcohol but like, I would be like, ‘what are you doing [laughing], I'm not hanging out with you later, you know, you're shooting heroin’. So I really changed my thoughts on that and that is before I came to the DTES. Society just decided to outlaw these ones and these ones aren't.

Kelly, Valerie and Jack agreed that drug prohibition had a profound impact on how they once thought about drugs. It seems apparent that the nurses are also aware of the influence that the moral and disease models of addiction played on their belief systems in relation to drugs. The permeating influence of the moral model of addiction on the abiding cultural narratives was described by Valerie. She had not previously questioned her belief that alcohol was a “better” drug than heroin. The social constructs that underpin the discourses dominating the beliefs and attitudes about drugs, drug use and people who use drugs has a wide base of support in the literature (Alexander, 1990; Boyd, 1991; Carstairs, 2006).

I don't know if I just did a good or a bad thing

Harm reduction and nursing practice with people who use drugs challenged the nurses on many levels. The nurses in the study found themselves in circumstances in which they struggled with profound ethical and practice dilemmas. At times, the ambivalence of the nurses was palpable as evidenced by the simple yet elegant quote of Mary's that I used to define this section.

The stories the nurses told were varied and at times intense. Jack, Valerie and Jane, talked about being in situations in which they were trying to establish therapeutic relationships and about feeling they may have been "too loose" and being put into "so many scary situations here that you could really get into trouble" (Valerie). Jack described doing an outreach interview in a crack house and discussed almost being overwhelmed by the fumes. Jane told a recent story about being "swarmed" on the street because her outreach partner was being too restrictive and rule-bound, in her recollection, in dispensing crack pipe kits. Lori discussed an encounter she had, during a day off, in which she inadvertently found herself involved in keeping custody of stolen property for a client. Jack talked about nurses, he called "the 'I am going to save this person' nurse", who comes to the DTES on weekends and who he knew to be having "quite serious relationships" with clients. The nurses all discussed the importance of debriefing these incidents with peers and superiors. They also identified their belief that the potential for challenging circumstances to occur was greater when they were new to the DTES and to the population.

At times, the prohibition of drugs places nurses who work with people who use them very close to the margins; the nurses discussed the conflict they sometimes feel in

certain circumstances between what they know to be legal and illegal. Kelly shared the story of taking a client to an appointment and her client needing to stop, in her presence, to buy and to then inject illicit drugs. Valerie discussed her sense that some of the decisions nurses made, based on the situations in which they found themselves, “was the right thing to do as a person” but she also felt they were in a difficult place in terms of being a nurse. Valerie also talked about particular issues related to the supervision of injection drugs that she knew to be challenging for herself and for other nurses.

In particular, the group conversation turned to assisting people to inject street drugs who are unable, for any number of reasons, to do it themselves. I entered into the discussion in an attempt to offer clarity and said that while doing so was illegal, it was not technically outside the scope of nursing practice. I said nurses physically helping people who use drugs inject street drugs was clearly something that we should not do. I explained that doing so would impinge upon professional boundaries, contravened the drug administration laws that governed our practices, and that injecting street drugs of unknown quantity and purity was dangerous to clients. The nurses felt that the nature of this conversation was important for nurses working in harm reduction to engage in and expressed their desire to have more opportunities where they could problem-solve various scenarios together.

Doris and Jack discussed the cumulative effects that watching people use drugs can have on nurses. Jack said, “I think it wears on people, working with staff who have regular nightmares ... have to take LOAs [leave of absences], the nightmares, people talk about that all the time and you see it over and over” and he believes that nurses that supervise people who use drugs are subject to an internal process where “it kind of

normalizes it a bit” and that he believes that it can make nurses “less effective in our ability to teach, our ability to maybe notice things”. Doris went further and said she believed that watching people injecting drugs actually produced what she called “desensitization”. Numbed feelings, withdrawal and nightmares are all described as common among both people who have been victimized and those who have cared for them (Clark and Gioro, 1998). The importance of having strategies in place that are aimed at minimizing these occurrences (again, such as effective nursing management teams and the availability of colleagues for debriefing) are critical for nurses, such as the study participants, who work in challenging practice environments.

The nurses talked about the issue of being asked for money by their clients and knowing that the money was going to go for the purchase of drugs; they expressed feeling conflicted about their desire to give it to them regardless. Mary talked generally and very poignantly about her struggles at times in using a harm reduction framework in her nursing practice,

I can't remember so much even the stories but I know, sort of more, the way I felt afterwards. Especially at the [harm reduction-focused health care setting] where I would go away and I would think, I don't know if I just did a good or a bad thing, like sort of thinking from a harm reduction thing. Then having to debrief with a colleague, to sit down and say, 'tell me again, why it is a good thing, because somehow I have lost it and it feels like I have done something that is not so good.' Then to reframe that again, for myself: Why am I working here? What did I just do? Why did I just do it? To convince myself again that it was a good thing.

After my probing, she gave the example of someone coming into the (harm reduction-focused health care setting) and asking for safer injection teaching and her becoming aware that they had never injected before. This scenario is reminiscent of the experiences shared by Kelly and Jane in regard to street youth and their feelings after teaching them how to use drugs more safely.

Nursing practice through the lens of harm reduction appears to require vigilance in both personal self-care and praxis. At times, the nature of the work exposes nurses to legal and ethical quandaries. This also speaks to a need for them to acquire skill in negotiating consistent and clear professional boundaries. The ability of nurses and managers to offer mentorship and to provide opportunity to debrief scenarios with peers are also identified as important. Moral distress in healthcare has been defined as a serious negative effect that is experienced by nurses when an appropriate course of action cannot be taken because of a lack of resources (Vinje and Mittelmark, 2007). In extrapolating this definition to nurses who are engaged in nursing practice through the lens of harm reduction, it becomes easier to see how the nurses may at times experience moral distress. As an example, in the study participants' practice context, "lack of resources" might mean their inability to access treatment centres and shelter beds for their clients on a day to day basis. On a larger scale, the nurses may appear to be describing moral distress because of their perceived inability to affect change in the larger socio-political context and in the sustained marginalizing experience of people who use drugs. Vinje and Mittelmark believe that although no research has been done describing moral distress in the community nurse subspecialty, there is reason to suggest it is prevalent and contributes in the same way to burn-out and to nurses leaving the profession as in acute care settings.

Support for nurses is not well thought out

The nurses expressed concern because the very nature of harm reduction at times appeared to place them in practice situations in which they felt vulnerable. At times, they seemed conflicted between their role as socially progressive community members and the

professional practice limits by which they were mandated. Diane believed there to be an “incredible responsibility in this field” and that “policies and procedures are not in place” and that nurses are called upon to use “your own wisdom and your own judgment call in a lot of situations”. Lori shared that she felt that “as a profession we don’t support this area well at all, the ethical decision making with harm reduction” and she believes the “support for nurses is not well thought out”. Jane added, that what “happens in our job is you’re coming face to face with ridiculous laws that have been made for, god knows, whatever reason” and “they hurt people, and so you have to make a decision as a nurse, kind of Johnny-on-the-spot, wow, this is really not working out for these people and it is really bad and I am not going to continue to support it because, it is like, hurting these people”. Lori continued with “it is a really interesting thing, that intersect between public health and the legal system” and agreed with Jane that, in her opinion, “the laws are not designed for the health and well-being of people in society”.

While the nurses have identified the need for practice support in a number of areas, unfortunately, there has also been little research which describes how nurses negotiate the unique demands that are placed on them in community settings (Bramadat, Chalmers & Andrusyszyn, 1996). In addition, there is a lack of research related to the efficacy of ethical-decision making models in nursing practice (Cameron, Schaffer & Hyeoun-Ae et al., 2007). Holder and Schenthal (2007) report that there is a scarcity of contemporary in-depth inquires and critical analyses addressing therapeutic boundaries in the nursing literature. At the same time, the boundaries of the scope of nursing practice are always changing; nurses are required to pause and to engage in critical thinking and

praxis in situations in which they believe their nursing practice is outside their traditional boundaries (Davidson & Bloomberg, 2007).

A place where they can come and be respected

The nurses shared what they believed expanded harm reduction facilities meant to people who use drugs. I believe the quote contained in the title is representative not only of their responses in this regard but to the study nurses expressed belief in the saliency of the approach as a public health intervention and as a response in a civil society as well.

I had asked the nurses if they were aware that the Canadian government was announcing a tough new anti-drug strategy; I asked them how they felt about the fact that harm reduction strategies may no longer be funded through any federal ministry (Note: The announcement in which this did happen had not yet occurred, so the nurses' responses were at the time hypothetical). Harm reduction interventions remain highly politicized and it is not surprising that the nurses are not apolitical. The nurses had the following to say. Valerie said, "I think harm reduction services are not being under utilized" and "people are going to feel the consequences of it and those consequences are not going to be seen by the larger public, probably for some time". Kelly said, "it would make me really angry because harm reduction works. There has been so much research on it ". She also said, "I just think it's this particular government that wants to take it away because of how they feel about drug addicts". She called on nurses to "organize; we need to speak out because it is an opportunity for us to step up to the plate and use our professional status to be activists". Jack concurred, "absolutely, I agree, support what we are doing or we will lose it". As demonstrated by an increasing professional mandate in relation to the responsibility of nurses in issues related to social justice (Fahrenwald,

Taylor, Kneipp & Canales, 2007), the participants would appear intent to continue to advocate for harm reduction initiatives for people who use drugs. Doris said that if InSite had to close she would feel “angry and sad, feeling like people who are making decisions for stuff like this to happen can't possible be anywhere close to the frontlines or have any possible idea of what the influence of having an establishment like that in the DTES actually has on the population”.

I asked them specifically what they believed that having harm reduction facilities for their clients had provided. Valerie said, “it saves lives and gives people opportunity”. Kelly simply said, “it allows them to inject safely”. Valerie added, “it gives them a place where they can come and be respected despite the fact that they do use”. Jack said, “and that whole connection with professionals, like ourselves, if you are shooting all your dope in a hotel room ... before these places were there ... if you are going daily to an injection site, just that little conversation, ‘hey, how you doing today?’” Valerie interjected, “exposure to people that don't use” and Jack agreed, “you see someone over and over build a relationship. They may be a little more apt to try some sort of treatment program or whatever would work for them”. Valerie added, “it has given them a sense that it is the only place that they do connect with, the only place they would call like home and they maybe come there like 20 times in one day so for some people it is a big part of life”. Doris added, “we see the women who aren't working as much and who are now not as exposed to HIV and Hepatitis C”. The participants’ responses are in keeping with one of the stated objectives of the medically supervised safer injection facility; to provide a “far greater opportunity for health care workers to connect meaningfully with injectors than conventional public health services and programs”(VCH, 2003b, p.11).

I also asked the participants how they would feel, if in twenty years, nothing had changed and people still had need to use InSite twenty times a day. The nurses were pragmatic in response. Valerie said, “I think it is sort of ok” because she believes that “is what addiction is” and “it’s going to be new people that are coming in twenty times a day and they are going to have to go through that themselves, whether they keep doing that the rest of their lives or not, they have to go through that themselves and at least there is a place for them to do that”. Jack said, “drugs are here to stay, they have been here since the beginning” and he said, “I hope there are three InSites in different communities”. He added, “I hope people can have the access, it’s about access. They don’t have to use it, or if they do want to use it, but it is about having the opportunity to have the access to the education and to the healthcare if they want it”. Again, the central components of compassion and pragmatism in a harm reductionist orientation to practice are visible in the manner in which the nurses articulate their responses (Stimson, 2007).

How can you measure interaction or a nurse’s dedication?

The title quote for these paragraphs illustrates what I understood to summarize the nurses’ awareness of both the incalculable nature of the nurse-client relationship while at the same time acknowledging the quintessential value of that same relationship. They are cognizant of the time and commitment required, at all societal levels, in order to positively affect the health of this community of individuals and they believe that, despite challenges, the harm reduction approach to be an important component within the addictions service continuum.

In response to the question about the Canadian government’s new anti-drug strategy, the nurses made the following responses. They were also angry; Lori said, “it

makes me really angry because they are equating harm reduction with enabling drug use and the second thing they are doing is, if you are a proponent of harm reduction, you are opposed to treatment and you are opposed to ensuring the health and well-being of clients on the street". She added, "I think they have completely got their heads in the sand, well, they are politicians and everybody knows it is more the US agenda and there is trade involved but yeah, I mean, harm reduction is part of a continuum". I then asked them if they believed that what they were doing was making a difference. Lori answered, "nurses were the first people to hand out needles, you know, nurses were the first people to push for the safe injection site. Nurses are on the cutting edge of public health". The conversation shifted into a discussion of how difficult it is to quantify health against a backdrop in which, according to Jane, the "social determinates of health" are so all encompassing. She said, "like how can we say we are good? Homelessness quadrupled with the new government and with homelessness comes increase in addiction, increases in crime. You make people poor, you make them desperate; it is really hard to know how you make a difference when you are working in a conservative narrow-minded milieu". Jack and Kelly also discussed the impact of poverty, substandard housing and the ghettoization of the DTES as key issues that made their work both frustrating and difficult. The public health literature reflects the importance of affordable housing as one of many determinants of a "healthy city" (Awofeso, 2003, cited by Myers Schim, Benkert, Bell, Walker & Danford, 2006, p.74).

In order to improve health and health-care for all populations, Browne (2001) challenged nurses to expand the focus of nursing knowledge development on issues of social justice and social transformation. Considering the nature of this politically charged

and socially constructed nursing work, it is not surprising that the participants, who are also nurses working on the frontlines, are aware of issues of social justice. The linkages to marginalization theory and the role of nursing in understanding and working to change oppression is evident in the nurses' responses (Hall et al., 1994). The history of nurses working within social movements has a long precedent (Reimer Kirkham and Browne, 2006). In her statement, Lori infers that the "US agenda" is influencing the Canadian government's drug strategy in an escalation of the "war on drugs". There is support for this interpretation in the review of the literature. Although the nurses favour the commitment by the Canadian government to increase funding for treatment and prevention strategies, they are aware that funding for harm reduction strategies is not in any federal ministerial budget. The need, expressed by the study nurses, to anchor harm reduction within a continuum of services is supported by the holistic model of addictions and described in the review of the literature. The participants' awareness of the health issues they see as affecting large urban centres is supported; economic and social marginalization, disparate access and use of health care systems, higher mortality rates from acute and chronic diseases and higher morbidity from preventable disease (Myers Schim et al., 2006). Lori said, "the product of what we are doing is so intangible, I mean, how you can measure? You can measure public health outcomes and stuff like that but how can you measure interaction or a nurses' dedication?" Jane added,

I mean there is very different things that happen in interactions, because [from] some you walk away and you kind of go, 'you know, I have made a difference in this person's life'. And there is other interactions where you walk away and you are not so sure, but they come back later and say, 'you made a huge difference in my life' and then there is other things where you don't make a difference for anybody and its kind of like you get up and you go and you just keep trying.

In the emerging holistic approach to addictions treatment, there is an acknowledgment that there is difficulty in sorting out responses that are evidence-based and those that are not. There is a greater awareness in addictions treatment that the ability of people to manage their lives increases with information and supports (BC Ministry of Health, 2004). It is logical to assume that nurses, as the frontline healthcare service providers in harm reduction settings, are integral to the provision of both. Jane, in concluding the focus group interviews made this final comment; “you go where the winds take you, it unfolds, the universe, it kind of happens and you are there and you are responsible and you are present and you try to be as grounded as you possibly can in order to respond to what is put in front of you”. Jane’s response, as a final note, does much to capture the subtle nuances of nursing practiced through the lens of harm reduction with people who use drugs.

During the course of the interpretive description analytic process certain notions permeated the responses made by the study participants. I have chosen to describe the experiences and perceptions of the nurses as notions or ideas to give credence to the evolving understandings that represent the nurse’s articulation of how they are making sense of harm reduction as an approach in their nursing practice with people who use drugs. In the following paragraphs, I will provide a description of the responses I believe to be evident. I will then introduce the broad theme most representative of the identified notions and upon which the subsequent chapter describing the study findings will be based.

A Discussion of the Central Ideas and of the Over-arching Theme

A Discussion of the Central Ideas

Through the analytic phase of the study, a number of notions became apparent which lend understanding to how the study nurses, the pioneers in their field, are making sense of their nursing work through the lens of harm reduction. I will describe them here.

The study nurses believed themselves to be motivated to provide nursing services in a different manner than had been their experience working within acute care settings. They believed that the experience of people who use drugs within acute care health care facilities was frequently stigmatizing and marginalizing. The nurses empathized with these experiences and felt that they paralleled, in some small way, the nurses' own experiences of feeling different when working within those facilities. A feeling of being different or "other" was adopted by the study nurses both to describe aspects of themselves and to describe the systematic processes that they believed impacted in the lives of people who use drugs.

The study nurses described being drawn to the DTES and to their work with people who used drugs as arising from a desire to deliver client-centered care in a more holistic manner than they had evidenced in other settings. They believed that a large learning curve existed for nurses new to the subspecialty related to coming to understand the complexity of issues impacting the daily lives of people who use drugs. They described undergoing both a transitional process and personal evolution in their knowledge and understandings in relation to the issues of drug use. The study nurses also described their first experiences in bearing witness to the reality of addiction and to the magnitude of its impact as it played out in the lives of their clients. They experienced this

as being difficult to witness. The nurses described knowledge and respect for the larger DTES community, the issues affecting social justice, and the impact of multiple determinants of health to be critically important for nurses to understand in order to do their work well.

The study nurses believed that having supportive peers, nurse mentors and positive workplace cultures to debrief and understand potentially challenging scenarios critically important. They also believed that nurses new to the DTES were particularly susceptible to situations of vicarious trauma, the erosion of professional boundaries and queries related to the scope of nursing practice.

In general, the efficacy of harm reduction as a public health strategy, as described by the experiences of the study nurses, was expressed. Harm reduction was seen by them to be a responsive, realistic and pragmatic approach. A belief that a harm reduction focus in their nursing practice allowed the study nurses to create opportunities for health for a client group who found access to healthcare difficult was described. The study nurses also repeatedly stressed the importance of making connections and creating therapeutic nurse-client relationships. Good communication skills were valued amongst the nurses and were described as critical to their ability to develop the much valued therapeutic relationships.

The study nurses believed that their current nursing role included been called upon to, at times, champion harm reduction and to be advocates for people who use drugs, especially when discussing the rationale behind harm reduction. They believed their nursing role included being agents for positive change in relation to the controversial uptake of harm reduction. The study nurses believed harm reduction to be

compatible with the nursing role and was congruent with how they understood the art of caring. They also believed that harm reduction married well with their understanding of the relationship between nursing and of the issues affecting social justice. The study nurses saw harm reduction as an important and necessary component within a comprehensive addiction services continuum.

The nurses who participated in this study also believed that for many people who use drugs, life events led to the erosion of self esteem which has contributed to their current circumstances. They felt that the presence of supportive persons and environments in their own lives, especially during their formative years, was a key determinant in their understanding of why they were not people who had problematic relationships with drugs. Responses in which a sense of compassion underscored the study nurses understanding of the experiences of people who use drugs and the issues of addiction were consistently expressed. The study nurses believed that, in addition to harm reduction interventions, more was required at many different systems levels to address the issues of problematic drug use. They also believed that it was difficult to quantify and measure outcomes in nursing practiced through the lens of harm reduction; they believed that their nursing work was relational and usually occurred over time.

At the same time, and consistently tempering the above ideas, was the notion of ambivalence expressed by the study nurses about the harm reduction approach. Harm reduction was not seen, by the study nurses, as existing in isolation as a public health strategy but was believed to be an important adjunct in the addiction services continuum. And within that continuum, they found that practicing nursing by a constant immersion in harm reduction environments to challenge them on many levels. The reality of witnessing

daily ongoing drug use and all its attendant chaos was described to be difficult. They discussed the challenges of being subjected to unprovoked anger and aggressive behaviours. The study nurses discussed many circumstances in which they felt themselves to be professionally or ethically compromised; in which they felt very unsure as to whether their role was affecting positive outcomes or reinforcing negative ones. It was difficult for them to divorce themselves from both the controversy surrounding the harm reduction approach and the evidence they daily witnessed of lives ruled by addiction and their deeply human desire to want to make it all stop. The study nurses straddle an uneasy divide in their community's health care approach to addiction. While they aspired to understand and to not judge people who use drugs, they found that consistently doing so did not make for easy nursing work.

While harm reduction in nursing practice is challenging, the study nurses consistently incorporated the two key elements of harm reduction philosophy, compassion and social justice, into the language that they used in describing their nursing experiences working with people who use drugs. In addition, they have adopted Marlatt's (1998) axiom, meeting people where they are at, consistently into the verbal lexicon they use in describing their nursing work. The concept also captures the essence in understanding how the study nurses make sense of their nursing work through the lens of harm reduction.

A Discussion of the Overarching Theme

I believe that the overarching theme that describes how the nurses, in this study, make sense of their nursing work, through the lens of harm reduction, is meeting people where they are at. While the expression was coined in the very earliest harm reduction

literature, the nurses working in the DTES have appropriated the term and have made it uniquely their own. The power for the nurses contained in the term “meeting people where they are at” both frees and challenges them to strip away the complex layers surrounding the conventional ideas associated with health, treatment, stigma, drugs, values and beliefs and a host of other influences that traditionally create barriers between nurses and people who use drugs. It places the nurses fully beside their clients and reminds them, when situations challenge them personally and professionally, that harm reduction is all about healthier outcomes for people who use drugs. Therefore, meeting people where they are at becomes about therapeutic-relationship building and capitalizing on moments to help people who use drugs achieve healthier outcomes within the context of health defined by the clients themselves. As shared frequently by the study nurses this is by no means easy; perhaps that is why the repeated use of the term, meeting people where they are at, could also be seen as serving as a mantra for the nurses in order that they remember the focus of a harm reduction orientation in their nursing work.

The study nurses consistently engaged in dialogues, related experiences, and shared perceptions, in which they discussed on personal and professional levels their attempts to understand the complexities of the socio-cultural constructs attached to drugs, drug use, addiction, and the impact of these influences on the health of their client group, people who use drugs. The nurses rested most definitively on understanding addiction, and subsequently the importance of nursing practice through the lens of harm reduction, by returning time and time again to the idea inherent within the concept of meeting people where they are at. A broader discussion of Marlatt’s concept will begin the next chapter.

Based, on the review of the literature, it was not surprising that a polarity of influences were weighed by the nurses in the study in order for them to make sense of adopting a harm reduction framework in their nursing work. This was not a surprising finding, given the divergent beliefs surrounding the uptake of harm reduction, as a public health response to problematic drug use. The nurses appeared involved in a dynamic process in which they reconfigured on many levels their understanding of drugs, people who use them during the process of adopting of a harm reduction framework in their nursing practice. In order to negotiate and define the terrain of their new and controversial arena of nursing practice, the study nurses appear to achieve a balance in their understanding through a process of ongoing personal reflection and professional praxis. They ultimately make sense by striving to pragmatically, realistically, respectfully and with a commitment to engagement in therapeutic relationship meet people where they are at.

In addition to their personal and professional reflections, the very real tradition of marrying the profession of nursing with the issues of social justice continues in the work of these Canadian nursing pioneers. As proponents of a philosophy and a set of interventions that accepts the reality of ongoing drug use for some people, nurses who work in harm reduction settings are placed in the margins of what has traditionally constituted the health care approach to addiction. The dynamic of the margins and the practice of nursing from within the margins are rooted in the literature, in specific, in marginalization theory as described by Hall, Stevens and Meleis (1994) and Hall (1999).

The nature of the work of nurses who practice nursing through the lens of a harm reduction framework with people who use drugs in the DTES places them in physical

proximity with a traditionally marginalized population. Through the development of therapeutic relationships and informed by the principles of harm reduction, this group of nurses provides health opportunities for people who use drugs. The therapeutic relationship, the essence of nursing as an art form, places them not only beside their clients but firmly within the margins as well as they commit to meeting people where they are at.

Utilizing harm reduction philosophy to guide the nursing service delivery with people who use drugs is a new professional practice area with a specific mandate. While not without very real personal and professional challenges, the study participants are engaging in a dynamic process of ongoing critical reflection and praxis in order that their understanding of their professional responsibilities evolves at the same rate as their actual practice. They maintain that it is their ability as registered nurses to develop therapeutic relationships by meeting people where they are at that has the potential to create opportunities for healthier choices for people who use drugs. This finding has the potential to lead to new understanding of how a harm reduction orientation to nursing practice with people who use drugs can be utilized in nursing education, research and policy development.

In this chapter, I have described the interviews extensively and have identified a number of patterns representative of the study nurses' responses. The notions expressed by the nurses have been merged in one over-arching theme to describe how they make sense of meeting people where they are at. Included in the overarching theme are five key findings. To summarize, the findings are described below:

1. Nurses weigh a polarity of influences during the process of adopting of a harm reduction framework in their nursing practice in which they reconfigure, on many levels, their understanding of drugs and the people who use them.
2. The process for nurses involved in making sense of harm reduction includes ongoing personal reflection and professional praxis.
3. Using a harm reduction framework with people who use drugs exposes nurses to potentially challenging circumstances
4. Nurses who use a harm reduction framework in their nursing work are engaged, by the very nature of their work, in an appreciation of the issues affecting social justice for a marginalized population
5. The therapeutic nurse-client relationship, the essence of nursing as an art form, has the potential to provide opportunities for people who use drugs to make healthier choices.

Based on both the review of the literature and my own understanding of harm reduction in nursing practice, none of the above findings are surprising. Despite the oftentimes chaotic and very challenging aspects inherent to nursing practice with people who use drugs the tenets of pragmatism and compassion, so central to the harm reduction philosophy, are consistently in evidence in how the nurses in the study understand their practice. In the next chapter, it is my intent to discuss the findings by using Marlatt's (1998) phrase, meeting people where they are at, as the thematic conceptualization critical to understanding how the study nurses have come to make sense of using a harm reduction framework in their nursing practice with people who use drugs.

CHAPTER FIVE

Discussion of Findings

In this study, I used a descriptive interpretive approach to describe the practice experience and perceptions of nurses working with people who use drugs. The specific research objective was to gain an understanding of how nurses make sense of nursing practice by using a harm reduction framework. I anticipated that the nurses, who are working with people who use drugs in the DTES, might have a unique perspective on the issues inherent to using harm reduction in their nursing practice. By exploring how they understood their nursing work, it was my hope that an enhanced understanding of the utility of a harm reduction approach as a public health strategy for people who use drugs would be provided for nurses in Canada.

It was apparent from the focus group interviews that I conducted for the study, that the ways in which nurses make sense of nursing practice using a harm reduction framework is affected by a number of interwoven factors. In utilizing a process of constant comparative analysis, I was able to identify an overarching theme which was described in the previous chapter. The nurses in the study, using the uniquely nursing orientation to healthcare service provision, have described how they understand the utility of harm reduction service delivery to people who use drugs.

Generating a broader understanding of how the study nurses make sense of nursing practice with people who use drugs is predicated upon an interpretation of the findings described by the overarching theme, meeting people where they are at. In that light, I begin this chapter with the genesis for Marlatt's (1998) term to provide the foundation for understanding how the study nurses make sense of their own practice

experiences. I will then extend the interpretation by discussion of the importance of praxis to the study nurses and also the challenges, successes and benefits in using a harm reduction framework.

Meeting people where they are at

Marlatt (1998) first used the term in his book, *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviours*. Societal stigma and the resulting process of marginalization resulted in the reduced ability of people who use drugs to access traditional health care settings. When it became apparent in the mid-1980s that large groups of people using drugs were becoming infected with HCV, HBV and HIV/AIDS, harm reduction strategies began to inform the public health approaches to the problems associated with drug use in communities around the world (Stimson, 2007). Marlatt described the importance of low-threshold access to health care services as opposed to high threshold access which traditionally associated drug abstinence as a precondition for treatment. It was anticipated that providing street-based outreach programs would foster opportunities for people who use drugs to more readily access supports and healthcare services. In so doing, drug using behaviours would be normalised and stigma would be reduced. The rationale was to “meet you where you are” as opposed to “where you should be” (p.55). And so, the phrase entered the harm reduction vocabulary in explaining a central tenet of a harm reduction philosophical orientation.

The influence of cultural narratives and the dominant discourses in shaping the study nurses understanding of drugs, drug use and people who use drugs are profound. The shift required in adopting a meeting people where they are at stance over a where

they should be requires a process of ongoing critical reflection. In stripping away the professional veneer that had traditionally shielded nurses from the actual drug use and drug use practices of their clients, the study nurses, who are now working in harm reduction practice settings, have become privy to their clients' lived reality. They are pragmatic in their acceptance that problematic drug use will inform the lives of some people and they are committed to the need to decrease its associated risks. Yet it is challenging for the nurses in the study to bear witness, on an ongoing basis, to how addiction is made manifest in the lives of their clients. It appears that one of the ways in which the study nurses have been able to do this is through praxis.

The art of caring praxis

Wood, A et al. (2003) described the need for nurses to engage in ongoing critical reflection and praxis in regard to their professional nursing practice and their personal values and beliefs related to drugs and drug use. Praxis, for nurses, can be understood as the dynamic "integration of knowing, being and doing" that infuses all aspects of what they bring to their practice (Bent, 1999, p.30). Throughout the interviews, the study nurses demonstrated a comprehensive knowledge of their area of nursing practice and were able to locate that knowledge in an ever-burgeoning empirical evidence base. They actively engaged in harm reduction health teaching and health promotion. An example of this as described, by one of the study nurses, was teaching people who use drugs how to inject their street drugs in a safer manner. A second example described by a study nurse was teaching clients how to best optimize the integrity of their veins. The findings also confirmed the core valuing of the nurse-client therapeutic relationship. It was in establishing connections with people who use drugs that the study nurses expressed

assuredness in their ability to impact the health of the DTES community in which they worked.

The study nurses appeared aware of the importance of a commitment to critical reflection and praxis in order that they stay engaged in the daily reality of meeting people where they are at. The study nurses are continually challenged to re-conceptualize the notion of health and health behaviours for people who use drugs in the DTES. It was a little over twenty years ago that the Ottawa Charter recognized the relationships between health and the broader political, economic, social, and environmental experiences, that happen in communities and in particular cultural contexts (Myers Schim et al., 2006). The World Health Organization (WHO) named nurses as the frontline health professionals to create communities that are healthier for the individual and for the whole population (Bent, 1999). Nurses, in accepting the mandate of the WHO, understand the importance of health promotion and the need to be actively partnered with community members in order to affect the health of the community (Bent, 1999; Myers Schim, 2006). The study nurses, who are working in the DTES, are no exception and they believe that adopting harm reduction interventions as a part of a holistic approach to health for the community is necessary.

Challenges to nursing practice using a harm reduction framework

Despite this “knowing”, the study nurses describe nursing practice which involves supervising people while they are injecting drugs as a difficult and surreal experience. There is not a parallel practice experience in North American public health nursing. As identified in the findings, the study nurses are entering into a practice environment that is different in many ways from other environments in which they have worked as nurses.

The study nurses described having to learn a new culture, a different way of being as nurses and as people. The study nurses described learning another language and another way of acting the role of “nurse”. They discussed knowing that their nursing practice with people who use drugs is informed by the multiple factors that influence their client’s lives. The study nurses discussed an awareness of the impact of the war on drugs and the global ramifications of prohibition on the lives of their clients. They expressed being cognizant of the disempowering effects of disenfranchisement and the implications of systemic marginalization on the lives of people who use drugs in an urban environment. The study nurses were mindful of the multiple determinants of health, not the least of which are poverty and homelessness, which affects people who use drugs and the communities in which they live. They discussed an awareness of the prevalence of historical trauma, concurrent disorders and poly-substance abuse issues and the attendant challenges they present in the lives of people who use drugs. The study nurses described being continuously reminded of their client’s ownership of their own health care needs. They discussed an awareness of the personal capacity and resiliency of their clients and awareness that, despite addiction, people who use drugs have the “competency... to manage their lives when information and supports are available” (BC Ministry of Health, 2004, p.75). The study nurses were also acutely aware that there is no Band-Aid large enough for them to apply to heal the pain they witness in their clients. It is perhaps because of this that the study nurses appeared so aware of the larger political and social justice issues affecting the lives of people who use drugs.

For the nurses in the study, working on the frontlines in harm reduction practice settings, the particular challenge becomes not only meeting people where they are at but

also seemingly about their ability as nurses to be there beside them and to witness, without expectation of change, the reality of lives lived in the chaos caused by addiction. The study nurses are implicitly being asked, because of the nature of their practice contexts, to gain an understanding of the width, depth, and breadth of a caring stance in a practice environment in which caring is not usually hands-on. This, therefore, is by no means an easy arena of nursing practice. The study nurses describe being required to creatively and professionally negotiate how to facilitate problem-solving and provide opportunities for people who use drugs to make choices that benefit health. The nurses discussed being placed in practice situations in which they must be cognizant of their professional responsibility and power. The importance of an ongoing personal process by which the study nurses were able to examine their values and beliefs related to drugs, to the people who use drugs and to the reality of ongoing drug use for some people cannot be overstated. Regularly scheduled avenues in which nurses can critically reflect on professional challenges with peers are of vital importance.

The study nurses described areas in which vigilance to practice dilemmas, such as being susceptible to the erosion of professional boundaries, subjected to vicarious trauma, and vulnerable to moral distress, are required. Negotiating professional boundaries necessitates that all nurses have a clear understanding of their role and that they have firm limits in place in order to protect the space between their power as nurses and the client's vulnerability (Holder and Schenthal, 2007). The skill required in maintaining this balance requires supportive practice environments in which all staff members model limits in a consistent manner. Traumatic stress is insidious and inevitable according to Clark and Gioro (1998) and occurs when there is a "transformation in the inner

experience of the therapist that comes about as a result of empathetic engagement with client's trauma experience" (p.1). Nurses, as shared by the experiences of those in the study, who work with people who use drugs are exposed to life stories informed both in the past and the present by intensely traumatic experiences. The study nurses discussed working in harm reduction healthcare settings and finding themselves in the unenviable position of having to, on some occasions; straddle both the conventional and emerging approaches to addiction service delivery. The nurses were placed in circumstance where they were forced, if you will, to "talk out of both sides of their mouths" in advocating for health care service access for people who use drugs and, at the same time, to simultaneously convince their clients to access those same services. Zrinyi and Balogh (2004) discussed the paradox involved in health care workers attempting to gain access to services for clients that have been designed to keep them out. The quandary for the study nurses, as members of a "helping" profession designed to provide health care services, was in knowing that their clients required health care and were unable to do so for many reasons. They recounted this to be both personally distressing and very difficult to reconcile professionally.

The nurses in the study believed that nursing peers who were most vulnerable to practice dilemmas were generally new to the DTES or were nurses who had not accessed the guidance and support believed necessary, by the study nurses, in order to problem solve, critically reflect or process the challenging situations that could possibly occur when working with people who use drugs. The sequelae that Vinje and Mittelmark (2007) describe, as contributing to moral distress, could serve as a cautionary tale for nurses working with people who use drugs. Vinje and Mittelmark believe that all nurses

are inclined and trained to look beyond themselves and towards others who are in need of care and that nurses have a deep need to make a difference in the world and to work in accordance with core values. When nurses are able to achieve this, they feel that life is meaningful and that they are important and useful. When they are unable to find the meaningfulness in their nursing work an existential crisis occurs and moral distress follows.

It appeared difficult at times for the study nurses to balance the challenges of a very vulnerable client group and the multiple determinants of health that impact their clients' daily lives when working in harm reduction practice settings. Nurses, in general, are inclined to want "to do" more to help; nursing practice in the study context provides little opportunity, in the moment, to affect tangible change for people who use drugs. The necessity of having nursing colleagues to mentor, support and debrief nursing practice scenarios and situations was emphasized repeatedly by the study nurses. In the same light, the importance of having understanding family and friends and maintaining a well balanced personal and professional life was also stressed by the study nurses. Supportive nursing leadership was valued. The ability to successfully attend to professional and personal reflective processes created the opportunity for the study nurses to focus on the significance of the therapeutic nurse-client relationship in making sense of their nursing practice through the lens of harm reduction.

Successes with nursing practice using a harm reduction framework

The study nurses clearly and resoundingly identified the importance of establishing therapeutic relationships with their clients both in how they approximated the success of their interventions over time and in how they validated their own

professional contribution. A harm reduction orientation to practice, as described by the study nurses, is predicated on nurses engaging with people who use drugs and creating opportunities to empower them. As evidenced by the experience of the study nurses, this can be achieved through health teaching and health promotion in order to facilitate the client's ability to make the best choices that they can in the situation in which they find themselves. A particular way the study nurses understand enacting care within a harm reduction practice context is in the making of connections that can lead to therapeutic engagement. The study nurses value the actual moments of connection without expectations of more or of different; the moments are cherished in and of themselves. The study nurses did not question how they knew that they had made a connection with their clients, but they knew when they had not. Summers (2002), in her work describing an essential component of provider/patient communication and mutual timing, evokes the metaphor of a dance and sheds light on this aspect of the nurses' knowing:

...what they do and say seems right and the responses from their patient indicate that a common ground of understand is achieved. Mutual timing occurs within this common ground. This phenomenon is the difference-making moment emerging from common ground in the midst of engagement. Mutual timing is similar to a dance, with the provider's step coinciding with the patient's step
p.19.

The ability to connect in these moments appears fundamental to how the study participants make sense of nursing practice through the lens of harm reduction with people who use drugs. The study nurses' ways of knowing appear firmly rooted in knowledge derived through and informed by their practice experience. Carper, whose

writings have influenced how nurses have traditionally understood the multiple ways of knowing for years, might well have described the study nurses' knowing as an aesthetic pattern. It is now understood that the emic perspective of experience allows for the subjective construction of knowledge that is transferable (Cloutier, Duncan and Bailey, 2007). The study nurses believe that they know when they have formed connections, they know that these connections can lead to the creation of therapeutic nurse-client relationships, and that these relationships can, over time, create health opportunities for people who use drugs and for the DTES community in which they live. Bent (1999) used the term "caring praxis" to describe community caring. It adds texture relevant to a harm reduction stance in nursing practice:

...the holism of caring is integrated with the connections between health and what was formerly non-health, such as energy, income, housing, civil rights, environmental protection, and all possible ecologies of relatedness. It includes taking a reflexive stance to examine nurses' praxis for embedded normative patterns as well as alternative worldviews. Caring is not an isolated variable in community; it is interactive, with ties to economics, politics, policy and law...the very act of participating in community caring creates change through critical thinking ... which can lead to outcomes such as healthier policies, access to health and human services, or observance of human rights

p. 34-35.

The study nurses, working in innovative cutting-edge harm reduction practice settings, through a commitment to praxis and critical reflection, believe that connecting in the moment with people who use drugs can affect health for their clients and the

community in which their client's live. Gaining an understanding of the relational process was not static for the study nurses and it was influenced by the impact of the myriad factors that affect, on all socio-political levels, the day to day lives of people who use drugs. The ways in which the study nurses appeared to create opportunities for difference-making moments with their clients was developed with specific applicability to their practice context. Their knowledge of the issues affecting the health of their clients was shaped, enhanced and transformed over and over again; it is transferred to other nurses and permeates their collective knowing of the larger DTES community. Thorne et al. (1998) assert that, "nursing's relational practice and science are directed toward the explicit outcome of health related quality of life within the immediate and larger environmental contexts" (p.1262). The marrying of the simple pragmatism of a harm reduction approach with of the art of nursing and an ample empirical knowledge base underscores why nurses, such as the study nurses who are working in the frontlines, are the key stakeholders in a position to most advance the public health of people who use drugs and in all the communities in which they live.

Benefits to nursing practice using a harm reduction framework

As a direct result of their place on the frontlines of health care service delivery, the study nurses working in harm reduction practice settings in the DTES are actively engaged in health promotion. The concept of health promotion has evolved radically; it is now dominated by socio-political action and refers to a commitment for the fundamental reform of health structures within communities and society as a whole (Whitehead, 2004). Despite an overwhelming body of scientific evidence attesting to the efficacy of harm reduction interventions, nurses, like those in the study who work with people who

use drugs from a harm reduction orientation, find themselves working on the fringes of traditional healthcare addiction services. From this perspective, the study nurses in an admittedly very limited and privileged way can more readily identify the processes that underpin the displacement of people who use drugs to the margins of societies (Hall et al. 1994; Hall, 1999). They become very aware of the power and homogeneity located in the social centre and through their nursing practice with people who use drugs the nurses in the study have recognized how individual diversity results in societal stigma and the process of peripheralization. Vasas (2005) named the process “othering” whereby those identified as “different from oneself of the mainstream” are exteriorized from the “center” and become “other” (p.196). Nurses, in general, bear witness to the harms to health that result from these societal constructs and through their position on the frontlines they commit to altering the social landscape through social justice (Reimer Kirkham and Browne, 2006).

Reimer Kirkham and Browne (2006), adhere to the politics of difference as described by Young (1990), in describing the importance of a social justice discourse in nursing. They suggest conceptualizing the difference between oppression and domination as a way of understanding issues of social justice. They advance Young’s notion that it is not individuals that are oppressed but social groups. In adopting that awareness issues of inequities of decision making, division of labour, and culture are made more obvious. In extending this understanding, the oppression of people who use drugs is then made tantamount through their collective marginalized status in contemporary societies.

Yet the study nurses, as evidenced by the fact that they are the only nurses working in legally sanctioned harm reduction practice environments in North America,

have been privy to an interesting shift that happened to this oppressed social group, the people who use drugs in the DTES community of Vancouver, BC. The dynamic tension that resulted from the diversity located in the margins, where social change occurs, came together with the center to create a shift in understanding and a degree of power was redistributed (Hall et al., 1994). The margins stretched to include the introduction of harm reduction interventions for people who use drugs. Small et al. (2006) contend that a cultural change did indeed happen in Vancouver in order for the medically supervised safer injection facility to open. Nurses, including some of those in the study, contributed to the socio-political change in public opinion that occurred in the city through health education. They worked in conjunction with people who use drugs and the DTES community and were instrumental in advancing, albeit incremental, social change for people who use drugs.

Despite the current threat to harm reduction interventions in Canada resulting from shifting political will, the study nurses appear poised to continue to partner with people who use drugs to advance a harm reduction orientation in public health. In “meeting people where they are at”, the study nurses have been privileged to come to know first hand the lived reality of people who use drugs and the inequities that contribute to their continued disenfranchisement from access to the systems that the rest of society takes for granted. The study nurses are very aware of the professional responsibility that accompanies that privilege. Reimer Kirkham and Browne (2006), in paying homage to the long tradition of nurses, including Margaret Sanger, who have been “committed to social justice agendas by emphasizing political activism and broad system change as public health interventions aimed at improving the health of whole groups and

populations” could be talking about the study nurses and others who work in the DTES as well (p.329).

By virtue of the fact that they are working in cutting-edge harm reduction practice settings, the study nurses are not only affecting social change but are immersed, by the art of caring praxis, in social change. They are quite literally in the margins beside their clients who use drugs in their commitment to meeting them where they are at. The study nurses believe that people who use drugs require access to pragmatic programs that facilitate health and health opportunities for themselves and for the communities in which they live. They make sense in using a harm reduction framework in their nursing practice because they believe that a holistic public health model for addictions requires a broad range of services with some of those services specifically aimed at addressing the potential for harm to people who use drugs. In working through the lens of harm reduction in the inner city community with people who use drugs, the study nurses appear to be doing what nurses have a long history of doing in urban public health in “demonstrating the efficiency and effectiveness of nursing services for meeting the needs of special urban populations” ((Myers Schim et al., 2006, p.78).

Limitations of the Study

There are a number of issues that limit the study. As with all qualitative research, this study offers an interpretation from a small group of participants. Further, the data collection method of focus groups contributed to a subsuming of the individual into the collective voice. The findings cannot be generalized in a statistical sense, but there is a strong degree of analytical generalizability. “Generalizability in qualitative research

refers to the extent to which theory developed within one study may be exported to provide explanatory theory for the experiences of other individuals who are in comparable situations” (Horsburgh, 2003).

My personal inexperience as a researcher also imposed limitations. This inexperience affected the quality of the interviews, the structuring of the focus groups and the data collected. The process of analysis was also impacted. I had never conducted a focus group interview before and I found it initially challenging to conduct the interviews in a manner that allowed the study nurses to be comfortable disclosing their thoughts and feelings. It was particularly challenging because of the collegial relationship between me and the participants. In addition, it was difficult to analyze the data while not bringing my own biases and expectations into the process. I have worked in harm reduction practice settings in the DTES since their inception and have internalized a number of opinions and perspectives regarding harm reduction. The questions that I asked my study participants were directly related to my area of practice interest. I engaged in a process of reflexivity throughout by using a tape recorder to record my thoughts and impressions during the entire data collection process. This was very useful as I conducted my data analysis to help me identify my biases, pre-formed opinions and also my hunches regarding the themes that were emerging from the data. My thesis advisor provided invaluable feedback throughout all aspects of the research process.

The utility in adopting a harm reduction framework for nursing practice may also have limitations. However pragmatic it might appear to be as an intervention, harm reduction remains a controversial and challenging public health approach in the arsenal of available treatment approaches for people who use drugs. Mediating the dynamic

tensions that exist between the traditional ideas surrounding addictions' treatments coupled with the frequently challenging behaviours of some people who use drugs and our socialized values and beliefs associated with illicit drugs is complex and quite naturally at times fostered ambivalence for the study nurses. If harm reduction philosophy was uncomplicated and the "right solution" to the problems associated with problematic drug use, Vancouver BC would not be the only community in North America that has adopted interventions such as supervised safer injection facilities. The harm reduction approach challenges all members of societies, not just nurses, to accept ongoing, problematic drug use. For many people it is that central notion of harm reduction that is anathema not only to their personal values and beliefs but to their understanding of what a just and caring societal response should be in addressing the issues facing people who use drugs.

Summary

In order to move forward and provide access to health care services for people who use drugs that is not contingent upon abstinence, attention must be paid to the intersecting factors that constrain their lives. It is equally important to understand the value of the therapeutic nurse-client relationship in providing access to care for vulnerable populations and it appears increasingly imperative that nurses working in public health nursing understand the importance of health promotion underpinned by a social justice mandate. A nursing commitment to a process of critical reflection and caring praxis is also necessary to integrate the challenges that may arise in nursing practice using a harm reduction framework with people who use drugs. Nursing

education, practice, research and program development must continue to take these concepts into account in order that people who use drugs and the communities in which they live are able to better conceptualize health. The concluding chapter will discuss how the study has contributed to an understanding and clarification of the research problem and the implication of the findings in the development of clinical practice, administration and education, as well as health and social policy.

CHAPTER SIX

Summary and Recommendations

Summary of the Study

The purpose of this study was to identify how nurses, who work with people who use drugs, make sense of their nursing practice. I undertook this project because I was interested in enhancing the understanding of the philosophy and interventions of harm reduction as a public health approach, in the practice of nursing with people who use drugs, in Canada. The study participants were nurses who work in the DTES community in Vancouver, BC. The largest range of harm reduction interventions, within North America, is offered in this community as part of a comprehensive public health strategy. The findings from the study may inform future research in this area. Insights into how to design and deliver holistic health care services to best meet the needs of people who use drugs, in a client-centered, pragmatic, effective, and accessible manner are provided, from the perspective of nurses who are leading the way in using a harm reduction orientation in their practice contexts.

In keeping with the methodological strategy, I reviewed the existing literature to gain an understanding of harm reduction philosophy and interventions. I was also particularly interested in gaining an understanding of the influences that permeate the values, beliefs, and worldviews of the study nurses in order to better know how they may have come to understand the issues associated with problematic drug use. It was clear from the literature that the global population of people who use drugs experience alarming rates of HCV, HBV and HIV/AIDS and other blood-borne pathogenic diseases as a result of the high-risk behaviours associated with IDU. It was also clear that in

communities where harm reduction strategies have been implemented into public health programs, improvement to health has been achieved.

Despite these advancements, harm reduction philosophy and interventions remain controversial. The nurses involved in the study were at times ambivalent as to its true efficacy. The review of the literature demonstrated that the reasons for this were, in large part, due to the perpetuation of stigmatizing cultural narratives and the dominant discourses related to drugs and people who use drugs that continue to assert great contemporary social influence. The US led war on drugs, ostensibly designed to eradicate drugs, drug trafficking and to, therefore, stop people from using drug, underpins international narcotic laws and the criminal justice systems related to drugs in many countries. People who use drugs are cast to the margins of societies where multiple determinants culminate to create increased barriers and challenges to health. It is in this resulting climate that nurses, like those in the study, work to promote the health of this client population. A small body of literature exists which describes the anecdotal experience of nurses working with people who use drugs. The nurses who participated in the study and who are working in the DTES have been afforded the unique practice opportunity to work in cutting-edge harm reduction settings with people who use drugs.

I used a qualitative interpretive descriptive methodology to gather data from eight nurses who work in a harm reduction focused-health care setting. Data was collected from four semi-structured focus group interviews. The study nurses were divided into one of two focus groups according to the order in which they enrolled in the study; each focus group met twice. The interviews were audiotaped and subsequently transcribed verbatim. Informed consent was obtained and anonymity was strived for by changing the names of

the study nurses. The second series of focus groups began with a brief review of the preliminary findings. I proceeded with data analysis simultaneously with the interviews using a process of constant comparative analysis. Thematic identification and analysis occurred as I moved between the transcripts to identify patterns and variations within the emerging themes. The ultimate result was a description of one overarching theme that was shared across the focus groups and by all the participants.

The theme that I identified was: meeting people where they are at. Ultimately, through the interpretive process, I have come to understand that there are a myriad number of complexities that inform the process by which the study nurses, using the framework of harm reduction, make sense of nursing practice with people who use drugs. A number of findings were linked to the interpretation contained within the thematic conceptualization of meeting people where they are at. The study nurses were aware of the influence of the prevailing cultural narratives, related to drugs and people who use drugs, on how they understood their work. More specifically, they also described a process which included ongoing personal reflection and praxis in negotiating those influences in order for them to understand using a harm reduction framework in their nursing work. The study nurses appreciated the issues of social justice which affected the lives of people who use drugs and they shared a core valuing of the therapeutic nurse-client relationship in how they made sense of their nursing work with people who use drugs.

It became evident from the stories that the study nurses told in articulating their experiences working in harm reduction practice settings that they believed that the pragmatic strategies designed to decrease the associated risks of problematic drug use

were important. It was also evident that the nature of this sub-specialty of nursing practice was prone to some ambivalence and to particular challenges, successes, and benefits for the nurses who were involved in the study. Most importantly, in providing the study nurses an opportunity to describe their unique experiences and perspectives, both insights into how other nurses might make sense of nursing practice, using a harm reduction framework, with people who use drugs were explored.

Conclusions

Based on the findings from the study, some broad conclusions can be drawn about how the study nurses, using the framework of harm reduction, make sense of nursing practice with people who use drugs. The concentration of people who use drugs, living in the DTES of Vancouver, BC, contributes to its uniqueness amongst North American cities. The public health concerns that resulted from this concentration of people who use drugs created the need for a large number of innovative health and social services designed to address problematic drug use to be introduced to the community. It was into this environment that some of the more controversial harm reduction interventions, such as InSite and the NAOMI Study began. Due to the singular nature of the harm reduction-focused health care settings in which the study nurses work their specific perceptions and experiences cannot be extrapolated to nurses working in similar practice environments. This is because they do not exist. Until such time as the conclusions can be applied to other nurses in the same practice context, it is hoped that the conclusions may resonate for nurses who are working in circumstances that are similar to those of the nurses in the

study. Since drugs are everywhere and the people who use them live in every community, all nurses may have reason to find the conclusions applicable.

1. The availability of harm reduction-focused health care facilities afford nurses increased opportunity to affect the health of people who use drugs. Breaking down the barrier that had traditionally required separating people who use drugs from their drug use as a precondition for health care access, creates opportunities for nurses to develop authentic, respectful therapeutic relationships with a much marginalized client group. It is the nature of the therapeutic relationship that makes nurses, who use the framework of harm reduction, both uniquely suited and situated to engage in health promotion activities that are based on the lived reality for people who use drugs.

2. The practice of nursing, using the framework of harm reduction, can present challenges for nurses who work with people who use drugs. Nurses negotiate on an ongoing basis a range of attitudes and beliefs about drug use and the people who use them both on a personal and on a professional basis. They are aware of the influences that continue to contribute to the polarity in socio-cultural attitudes and foster controversy related to the uptake of harm reduction initiatives. Public and professional education is important to change the attitudes that continue to foster stigmatization and to begin to address the issues affecting the determinants of health for marginalized populations.

3. Nurses who use the framework of harm reduction believe that the philosophy of harm reduction is as congruent and intrinsic to nursing practice in general and

specifically germane to addressing, in a holistic, client-centered manner, the delivery of nursing services to people who use drugs.

Implications for Health Care Providers and Policy/Program Developers

Problematic drug use is a social problem that requires a social solution. Solutions will only come when there is a significant shift in the societal relations that position people who use drugs outside the systems that are designed to benefit all members of society. The findings of this study present implications for education, administration, clinical practice, research, public policy, and nursing leadership. The recommendations are formulated to address the conclusions reached above and are presented to inform the development of appropriate policies and programs that will support the health and well being of people who use drugs.

Education

The conclusions of the study suggest a number of educational opportunities that should be undertaken. Health care workers need to have a much better understanding of the issues that affect the lives of people who use drugs. There are numerous studies that indicate that health care providers who are better educated about the complexities of addiction have a better attitude towards people who use drugs (Kelly, 1982; Martinez & Murphy-Parker, 2003; McCarty, Fuller, Arfken, Nunes, Miller, Edmundson et al., 2007; Zrinyi & Balogh, 2004). Based on the experiences of the study nurses in which they disclosed being unprepared by their nursing education to work with people who use drugs suggest that more applicable resources are required. The recently completed film, *Bevel-Up: Drugs, users and outreach nursing* (2007) and the accompanying teaching module,

developed by the BCCDC street nurse program, should therefore become a part of the education programs in all schools of nursing across the country. It would also be an appropriate staff development teaching tool for use in acute and community health care settings.

Administration

It is clear that the study nurses' experiences, in which they related their understanding of the health care encounters of people who use drugs, particularly in the acute care hospital setting, were fraught with discriminatory and judgmental behaviour on the part of health care staff. Health care administrators have a crucial role to play in ensuring people who use drugs, in particular those who are dealing with complex social and economic challenges, encounter a positive and healing environment when they present for treatment and care needs. They need to ensure all personnel that people who use drugs are likely to come into contact with receive appropriate education.

Administrators, particularly those in charge of harm reduction-focused health care facilities, also need to create an environment that supports the efforts of health care providers to fulfill their professional obligations to their clients. The nurses in the study clearly identified the need for mentoring, guidance in establishing clear professional boundaries and supportive practice environments. Moral distress, vicarious traumatization, ethical dilemmas, and burnout have been identified as barriers to appropriate care in the literature (Biley, 2006; Cameron, Schaffer & Park, 2001; Clark & Gioro, 1998; Duncan, 1992; Kelly, 1982). Workplace environments that provide appropriate administrative supports and that prioritize venues in which the study nurses can consistently and safely debrief and problem-solve complex situations need to be in

place. It is equally important that administrators both support and clearly delineate the scope of practice for nurses who are working in these innovative and challenging harm reduction- focused practice environments. This is critical so that there is no ambiguity in practice standards. Administrators also have a responsibility to provide a safe environment for all staff, including nurses, and the people who use drugs. It is important that administrators develop the appropriate mechanisms so that all parties have a clear understanding of the regulatory policies governing the facility. They should also facilitate the inclusion of staff and clients in the shared development of any required rules.

Clinical Practice

There were two issues, in particular, that arose in the study that need to be considered in the context of clinical practice. The first issue was the discriminatory and judgmental practices of many health care providers that were reported by the study nurses as negatively influencing the healthcare experiences of people who use drugs. The second issue was related to the scope of regulatory practice by nurses who work with people who use drugs. In the latter instance, the questions were specifically related to practice boundaries surrounding the supervision of illicit drugs. The study nurses shared their experience that some nurses in a desire to minimize harm, the stated objective of a harm reduction strategy, have reportedly found themselves in situations where physically assisting someone to inject their illegally procured drugs might appear to be the safer and less harmful option. Even though it is doubtful that it would occur, nurses who currently work in these practice environments must know that the illegal nature of the drugs in the syringe could technically place them in a position where they could be charged with possession should they even hold a syringe containing leftover residue (Gold, 2003). The

scope of practice is clear. The RNABC, in response to an inquiry made by the nurses at the Dr. Peter Centre in 2002, stated that “providing clients with evidence-based information to more safely give themselves intravenous injections is within the scope of nursing practice” (Wood, A. et al., 2003, p.23). Despite a client’s request for additional or hands-on assistance doing so would contravene the law. Nurses should be aware that according to the CNA’s Code of Ethics for Registered Nurses (2002), “nurses are not obligated to comply with a person’s wishes when this is contrary to law” (p.12).

Vigilance is required to ensure that practice boundaries are maintained equally in a consistent and supportive manner across the nursing team. It is particularly important, as evidenced by the experiences of the study nurses that all nurses are appropriately mentored and are provided with amply supported opportunities in which they can problem solve, practice boundary setting, and optimize their communication skills.

Research

Research almost always provokes more questions; this study is no exception. It would be interesting to conduct a larger scale ethnographic study that more clearly explicates how nurses, who practice from a harm reduction framework, develop therapeutic nurse-client relationships that contribute to the health of people who use drugs. In the present study, a number of the study nurses described having people return, after years had passed, and having them share the importance that the therapeutic relationship held for them at a particular time in their life. It remains difficult to quantify the specific interventions which produce positive outcomes in a holistic approach to addictions service (BC Ministry of Health, 2004). Nursing research with the specific aim

of exploring the quintessential nature of therapeutic engagement between nurses, who use a harm reduction framework, and with people who use drugs, is required.

Public Policy and Program Development

Decision making around policy and program planning has seen a shift away from opinion-based decision making to evidence-based decision making (Gray, 1997). In a recent reversal of this trend, the current Canadian national drug policy appears to be based more on opinion than evidence. It is important for policy planners to take heed of the massive body of global evidence and the ongoing research efforts in relation to the interventions of harm reduction as they continue to develop and modify relevant public health policy and programs. Pauly et al. (2007), in a recent article on harm reduction, exhort nurses to take action at the policy reform level to improve the lives of people who use drugs. They advise that nurses should,

Join those who recognize the failure of prohibition and its impact on public health as part of their ethical responsibilities within a broader commitment to social justice. Action on drug policy reform must be part of a broader agenda to enhance social justice that seeks to take action on the underlying conditions that produce poor health such as homelessness, violence, poverty and racism.

p. 22.

The call for action is both clear and necessary. Nurses are well positioned professionally to advance the interests of this marginalized client group. Reversing the current government's decision to limit the expansion of, and to close, the existing harm reduction-focused health care settings are the first order of priority. A larger call for nurses to stop prohibition by lobbying for amendments to the Canadian Controlled Drugs

and Substances Act appears necessary. Introducing a regulatory market system to control currently prohibited drugs would do much to alleviate the misery and death that nurses know to be a direct consequence of prohibition. Pauly et al. cite the CNA Code of Ethics, which says “an ideal system of law would be compatible with ethics, in that adherence to the law should never require the violation of ethics. There may be situations in which nurses need to take collective action to change a law that is incompatible with ethics”. They then assert, “the criminalization of illicit drugs is such a law” (p.22). The gauntlet has been dropped; as a starting point nurses should insist that the harm reduction approach be made available, in all nursing practice settings, to people who use drugs.

Concluding Remarks

Although the findings of this study are pertinent to anyone who delivers care and support to people who use drugs, nurses have a pivotal role to play due to their ability to provide health care service delivery care to clients in various health care settings. With their history of acting as advocates and promoters of holistic care models, nurses, in collaboration with other health care providers and policy makers, are positioned to lead the way in advancing a health care approach using harm reduction philosophy and interventions, to conduct pertinent research, and to develop policies and programs that begin to address the lived reality for people who use drugs.

The findings from this study can be used to highlight and make visible the issues that people who use drugs confront in the context of their daily lives. Increasing the visibility of these issues is the first step towards ensuring that programs and policies are designed in a manner that best meets the needs of people who use drugs. In the same

way, the perceptions and experiences shared by the compassionate and dedicated group of nurses, who are working in a unique and cutting-edge practice environment, need to be heard by others. Despite personal challenges and ongoing controversy, the study nurses' commitment to advancing, on the frontlines of health care service delivery, a harm reduction framework in practice is inspiring. Policy and procedures delineating clear practice guidelines, administrative support, and opportunities for mentoring are required to further advance nursing practice through the lens of harm reduction. It is imperative that the findings of this study are circulated and discussed, and that future research is directed towards understanding the lives and experiences of people who use drugs. It is also critical that the development of programs and policies bring about a positive change in the health and well-being of people who use drugs. It is past the time for debate, rhetoric and a war on drugs mentality. It is necessary that the cultural script in regard to drugs, and to the people who use them, continues to be rewritten.

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Appendix A: Letter of Initial Contact for Potential Participants

Attention Nurses!

Your participation in a UBC School of Nursing Research Project is requested

Study Title:

A Harm Reduction Orientation in Nursing Practice: How Nurses who work with Injection Drug Users in the Downtown Eastside of Vancouver Make Meaning of their Nursing Practice

Why You?

- You work in a cutting edge nursing practice setting using harm reduction interventions in your daily nursing work.
- You are one of the few nurses in North America working in an environment where a wide-range of harm reduction interventions is offered to injection drug users.
- The larger discipline of nursing would benefit from hearing about your unique experiences in working with injection drug users using a harm reduction approach.
- The voice of nurses who use harm reduction in daily nursing practice with injection drug users is missing from the nursing literature; you can help address this omission through participation in this nursing research.

What do you have to do?

- Respond to this email indicating your interest.
- Wait to be contacted by Patti Zettel, the study co-investigator.

Then what do you have to do?

- Donate a maximum of four hours of your time to participate in two group interviews (each lasting no longer than two hours) held in a relaxing, low-key setting with your nursing peers and have a discussion focused on your nursing work: harm reduction in nursing practice!

We Look Forward to Hearing from YOU (We really do NEED YOU!)

Appendix B: 1st Interview Guide**First Group Interview Question Guide, January, 2007****1. What led you to work with injection drug users in the downtown eastside of Vancouver?**

Describe your first exposure as a nurse to injection drug users?

How would you describe your view of drug use and drug users then?

What, if anything did you know about harm reduction?

2. What do your family and friends say when you tell them where you work?

How do you describe a typical day at work to them?

What do your family and friends say when talk to them about harm reduction?"

3. Can you think of a day when you went home feeling good about yourself as a nurse? What happened that day?

How would you describe yourself as a nurse on a day like that?

What do you value about yourself on a day like that?

4. Can you think of a day when you went home feeling badly? What happened that day?

Can you tell me how you view harm reduction on days like that?

5. What keeps you coming back to work everyday?

Have your views about drugs users and harm reduction changed since you began working with people who use injection drugs in the DTES?

Is there a difference in working with injection drug users in a practice environment with a harm reduction philosophy?

Tell me how you would describe yourself as a nurse now that you do this type of work?

What, if anything, most contributed to this change?

Do you see yourself doing this type of work in 2 year? 5 years? 10 years?

What, if any, advice would you give to a nurse new to harm reduction in the nursing care of people who use injection drugs?

6. Is there anything that you might not have thought about that occurred to you during this discussion?

Is there anything you would like to ask me?

Appendix C: 2nd Interview Guide**Second Group Interview Question Guide, May/June, 2007**

Now, I want to dig a little deeper and talk more about us, as a group of nurses. I want you to know that I may be poking and prodding around a bit more but I believe it is necessary so we can get to the heart of why we are doing what we do.

Why? Because we remain the only group of nurses in North America doing what we are doing in harm reduction within the scope of our daily nursing practice.

I am interested in really describing not necessarily what we do but how we do it and who we are. What skills do we have? What do we have in common? What do we personally have (those of us who do this work) that makes us so suited to it.

So, I want to get to some of the hard questions about this work and what we have in common besides being wonderful.

- 1. A new nurse comes and starts working with you and you know that she doesn't have what it takes? How do you know and what happens to her?**
- 2. What makes you good at what you do?**
- 3. What do you personally get out of the work you do?**
- 4. Why are you doing this? What do you bring to this work that makes you do what you do?**
- 5. What nursing skills has your frontline harm reduction practice given you that you could share with nurses still in the hospital?**
- 6. Do you see any similarities with yourself and the people who live down here?**
- 7. What is it that makes you a person who nurses the people on the DTES instead of being one of them?**
- 8. Sometimes a situation in our work puts us in some pretty dicey circumstances; between legal and illegal, street and establishment, safe and unsafe health care practices. Let's talk about what those situations are like for you?**
- 9. Can you describe what it is like when you are pushed to the edges of your comfort zone? Or over?**
- 10. What is it like to be a nurse in one of those facilities; in a place where you are watching drug use all day long?**

11. How do you cope? What do you do?

So...Harm reduction is both a philosophy and a set of interventions.

Examples of the interventions are the safe site and prescription heroin (NAOMI).

12. Do you agree with harm reduction initiatives? Why?**13. What do you really feel about drug users?**

The Canadian federal government is slated to make a big announcement related to drug strategy. They are going to introduce tough new anti-drug legislation and dedicate lots of funding to prevention and treatment strategies. Very little is earmarked for harm reduction.

14. How do you feel about that?**15. How will you feel if they close Insite?****16. Do you think we are making the DTES a healthier community?****17. What exactly are we doing down here?**

What's our effect?

What's our purpose?

18. How would you feel in 20 years if InSite was still open and nothing had changed in the lives of users? Would that still be OK for you?**19. In doing this work, I sometimes think we are trying to prove something... to ourselves, to our clients, to the middle class. (Some big doomed social experiment) What do you think?**

I want to end where we left off in the first interview. **What advice would you give to a nurse new to working with drug users and harm reduction?**

THE UNIVERSITY OF BRITISH COLUMBIA

Appendix D: Consent Form



School of Nursing
T201–2211 Wesbrook Mall
Vancouver, B.C. Canada V6T 2B5
Tel: 604-822-7417
Fax: 604-822-7466

Consent Form**Title of Study:**

A Harm Reduction Orientation in Nursing Practice: How Nurses who work with Injection Drug Users in the Downtown Eastside of Vancouver Make Sense of their Nursing Practice

Principal investigator:

Dr. Angela Henderson, Associate Professor, UBC School of Nursing.
Telephone Number: 604-822-7426.

Co-Investigator:

Patti Zettel, Masters of Science in Nursing Student, UBC School of Nursing.
This research study is being undertaken to fulfill the co-investigator's MSN Thesis requirements.

Study Purpose:

The purpose of this study is to describe how nurses who use a harm reduction philosophy in their work with injection drug users make meaning of their nursing work.

You are being asked to participate in this study because you work as a registered nurse in a Clinic where the use of harm reduction interventions is part of your daily nursing practice with injection drug users.

Study Procedures:

Should you choose to participate in this study, you will be asked to participate in two group interviews, each lasting no longer than two hours (total time commitment = 4 hours), between January, 1 and April 1, 2007.

The group interviews will be audio-taped and conducted by the co-investigator.

Risks:

Your time and commitment to this research project is important and every effort will be made to minimize the risk of inconvenience. The researcher is appreciative of your understanding and will attempt to schedule the group interviews at a time and place of greatest convenience to the majority of the group.

The known risk associated with participating in this study is the unlikely prospect of uncomfortable or embarrassing moments in sharing experiences or stories in a group setting. The researcher will be alert to signs of stress or anxiety associated with the interview and every effort will be made to provide an atmosphere of group support, respect and safety.

In the unlikely event that nursing practices that could be described as dangerous or unethical are disclosed during the course of the group interviews, the researcher will arrange for the group or individual nurse group, as the situation dictates, to meet with a Nursing Practice Consultant from the CRNBC for purposes of clarification and direction.

Benefits:

There is no monetary compensation associated with this study. In appreciation of your participation the researcher will host a pizza party after both group interviews in which you are involved.

By contributing to this study you may derive potential benefit from the opportunity to share your experiences, beliefs and stories with the researcher and your colleagues.

Your unique perspective may also contribute to advancing nursing practice using harm reduction with injection drug users for the larger profession of nursing.

Confidentiality:

The data generated by this study will be used to fulfill the UBC School of Nursing Thesis requirement. The audiotapes and all data generated by this study will be shared with the co-investigator's Thesis Committee

(Angela Henderson, RN, PHD; Geertje Boschma, RN, PHD and Alison Phinney, RN, PHD). Raw data will also be shared with a professional transcriptionist hired by the co-investigator.

All original consents and audiotapes will be kept in a locked cabinet for a minimum of five years and documents stored on the co-investigator computer hard drive will be password protected.

Your name and other identifying information will be deleted on the transcripts. No participants in this study will be identified by name in any reports of the completed study. The data generated by this study will be used solely for the purposes of this study.

Contact for Information about the study:

If you have any questions or desire further information with respect to this study, you may contact Dr. Angela Henderson at 604-822-7426.

Contact for concerns about the rights of research subjects:

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598.

Consent:

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy.

Your signature below indicates that you have received a copy of this consent form for you own records.

Your signature indicates that you consent to participate in this study.

Subject Signature

Date

Printed Name of the Subject signing above



Appendix E: Ethics Approval

The University of British Columbia
Office of Research Services
**Behavioural Research Ethics
Board**
Suite 102, 6190 Agronomy Road,
Vancouver, B.C. V6T 1Z3

CERTIFICATE OF APPROVAL - MINIMAL RISK

PRINCIPAL INVESTIGATOR: Angela D. Henderson	INSTITUTION / DEPARTMENT: UBC/Applied Science/Nursing	UBC BREB NUMBER: H06-03486
INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:		
Institution	Site	
N/A	N/A	
Other locations where the research will be conducted: N/A		
CO-INVESTIGATOR(S): N/A		
SPONSORING AGENCIES: Helen Shore Nursing Endowment Fund (nursing) Katherine McMillan Fund (Nursing) Monica Mary Green Fund (nursing)		
PROJECT TITLE: A Harm Reduction Orientation in Nursing Practice: How Nurses who Work with Injection Drug Users in the Downtown Eastside of Vancouver Make Meaning of their Nursing Practice		

CERTIFICATE EXPIRY DATE: November 30, 2007

DOCUMENTS INCLUDED IN THIS APPROVAL:			DATE APPROVED:
Document Name	Version	Date	
Protocol:			November 30, 2006
Helen Shore Nursing Endowment Fund Grant Application	N/A	October 25, 2006	
A Harm Reduction Orientation in Nursing Practice: How Nurses who work with Injection Drug Users in the Downtown Eastside of Vancouver Make Meaning of their Nursing Practice	N/A	November 23, 2006	
Katherine McMillan Director's Discretionary Fund Grant Application	N/A	October 25, 2006	
Monica Mary Green Grant Application	N/A	October 25, 2006	

<u>Consent Forms:</u>		
HR Consent	N/A	November 23, 2006
<u>Advertisements:</u>		
HR Recruitment Material	N/A	November 11, 2006
<u>Questionnaire, Questionnaire Cover Letter, Tests:</u>		
HR Trigger Questions for Initial Group Interview	N/A	November 11, 2006
<u>Other Documents:</u>		
Permission to Conduct HR Study with NAOMI Nurses from Dr. Martin Schechter	N/A	November 11, 2006
<p>The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.</p>		
<p><i>Approval is issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:</i></p> <p>Dr. Peter Suedfeld, Chair Dr. Jim Rupert, Associate Chair Dr. Arminee Kazanjian, Associate Chair Dr. M. Judith Lynam, Associate Chair</p>		