COMMUNITY NURSES' EXPERIENCES AND PERCEPTIONS OF WORKING IN SUBSTANCE USE HARM REDUCTION: A PHENOMENOLOGICAL STUDY

by

Amanda Ruck

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Author's Declaration

I hereby declare that I am the sole author of this dissertation. This is a true copy of the dissertation, including any required final revisions, as accepted by my examiners. I understand that my dissertation may be made electronically available to the public.

Abstract

Canada is experiencing an ongoing and rapidly unfolding drug poisoning crisis that is especially prevalent in northwestern Ontario. Substance use is complex with significant physical and social impacts, including patient experiences of stigma, discrimination and resultant health inequities. Harm reduction is an important component to providing holistic care for individuals impacted by substance use. Given nurses' proximity to patients, along with their training in relational practice and compassion, they are in a position to implement harm reduction interventions and principles in their care. Harm reduction initiatives have been implemented in northwestern Ontario, but research on nurses' experiences and perceptions working in this area has been limited. The purpose of this dissertation was to explore the lived experience of nurses working in substance use harm reduction in a northern setting. van Manen's phenomenology was used as the methodology to guide the research. The study includes the voices of eighteen nurses who work in substance use harm reduction. Participants were interviewed and data was analyzed using van Manen's phenomenology to uncover the lived experience of their work. The data was analyzed and categorized in van Manen's lived world existentials, including lived relationality, space, body and time. Within the nurses' harm reduction practice, care was perceived and experienced as relationally contingent, with trust playing an important role in relationship development. Facilitators of trust and relationship development are explored. In addition to lived relationality, the nurses described the essence of their experiences related to lived space. The nurses' conceptualizations of the space of harm reduction and factors underpinning the conceptualizations are described. Related to lived body, harm reduction work as an embodied experience is explored, including several psychological and some physical experiences. Additionally, how nurses protected the body from these impacts are described. Finally, in lived

time, motivations to work in harm reduction, reasons to stay, shifted perceptions, and the future direction of harm reduction are detailed. This work offers implications for practice in northern settings, practice recommendations and potential areas for future research.

Committee

This dissertation is the work of Amanda Ruck in collaboration with her PhD Committee:

Dr. Rebecca Schiff, PhD, Deputy Provost and Professor University of Lethbridge and Adjunct Professor, Lakehead University

Dr. Helle Møller, PhD, Associate Professor, Lakehead University

Dr. Deborah Scharf, PhD, Adjunct Associate Professor, Lakehead University

Dedication

I dedicate this PhD to those who have been affected by substance use and/or lost someone to it.

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Table of Contents

1.0 Chapter One: Introduction and Rationale

1.1 Introduction

Canada is experiencing an ongoing and rapidly unfolding drug poisoning crisis that is especially prevalent in northwestern Ontario (Government of Canada, 2019; Office of Chief Coroner [OCC], 2025; Public Health Ontario [PHO], 2022). Of particular significance are the physical (Canadian AIDS Treatment Information Exchange [CATIE], 2018; Government of Canada, 2021b, 2022a, 2022b; PHO, 2022) and social (Meadows, 2008; Pauly, 2008a; Pauly et al., 2015; Simon et al., 2020) impacts of substance use. In 2024, Thunder Bay, a city in northwestern Ontario, experienced the highest population-adjusted rate of opioid toxicity mortality in the province (OCC, 2025). The World Health Organization (WHO; 2025a) recognizes the need for abstinent-based approaches to substance use, while also indicating that some individuals will continue to use, either temporarily or permanently. This highlights the need for approaches to reduce the negative social and physical impacts of substance use, which is consistent with how other organizations have described the need for harm reduction approaches (Canadian Mental Health Association [CMHA], 2026a; Harm Reduction International [HRI], n.d.).

Harm reduction involves practices, programs, and policies designed to reduce the negative health, social, and legal impacts of substance use, policy and law without requiring abstinence from substance use (HRI, n.d.). Nurses are, given their proximity to patients, along with their training in care and compassion, in a position to implement harm reduction interventions and principles in their care. Harm reduction initiatives have been implemented in northwestern Ontario (Kaufman, 2022), but research on nurses' experiences and perceptions working in this area has been limited. This paucity of research has been and continues to be

problematic considering the high rates of hospital admissions and the documented stigma and discrimination that individuals impacted by substance use face. Thus, research exploring nurses' work within harm reduction programs is warranted and understanding this lived experience may contribute to positive patient outcomes.

In this section, I position the topic by describing relevant background information related to substance use harm reduction, beginning with definitions of substance use, addiction, and the associated physical and social impacts of substance use. Then I review different theories of health and substance use, specifically outlining how substance use has been conceptualized by society. I describe the impacts of individualism and the resultant marginalization that individuals face, factors that increase health inequities and rationalize the need for harm reduction approaches and research around nurses' experiences and perceptions in harm reduction. Lastly, I describe substance use harm reduction, including its definition, principles, historical perspectives, and interventions.

1.2 Substance Use

1.21 Addiction Defined

Individuals use substances for a variety of reasons; however, for some individuals, use may lead to dependence and become problematic (Canadian Mental Health Association [CMHA], 2026b). The CMHA (2026b) defined addiction as a broad, complex phenomenon of problematic use that interferes with everyday life. Though many clinicians have used the term *substance addiction*, the *Diagnostic Manual of Mental Disorders* (American Psychiatric Association, 2022) has used *substance use disorder* as a mental disorder to describe the wide range of the disorder (i.e., from mild to severe), often encompassed by chronic relapses and

compulsive use. Although this is largely how addiction is defined, it is important to highlight that substance use has been understood in a number of ways, which are described in 1.24.

Illicit substances have been defined as substances whose nonmedical use is prohibited (Degenhardt & Hall, 2012). In Canada, these substances have been outlined in the Controlled Drugs and Substances Act and have typically included opioids, cocaine, amphetamine, and ecstasy-group substances (Government of Canada, 2020). Though the use of many illicit substances continues to be on the rise and have problematic impacts in Canada, this dissertation focuses mainly on opioids because of the current overdose crisis caused by opioids in Canada. The following sections describe opioid use statistics and impacts.

1.22 Opioid Use Statistics

Results from the Canadian Tobacco, Alcohol and Drugs Survey (2017) highlighted that the prevalence of psychoactive drug use among Canadians over 15 years old was almost 22% (Government of Canada, 2021a). Of the 3.7 million Canadians aged 15 years and older who reported use of an opioid medication in 2018, approximately 9.7% cited problematic use (Statistics Canada, 2022). In 2016, authors estimated the prevalence of people who inject drugs (PWID) in Canada to be 0.7 per 100 individuals aged 15 to 64 years, an increase from 0.55% in 2011 (Jacka et al., 2020). This increase was problematic, given the associated health and other impacts.

1.23 Opioid-Related Impacts

Recent trends show increasing and significant health-related impacts of substance use, in particular, the devastating effects resulting from the use of opioids among PWID demonstrate a need for harm reduction. The following section provides an overview of opioid-related impacts and their statistical trends: hospitalizations, overdoses/poisonings, overdose-related deaths,

blood-borne infections and chronic conditions. Mental health disorders as a comorbidity is also discussed.

1.231 Hospitalizations, Overdoses/Poisonings, and Opioid-Related Deaths. The rates of hospitalizations; overdoses, also referred to as poisonings; and resultant overdose deaths have pointed to a major opioid public health burden (Gomes et al., 2018; Government of Canada, 2022b, 2025a, PHO, 2020). From April 2020 to March 2021, Canadian data showed a 27% increase in opioid-related hospitalizations and a 62% increase in medical emergency service calls responding to overdoses when compared to the same time period for the year prior (Government of Canada, 2021b). Current 2025 data show that opioid poisoning related Emergency Medical Services (EMS) responses, emergency department (ED) visits and hospitalizations declined from the previous 12 months (Government of Canada, 2025a). The Government of Canada (2025b) attributes this decline mainly to changes in the drug supply (i.e., reduction in high-risk drug combination), improved availability of naloxone, and a reduction in the number of individuals at risk for overdose (as many individuals lost their lives previously). Canada is still experiencing 95 EMS responses, 64 ED visits, and 15 hospitalizations on average per day related to opioid toxicities (Government of Canada, 2025a).

Opioid-related deaths in Canada are also concerning, with the pandemic contributing to significant increases (PHO, 2020). There were 3,556 opioid-related deaths in Canada from January to June 2022, which equated to approximately 20 deaths per day. For a pre-pandemic comparison, there were on average eight deaths per day in 2016 and 12 per day in 2018 (Government of Canada, 2022b). More recent data show a decline in opioid toxicity deaths with 6,601 occurring in Canada from April 2024 to March 2025 (18 deaths per day), a 21% reduction from the year prior (Government of Canada, 2025a).

Indigenous people are over-represented in opioid death rates in Ontario. A report from the Chiefs of Ontario and Ontario Drug Policy Network (2023) indicate that from 2019-2022, the death rate from opioids for First Nations almost tripled and by 2022, stating "the rate of opioid-related deaths was 9 times higher among First Nations (12.8 deaths per 10,000 people; 196 people) compared to non-First Nations (1.4 per 10,000 people; 2,134 people) people" (p. 26).

Rates of opioid overdose deaths in northwestern Ontario remain particularly concerning. Public Health Ontario (2020) data indicated that Thunder Bay had the highest population-adjusted rate of opioid-related deaths in the province (i.e., 78.8 per 100,000), compared to the provincial average of 16.6 deaths per 100,000. This rate was an 82% increase from the year prior (PHO, 2022). Recently, the OCC (2025) reported that Thunder Bay still had the highest population-adjusted opioid toxicity mortality rate of 69.14 deaths per 100,000 in Ontario for the 2024-2025 period. For comparison, the provincial average for the same period was 14.3 deaths per 100,000 (OCC, 2025).

The negative impacts of opioids are not unique to Canada, reflecting an international crisis (Penington Institute, 2022). The United Nations Office on Drug and Crime (UNODC) (2024) estimates that globally the number of individuals using opioids doubled from 2010 (26-26 million) to 2020 (61.3 million). They recognize that opioid use disorder contributes to a high burden of disease, and "account for the majority of healthy years of life lost due to premature death and disability (71 per cent, 2019) and the highest share of global overdose deaths (69 per cent, 2019)" (p. 58). Much of this increase is attributed to opioid use and synthetic opioid availability (i.e., fentanyl and more recently nitazenes), being more dangerous and causing a higher risk of overdose than previous types of opioids, though type of opioid use differs by country (UNODC, 2024). International comparisons are also difficult as many countries do not

track opioid-related deaths in the same way, often due to substance use-related stigma, political climates, or fear of police harassment (Overdose Day, 2025).

1.232 Blood-Borne Infections. In addition to hospitalizations, overdoses, and opioid-related deaths, PWID are at risk of contracting human immunodeficiency virus (HIV) and Hepatitis C virus (HCV) from needle sharing. Research from CATIE (2018) indicated that when compared to individuals who did not inject drugs, individuals who did were 59 times more likely to contract HIV. In 2020, there were 1,520 new HIV infections in Canada, with 300 (19.8%) of them among PWID (Government of Canada, 2022a). This rate was an increase from 2018, when new infections among PWID were at 16.5%. In 2022, this percentage grew to 24.5%, with 453 new HIV infections among PWID (Government of Canada, 2024a). Blood-borne infections from injection drug use are also problematic worldwide (WHO, 2025b). Internationally approximately 10% of new HIV cases stem from PWID, with 1 in 3 HCV deaths from injection drug use (UNAIDS, 2020). Efforts to prevent blood-borne infections associated with injection drug use are important, given the health, social, community, and financial impacts not only on individuals affected by substance use but also the wider community.

1.233 Chronic Conditions. In addition to overdose-related deaths, and blood borne infections, literature links opioid use and chronic conditions, including gastrointestinal (i.e., constipation), respiratory (i.e., sleep-disordered breathing, respiratory depression, bradycardia and hypotension), cardiovascular (i.e., infarction and heart failure), central nervous system (i.e., dizziness, sedation, hyperalgesia), musculoskeletal (i.e., falls), endocrine (i.e., hypogonadism, sexual dysfunction, infertility, and fatigue), and immune system effects (i.e., infections; Baldini et al., 2012).

1.234 Mental Health as Comorbidity. Carleton University (2025) describes the term 'substance use health,' which emphasizes how substance use should be looked at holistically, not in isolation, highlighting the links between substance use and mental health. Other substance use-related health impacts have been described in the literature and have included behavioural and mental disorders (Unick et al., 2013). A report from the UNODC (2022) synthesized the literature on the connection between mental disorders and substance use disorder. Systematic reviews with meta-analysis have similarly found a high prevalence of substance use among people diagnosed with major depression disorder (Hunt et al., 2020), and mood and anxiety disorders (Lai et al., 2015). Hunt et al. (2020) found that the pooled prevalence of any substance use disorder in individuals with major depression disorder was 25%. For comparison, the prevalence of major depression disorder in Canada in 2022 was 7.6% (Statistics Canada, 2022).

The UNODC (2022) report details three interactions that can occur between substance use and mental health disorders. First, substance use disorder could occur due to a pre-existing mental health condition, often related to self-medicating. Second, substance use can precede and trigger a mental health condition. And third, environmental and other predisposing factors can increase the risk for substance use and mental health disorders (UNODC, 2022). Given the close association between substance use and other mental health conditions, an important focus of harm reduction involves understanding, preventing, and better addressing barriers to mental health treatment (Hunt et al., 2020; Kulig & Williams, 2011).

1.24 Theories of Health and Substance Use

The previous section described many of the negative physical impacts of substance use. This section discusses the four major theories of health (Bryant, 2016) and how substance use

has been conceptualized from each theory: medical paradigm (i.e., biomedical), behavioural/lifestyle, socioenvironmental, and structural/critical.

1.241 Biomedical Understandings. Nettleton (2013) noted that biomedical understandings of health and illness have historically dominated health care in the Western world. In biomedical understandings, social and material aspects of health are often ignored, with more emphasis being placed on physical health. This lack of attention to social and other non-physical dimensions of health was especially the case in Canada up until the Lalonde Report of 1974, which provided a broader perspective on health, paving the way for the Ottawa Charter on Health Promotion (WHO, 1986) and health care reform (Commission on the Future of Health Care in Canada & Romanow, 2002). Biomedical understandings are consistent with early understandings of substance use and addiction, especially in acute care, being medical treatment focused. Many substance use treatments and harm reduction interventions have come from and have relied on biomedical theories and understandings of health. However, an important criticism of the biomedical model has been the lack of consideration of the wider socioenvironmental context (Nettleton, 2013).

1.242 Behavioural Understandings. A medical understanding of substance use, as a brain disease requiring treatment, stemmed from the biomedical, behavioural, and lifestyle theories of health. Within these theories, behavioural risk factors often have been the focus, with an emphasis on individuals taking control to prevent their own health problems (Bryant, 2016) through active interventions requiring sustained effort (Stokols, 1996). Again, a criticism of the behavioural/lifestyle approach expressed by researchers has been the overemphasis on the ability of individuals to take control without consideration of the wider socioeconomic environment

(Nettleton, 2013; Raphael, 2009), or the social determinants of health (SDOH), further discussed below (Government of Canada, 2024b; Raphael, 2009).

1.243 Socioenvironmental Understandings. Building on the behavioural theory of health, the socioenvironmental approach has recognized the importance of the social environment and its impacts on health (Raphael, 2009). In addition, the socioenvironmental approach has emphasized that health is self-defined, meaning that individuals can experience a sense of health (Gregory et al., 2020), while simultaneously having an addiction and while living under unfavorable health determinants. Although there are largely agreements about many of the different factors determining our health including those listed by the Government of Canada (2024b; i.e., income and social status, employment and working conditions, education and literacy, childhood experiences, physical environments, social supports and coping skills, healthy behaviours, access to health services, biology and genetic endowment, gender, culture, and race/racism), determinants of health have been conceptualised in many different ways. One conceptualization that can be used to understand how substance use is understood is the one described in Loppie and Wien's (2022) "Understanding Indigenous Health Inequalities through a Social Determinants Model." The authors describe root, core, and stem determinants of health, as discussed further below.

1.2431 Root Determinants of Health. Root determinants are created as a result of political, social and economic contexts and "represent the foundations from which all other determinants evolve and are maintained" (Loppie & Wien, 2022, p. 15). The following section will discuss the association between colonization, residential schools, intergenerational trauma and substance use. It will also highlight the war on drugs and its impact on many other SDOH. Greenwood and de Leeuw (2012) indicate that consensus exists regarding the oppressive nature

of Canada's history of colonization, which have produced social and material inequities leading to health disparities. Urbanoski (2017) states that "...health inequities experienced by Indigenous people represent the embodiment of the structural and systemic disadvantages that result from the enduring legacy of colonization, which have served to displace and disconnect them from their communities, families and culture" (p. 1350). Research recognizes that problematic substance use is a "...symptom of the ongoing suffering experienced by Canada's Indigenous Peoples through colonial institutions and policies such as the residential school system" (Jumah et al., 2017, p. 616). Colonial practices including child abuse in the residential school system (Ross et al., 2015) and more broadly intergenerational trauma and racism (Jongbloed et al., 2017; Mutton & Fast, 2015) are associated with later problematic substance use (Ross et al. 2015).

Another related perspective is how the war on drugs treats substance use as a criminal issue, undermining individuals affected by substance use (Cohen et al., 2022). Cohen and colleagues highlight how employment (e.g., exclusion of individuals with criminal histories), housing (e.g., drug surveillance and evictions), and education (e.g., punishment) policies may undermine and negatively affect SDOH, further contributing to inequities. The authors indicate that, "healthcare professionals must understand the deep roots of the drug war as well as their role in both perpetuating and undermining drug war logic and practices" (p. 2032). Root determinants are critically important to recognize and address given they shape all other determinants (Loppie & Wien, 2022).

1.2432 Core Determinants of Health. Core determinants are defined as the precursors to the stem determinants (Loppie & Wien, 2022). The most commonly referenced core determinants of substance use are health care systems, access to health care (Canadian Nurses Association [CNA], 2017; Wang et al., 2016), community infrastructure (Spooner &

Hetherington, 2004), and the criminal justice system (Centre for Addiction and Mental Health, 2020). Both Schiff and Møller (2021) and Kulig and Williams (2011) make a case for how "place" is an important determinant of health, with Kulig and Williams concluding that place is a predisposing factor, which determines the health of a population and that with increased rurality, health status often worsens in Canada (Kulig & Williams, 2011). Related to substance use, distance to resources such as clean supplies, overdose prevention education, and mental health counselling may be a barrier in northern and rural settings (Pullen & Oser, 2014). In addition to place as a determinant, there is literature on barriers in accessing care among individuals who are affected by substance use. The first has to do with overall lack of services as historically substance use and addiction have been separated from other health problems and understood as a criminal issue (Cohen et al., 2022). In addition, lack of services, motivation, transportation, mobility challenges and stigmatization are common reasons given for not accessing services (Russell et al., 2019). Stigma and discrimination are commonly discussed in the literature as major barriers to health care access and will be explored further below.

In addition to health care access, community infrastructure, resources and capacities are important core determinants of substance use and can contribute to economic insecurity and further marginalization (Loppie & Wien, 2022). With a growing and evolving drug poisoning crisis, communities need investments to support human development across the lifespan (Spooner & Hetherington, 2004). Finally, the Center for Addiction and Mental Health (2020) developed a policy framework for understanding and addressing why individuals with mental illness and substance use disorder are over-represented in the criminal justice system, and highlight root determinants (Loppie & Wien, 2022) such as racism, structural poverty and

trauma, as well as other core determinants (Loppie & Wien, 2022) including lack of access to mental health resources, which need addressing (Centre for Addiction and Mental Health, 2020).

1.2433 Stem Determinants of Health. Emerging from both the root and core are the stem determinants (Loppie & Wien, 2022), which, related to substance use, include the physical environment, employment and income, education, food insecurity and health activities. Closely related and often described as an important social determinant of health are early childhood experiences (Government of Canada, 2024b). Several socioeconomic marginalization variables have been described in the literature related to substance use. Across the lifespan, some risk factors for substance use have been identified with a behavioural lens. These include substance use in pregnancy, difficult temperament among children, early emotional and behavioural disturbances, inability to self-regulate, and early exposure to substances in social settings (Spooner & Hetherington, 2004). These factors also have specific risk factors such as poor parenting, cognitive limitations, and low family income (Spooner & Hetherington, 2004). In addition to behavioural factors, several studies seek to describe how other stem determinants are connected with substance use. For example, a systematic review of homelessness as a predictor for substance use included 38 studies and found that housing stress and homelessness were associated with not only substance use, but also overdose mortality risk (Austin et al., 2021). This is echoed in a recent scoping review by Lin et al. (2024) reporting poor neighbourhood conditions as a risk factor for substance use.

In addition, van Draanen and colleagues (2020) conducted a systematic review seeking to explore socioeconomic marginalization as a determinant of opioid overdose risk. The authors described socioeconomic variables as “criminal justice system involvement, income, employment, social support, health insurance, housing/homelessness, education, and composite

measures of socio-economic status" (van Draanen et al., 2020, p. 1). The authors included 37 studies in the review and found that the majority reported an association between at least one socioeconomic factor and the risk of substance overdose (van Draanen et al., 2020). Within Ontario, authors Cairncross and colleagues (2018) conducted a population based descriptive study demonstrating that individuals living in lower income neighbourhoods have substantially increased opioid related harms compared to individuals living in higher income neighbourhoods. Low social economic status (SES) and substance use has shown a bi-directional relationship in that low SES can increase the risk of substance use, and substance use can increase risk of low SES. This contributes to "…a self-perpetuating cycle […] between low socio-economic status and drug use, which is likely to embed itself within disadvantaged sectors of the community" (Spooner & Hetherington, 2004, p. ix).

Another perspective on substance use and vulnerability stems from a review, which outlines how social based stressors can impact vulnerability to substance use (Amaro et al., 2021). The authors indicate that prolonged exposure to stressors (e.g., poverty, discrimination, conflict, abuse, neglect, isolation etc.) can predict substance use disorders. The authors say that "social determinants of health and inequities are systemic and structured external forces or stimuli that can result in chronic activation of the stress response" (Amaro et al., 2021, p. 5). Early childhood experiences have also been linked with substance use (Felitti, 2003). Felitti's (2003) work described a dose-response pattern between the number of adverse childhood experiences and adult alcoholism and injection drug use (Felitti, 2003). This work is consistent with how Dr. Gabor Maté (2008), a Canadian author, describes addiction and emphasizes how stress, trauma, and early childhood experiences can profoundly shape brain development and vulnerability to later substance use and addiction.

In addition to the socioeconomic variables described, prior use of illegal substances has been found to be associated with food insecurity (Bragazzi et al., 2021), and low educational attainment has been linked with future substance use (Kendler et al., 2018). Overall, food, housing, education, and income as stem determinants are basic human needs. Substance use harm reduction may play a role in addressing stem determinants, specifically by educating individuals and communities of risks, connecting individuals to housing and employment resources, and providing emergency food boxes. Social determinant models are important as they can "...inform collective efforts to reinforce our societal structure with integrity" (Loppie & Wien, 2022, p. 52). McKenzie and colleagues (2016) call for further investigation into the interaction of determinants and how they contribute to the experiences of substance use and addiction.

1.244 Structural and Critical Understandings. According to Raphael (2009), structural and critical approaches, also known as neo-materialism, have been concerned with the organization of society and "define health in terms of an unequal distribution and control of economic and social power and resources within a society" (Bryant, 2016, p. 42). Critical approaches have involved challenging those with power, understanding how political ideology and the distribution of resources impact health, and knowing how the SDOH are organized (Bryant, 2016). Overall, relying solely on biomedical and behavioural understandings of substance use fail to consider not only the impact of social inequities but also to see the whole person. Understanding substance use through a socioenvironmental and structural/critical approach is consistent with harm reduction approaches and principles (MacNeil, 2025).

1.25 Individualism, Stigma, and Discrimination

How substance use has been and continues to be conceptualized by society has contributed to stigma and discrimination of individuals impacted by substance use. In practice and in the public's view, substance use has often been understood as being caused only by proximal (i.e., lifestyle) determinants (McKenzie et al., 2016). Typically, substance use has been viewed through biomedical and behavioural theories of health perspectives rather than perspectives acknowledging the "ideological, social, and economic systems" (Lushin & Anastas, 2011, p. 382) that determine health.

Meadows (2008) stated:

> Drug addiction is not the failing of an individual and no one person, no matter how tough, no matter how loving, can cure a drug addict—not even the addict. It is only through understanding addiction as part of a larger set of influences and societal issues that one can begin to address it. (p. 2)

Substance use has often been viewed through a lens of individualism, attributing it to personal failures and leading to victim blaming. This view has been directly related to societal understandings of substance use (i.e., behavioural and biomedical perspectives) as well as the failure to accept substance use as a legitimate type of risk-taking behaviour, as society has done with other forms of risk-taking behaviours (e.g., mountain climbing, car racing, jet-skiing; Inciardi & Harrison, 2000). Biomedical and behavioural understandings of substance use alone without consideration of the wider socioecological determinants has been problematic because it has contributed to the stigma surrounding problematic substance use and addiction, resulting in stereotypes and further marginalizing an already vulnerable population (Bryant, 2016; Pauly, 2008a).

Researchers have broadly discussed the impact of stigma and discrimination among individuals who use substances and its relation to health inequities (Earnshaw, 2020;

Hatzenbuehler et al., 2013). Stigma has been defined as “a social process that exists when labeling, stereotyping, separation, status loss, and discrimination occur within a power context” (Earnshaw, 2020, p. 1301). The author differentiated between structural (i.e., public/organizational policies) and individual (i.e., perceivers and targets) stigma. Earnshaw made important distinctions between prejudice, a feeling toward individuals who use substances (e.g., disgust, hate, resentment), and discrimination, which “spans unfair or unjust behavior directed at people with stigmatized statuses” (p. 1303). Other researchers looked at structural stigma among individuals in in-patient care settings and found that it manifested in several ways (Rehmen et al., 2024). These include through health care access (i.e., observed shorter periods of care for individuals who injected drugs), financial/physical infrastructure (i.e., budget, resources, staffing), care plan development/delivery (i.e., skill sets, level of experience) and discharge/follow up (i.e., pre-mature discharge).

Stigma and discrimination can lead to social isolation (Earnshaw, 2020); delayed access to health care/medical intervention (CNA, 2017; Earnshaw, 2020; Pauly, 2008a; Raphael, 2009); and premature discharge from hospital against medical advice when needs are not being met (Simon et al., 2020). Additionally, Febres-Cordero et al.’s (2023) work outlines how individuals who are impacted by substance use are often impacted by being called ‘a drug addict.’ The authors’ work highlights social processes including the stigma associated with being labelled drug seeking, as well as other factors including medical stigma, racism, neglect, and insufficient pain and withdrawal management. These situations further contribute to health inequities experienced by individuals affected by substance use. The result can be worsened health outcomes and unnecessary, preventable, or avoidable health issues. All of these experiences, coupled with the high levels of opioid related EMS responses, ED visits and hospitalizations,

underscore the need for multifaceted ethical approaches to care involving substance use harm reduction, that promote human rights, dignity and access to care.

1.3 Substance Use Harm Reduction

Included in this section are a definition of substance use harm reduction and its associated principles, along with a historical perspective and descriptions of interventions currently in use.

1.31 Harm Reduction Definition and Principles

Although no universal definition exists for substance use harm reduction, a generally accepted one involves "policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws" (HRI, n.d.). The focus of harm reduction is to reduce the physical (e.g., blood-borne infections, overdoses, and high mortality), as well as social (i.e., stigma, discrimination) harms associated with substance use (Souleymanov & Allman, 2016). Harm reduction also has been described more broadly as a "philosophy and set of strategies that proposes a value neutral shift towards drug use in policy and practice" (Pauly, 2008a, p. 6). Drucker et al. (2016) referred to harm reduction as a new treatment paradigm that involves "meeting people where they're at." This paradigm requires understanding the continuum of behaviours in substance use that ranges from severe use to abstinence and working with individuals using non-judgemental attitudes in goal setting, regardless of where they are on the continuum, without expecting abstinence (HRI, n.d.). This strengths-based approach has been effective with individuals who have been otherwise resistant to traditional treatment regimens (Drucker et al., 2016). Indigenous harm reduction is defined by the First Nations Health Authority (2026) as more than just reducing harm from substances:

> It goes beyond keeping people safer while using substances. Indigenous harm reduction means undoing the harms of colonialism, which place Indigenous people – First Nations,

> Métis and Inuit – at higher risk of harmful substance use. This means a decolonized, Indigenized approach to harm reduction that re-connects people to culture, and rebuilds relationships with the interconnected spiritual, human and natural worlds. (para 2)

A harm reduction approach and philosophy to care are indicated by and concerned with the growing drug poisoning crisis and related health, social, and economic impacts. Canada and several other countries are continuing to experience an ongoing and rapidly unfolding drug poisoning crisis (UNODC, 2024), requiring a human rights approach.

Harm reduction principles in the literature (Ball, 2007; Beirness et al., 2008; Inciardi & Harrison, 2000) have included pragmatism, humanistic values, human rights, and transparency. The principles have focused on strong evidence, immediate goals, acknowledgement of change, challenges to harmful policies, and involvement of individuals with lived experience (Beirness et al., 2008). Pragmatism recognizes using substances as inevitable, citing both benefits and risks of their use (Inciardi & Harrison, 2000). A harm reduction approach promotes respect for individuals, autonomy, and dignity while focusing on the harms as being more important than the use (Inciardi & Harrison, 2000).

Harm reduction approaches have been consistent with recommendations that health care providers be less paternalistic and care approaches be more consumer driven (Nettleton, 2013). The use of harm reduction philosophy, principles, and interventions are grounded in social justice. At the intrapersonal level, authors discuss the need for shifts in the values that guide caring for individuals affected by substance use, including behaviours related to reciprocal trust, active listening, understanding life circumstances, and promoting empowerment (Iammarino & Pauly, 2021). The authors highlight the need for respectful language when referring to individuals who use substances. This includes the need to challenge stereotypes and harmful language. At the institutional level, the authors highlight the need to include harm reduction as

an important component of cultural safety to reduce discrimination and stigma. Overall, harm reduction involves an equity approach that emphasizes non-judgemental care and the recognition and understanding of the wider socioenvironmental and structural impacts on health (Jegede et al., 2024).

1.32 Historical Perspectives of Harm Reduction

Harm reduction policies go back to the 1920s, when a group of physicians in England suggested that it may have been occasionally beneficial for individuals to stay on drugs that allowed them to lead more productive lives (Hilton et al., 2001). Although methadone maintenance therapy was introduced in Canada in the 1950s, and nicotine replacement therapy in the late 1970s, it was not until the HIV and AIDS epidemics of the 1980s with increasing morbidity and mortality rates related to the impacts of injection drug use that harm reduction discourses increased (Danda, 2021; Drucker et al., 2016). In 1987, opioid harm reduction became the emphasis of Canada's national drug strategy, with the first needle exchange program opening, unofficially, in Toronto, Ontario (Fischer, 1999). Canada then saw an expansion of outreach and street nursing that focused on prevention, early detection, and treatment (Hilton et al., 2001). These efforts provided opportunities to develop and maintain trust between providers and high-risk and otherwise hard-to-engage individuals. Moving into the 2000s, harm reduction in Canada started to include safe consumption sites and the expansion of needle exchange programs. However, in 2011, the federal government threatened to close Insite (i.e., Canada's first safe consumption site in British Columbia) because it went against the Controlled Drug and Substances Act (CNA, 2013).

In response, the CNA (2013) wrote a position statement synthesizing literature and recommendations on harm reduction. In the same year, the Supreme Court of Canada ruled on

Insite and introduced Bill C-65 (now Bill C-2) entitled Respect for Communities Act, to amend the Controlled Drug and Substances Act to exempt the section disallowing individuals to bring pre-obtained substances to the site when indicated for medical purposes or public interest (CNA, 2013). This ruling led to exemptions under the act that "should be generally granted where evidence demonstrates that a site stands to decrease death and disease without negatively affecting public safety" (CNA, 2013, p. 6). Despite several challenges associated with obtaining exemption of section 56, as outlined by the CNA, several safe injection sites now operate across Canada (CNA, 2013). As discussed, legal barriers to harm reduction present significant challenges and researchers, such as Inicardi and Harrison (2000), have identified the need to change the way that certain laws are enforced as well as the laws themselves. More recently (i.e., shortly after data collection occurred for this work), the Ontario provincial government amended the Community Care and Recover Act and Bill 223 (Ontario, 2025a). The amendments mandated the closure of several safe injection sites and government encouraged the existing sites to submit proposals to transition to a Homelessness and Addiction Recovery Treatment (HART) Hubs model (Ontario, 2024). Reports indicate that while they would receive more funding under the HART Hub, they would not be able to offer supervised drug consumption services (CBC, 2025).

As portrayed in the aforementioned legal history in Canada, much of the harm reduction movement originated from the ground up—rather than from the top down—by activist and health care provider groups, with the nursing profession taking the lead. Many needle exchange programs and safe injection sites operated, unsanctioned, prior to the legal exemption. Often this situation was attributed to the "historical antagonism to drug users and continued misunderstanding of harm reduction" (Drucker et al., 2016, p. 246), that led to several challenges in addiction medicine and care. Insite has been celebrated as a significant example of harm

reduction in Canada, driving pressure in other sectors of health (Drucker et al., 2016). Overall, health care providers, nurses in particular, and activists have the power to enact change, promote social justice, and influence public policy.

1.33 Harm Reduction Interventions and Evidence of Effectiveness

As previously defined, harm reduction refers to an approach to care with specific interventions to reduce the risk of harm associated with substance use. Examples of specific harm reduction interventions are needle exchange programs, opioid overdose prevention programs, naloxone programs, drug maintenance approaches, heroin-assisted treatment, and prescribed opioid alternative therapies. Details about each example follow.

1.331 Needle Distribution Programs. Often cited as the first harm reduction intervention, needle distribution programs supply sterile needles to individuals who inject drugs or are at risk for injecting drugs, with the aim of preventing the reuse and sharing of needles, along with the spread of blood-borne infections (CNA, 2017). These programs also aim to increase access to support by providing education and referrals as necessary (CNA, 2017). The research on needle distribution programs is developed, having looked at positive outcomes such as HIV seroconversion, HIV seroprevalence, HIV risk behaviours, and cost effectiveness (PHO, 2024; Ritter & Cameron, 2006; Wodak & Cooney, 2006). An overview of 13 systematic reviews, a total of 133 studies, found that needle distributions programs were effective in meeting their goal of reducing the transmission of HIV and injecting risk behaviours (Fernandes et al., 2017). A more recent scoping review looked at needle distribution program sustainability and described implementer factors (i.e., willingness and self-efficacy), implementation process (i.e., coalitions, activists, bottom-up approaches), community support, and policies as important considerations for sustainability (Resiak et al., 2021).

1.332 Opioid Overdose Prevention Programs. The following section presents descriptions of opioid overdose prevention programs, supervised injection and consumptions sites, and naloxone programs.

1.3321 Safe Consumption Services (Supervised Injection and Consumption Sites). In addition to needle distribution programs, supervised injection and consumption sites are also common substance use harm reduction interventions. Often referred to broadly as drug consumption facilities or rooms, they have been described as legal facilities allowing individuals to consume pre-obtained drugs under professional supervision (CNA, 2017). Supervised injection sites provide supervision for those injecting substances, and supervised consumption sites provide supervision for individuals inhaling substances (CNA, 2017). The main purpose of these sites is to prevent fatal overdoses, reduce the risk of blood-borne infection transmission and other precarious behaviours, provide support and referrals, and reduce public disorder (CNA, 2017). A systematic review of 22 articles evaluating supervised injection sites found that most studies reported reduced overdose morbidity and mortality rates, and reduced other harms due to safer injection behaviours, increased access to addiction resources, and no increases in crime (Levengood et al., 2021). A more recent scoping review found similar quantitative results and also included qualitative reports relating to patient safety (i.e., patient reports of learning safer injection practices and feeling safer when using the sites; Dow-Fleisner et al., 2022).

1.3322 Naloxone Programs. Naloxone programs are another well-known harm reduction intervention. Naloxone is an opioid antagonist that can temporarily reverse an overdose caused by an opioid (CNA, 2017). Several harm reduction programs include naloxone training as well as education and distribution of naloxone. A systematic review of 22 observational studies found

that take-home naloxone programs were effective in reducing the risk of fatal overdose (McDonald & Strang, 2016).

1.333 Drug Maintenance Approaches. Methadone and suboxone are two common opioid agonist therapies used in detoxification to relieve withdrawal symptoms and in maintenance therapy to reduce use. A systematic review of 20 studies found that methadone reduced withdrawal symptoms (Amato et al., 2013). Similarly, researchers noted that suboxone also was effective in reducing withdrawal symptoms (Mariolis et al., 2019). Suboxone became the first line of treatment of individuals with opioid use disorder because of its pharmacological characteristics and flexible dosing (Center for Addiction and Mental Health, 2021). Though a recent prospective cohort comparing methadone and buprenorphine effectiveness among a group of individuals diagnosed with opioid use disorder did not find a statistically significant difference between treatment type and response (Naji et al., 2025).

1.334 Prescription Heroin. Prescription heroin, also known as diacetylmorphine (CNA, 2017) or heroin-assisted treatment (HAT), is another pharmacological harm reduction intervention (Canadian Drug Policy Coalition, 2021). It is meant for use with individuals with chronic heroin addiction, with the goal of reducing heroin use and criminal activity to obtain heroin (CNA, 2017). From 2005 to 2008, Canada took part in the North American Opiate Medication Initiative, which included a clinical trial of HAT. Despite positive outcomes, the government was not supportive and ended the program in 2008 (Canadian Drug Policy Coalition, 2021). Some HAT still occurs in Vancouver, Canada, but not without legal challenges (Canadian Drug Policy Coalition, 2021).

1.335 Prescribed Opioid Alternative Therapies. Formally known as safe supply, a medicalized approach where health care providers prescribe medications to individuals with the

goal of preventing overdoses and resultant deaths. It is a relatively newer harm reduction strategy that has gained attention with recent policy changes to approve its implementation (Government of Canada, 2022c). An environmental scan of safe supply programs in Canada identified 81 safer supply sites. The research has described the medications prescribed, settings of sites, funding, and qualitative data to support indications for safe supply (Glegg et al., 2022). More recently, researchers have differentiated between safe and safe(r) supply approaches. Results from a scoping review indicate that safe(r) supply approaches can include both medicalized and non-medicalized approaches. The authors present several different model case studies, including prescribing opioids while also offering or co-prescribing opioid agonist treatment. The authors recommend moving away from the terminology "safe(r) supply [and instead use] prescribed opioid alternative interventions" (Do et al., 2026, p. 10). Other researchers recently conducted a qualitative study exploring facilitators and barriers to a safer supply pilot program in Canada (Nafeh et al., 2025). Facilitators included patient-centered models, ongoing evaluation, integration of wraparound services, partnerships, community support, evidence-informed practices, and multidisciplinary teams. Barriers included the unregulated drug supplies, complicated policies, funding, limited medication availability, limited space, and staffing (Nafeh et al., 2025). Additionally, quantitative research in Canada showed public support in Alberta and Saskatchewan for safer supply programs for individuals unable to stop using (Morris et al., 2023).

1.4 Summary and Overview of the Chapters

This chapter offered contextual and background information to understand the indications for harm reduction approaches, interventions, and research. The chapter included descriptions of addiction and associated opioid-related impacts, including the increasing rates of blood-borne

infections, hospitalizations, overdoses, poisonings, chronic conditions and deaths. Also discussed were the impacts of the ways that society understands substance use primarily from medical and behavioural theories and the risk of stigma and discrimination resulting solely from individualistic understandings of use. The role of SDOH in substance use was also discussed. All of this highlights the need for approaches to reduce the negative social and physical impacts of substance use, which is consistent with how many organizations have described the need for harm reduction approaches. This chapter then provided information about harm reduction as an approach to care by detailing its principles, historical perspectives, and interventions. This contextual information sets the stage for the following chapter, chapter two, which presents the results of a literature review on health care providers' experiences and perceptions of working in or using substance use harm reduction interventions/approaches. Details about the nursing role in harm reduction are included, as is an exploration of methodological limitations and gaps in the literature that led to the research questions and significance of the study.

Chapter three provides explanations of the theoretical framework, methodology, and methods that guided the research. The chapter outlines how critical social theory (CST) was used as the theoretical framework and describes my own philosophical assumptions and interpretive framework in the research. It provides indications for qualitative inquiry, more specifically detailing how phenomenology was employed. It describes specific methods that were used and explains ethical considerations in research. Chapter four, which presents the findings of the research, is organized using van Manen's (1990) lifeworld existentials of lived relationality, lived space, lived body, and lived time. Each section describes the themes and subthemes of the nurses' experience working in harm reduction related to that existential. Themes and subthemes are described and supported with quotes from the nurses' interviews. Chapter five, the

discussion, provides an overview of the major findings and discusses and situates them within the literature. Policy and practice recommendations are included, as well as areas for future research.

2.0 Chapter Two: Literature Review

I begin this chapter by describing the literature search that I conducted to ascertain, evaluate, and critique the existing knowledge on nurses' experiences and perceptions of working in harm reduction (see Appendix A). Literature was included in the review if it focused on experiences, perceptions, views, or roles in substance use harm reduction. The search produced articles with samples comprised of a variety of health care providers, and articles were included in the review if the study participants included nurses. An additional search that included gray literature was conducted to further clarify the nursing role in harm reduction and the ways that harm reduction parallels with relational inquiry and ethical nursing practice, the foundations of nursing curriculum.

2.1 Health Care Providers' Experiences and Perceptions of Substance Use Harm Reduction

The literature search identified studies using quantitative and qualitative methodologies to ascertain health care providers' experiences and perceptions of substance use harm reduction. The following are descriptions of the settings, populations, and types of programs represented in the literature. Also presented are the themes of the literature search, which included support/willingness/confidence, ethical considerations, burnout/unappreciation, perceived role, use of relational harm reduction and barriers and facilitators of integrating interventions and/or employing harm reduction.

2.11 Settings

The literature search revealed that substance use harm reduction occurs by health care providers in a variety of health care settings. Settings where studies were conducted included

Emergency Departments (EDs; Badke et al., 2024; Bessen et al., 2019; Criswell et al., 2024; Dieujuste et al., 2021; Ilievska et al., 2025; Jiao et al., 2024; Michels et al., 2024; Punches et al., 2020; Reed et al., 2023) and acute care in-patient hospital units (Cleirec et al., 2018; Forchuk et al., 2023; Gatewood et al., 2016; Osinski & Afseth, 2024). Other studies were conducted in community/primary/clinic care (Anderson et al., 2022, Carlberg-Racich, 2016; Creasy et al., 2025; Ellefsen et al., 2024; Limbu, 2008; McCall et al., 2019, 2023; Nguyen et al., 2024; Peckham et al., 2018; Speight et al., 2023; Van Hout et al., 2018; Whitfield et al., 2025) and others multiple or unknown settings (e.g., combination of clinical and non-clinical settings, combination of community and acute care; Bounthavong et al., 2020; Ford, 2010; Gray, 2014; Pauly, 2008b; Shreffler et al., 2021). In addition to specific settings in the health care system, studies were published in a variety of locations. For example, many studies were conducted in the United States (Bessen et al., 2019; Bounthavong et al., 2020; Carlberg-Racich, 2016; Creasy et al., 2025; Criswell et al., 2024; Dieujuste et al., 2021; Gatewood et al., 2016; Michels et al., 2024; Peckham et al., 2018; Punches et al., 2020; Reed et al., 2023; Shreffler et al., 202l; Speight et al., 2023). Eight studies were published in Canada (Badke et al., 2024; Denis-Lalonde et al., 2023; Forchuk et al., 2023; Ilievska et al., 2025; Jiao et al., 2024; McCall et al., 2019, 2023; Pauly, 2008b); two in France (Cleirec et al., 2018; Gray, 2014); two in the United Kingdom (Anderson et al., 2022; Van Hout et al., 2018); and one in each of Australia (Ford, 2010), South East/South Asia (Limbu, 2008), Vietnam (Nguyen et al., 2024) and Norway (Ellefsen et al., 2024). Two studies included clinicians from multiple countries: of these, one was a systematic review (Osinski & Afseth, 2024) and the other was a primary study (Whitfield et al., 2025).

2.12 Populations

In addition to the variable health care settings already described, the literature search found articles that included many different types of health care providers: physicians, nurse practitioners (NPs), nurses, nursing students, pharmacists, and social workers. Several studies focused primarily on prescribers, specifically physicians and NPs (Bounthavong et al., 2020; Carlberg-Racich, 2016, Dieujuste et al., 2021; Peckham et al. 2018; Speight et al., 2023; Whitfield et al., 2025). Many studies included a variety of health care providers (Badke et al., 2024, Cleirec et al., 2018; Creasy et al., 2025; Ellefsen et al., 2024; Forchuk et al., 2023; Haug et al., 2016, Jiao et al., 2024; McCall et al., 2019, 2023; Nguyen et al., 2024; Osinski & Afseth, 2024; Reed et al., 2023; Shreffler et al., 2021; Van Hout et al., 2018), while others focused solely on nurses' perspectives (Criswell et al., 2024; Ford, 2010; Gray, 2014; Ilievska et al., 2025; Limbu, 2008; Michels et al., 2024; Pauly, 2008b; Punches et al., 2020), with one study including only nursing students (Denis-Lalonde et al., 2023).

2.13 Types of Harm Reduction Programs

As described earlier, a variety of harm reduction programs and interventions exist, however much of the research on health care provider experiences and/or perceptions has focused on naloxone programs/administration (Badke et al., 2024; Bounthavong et al., 2020; Criswell et al., 2023; Dieujuste et al., 2021; Haug et al., 2016; Michels et al., 2024; Osinski & Afseth, 2024; Punches et al., 2020). Other research has been conducted on HIV prevention and care (Carlberg-Racich, 2016; Creasy et al., 2025; Limbu, 2008); opioid-assisted treatment (McCall et al., 2019; Speight et al., 2023); opioid-specific harm reduction (Jiao et al., 2024); and methadone programs (Nguyen et al., 2024; Van Hout et al., 2018). More recent studies have been conducted on fentanyl test strip distribution (Reed et al., 2023), safe supply (Whitfield et al., 2025), heroin-assisted therapy (Ellefsen et al., 2024), and safe consumption sites (Ilievska et al.,

2025). Some studies have been conducted in a variety of settings and/or not specifying the type of harm reduction intervention or program (Denis-Lalonde et al., 2023; Ford, 2010; Gray, 2014; Pauly, 2008b; Peckham et al., 2018; Shreffler et al., 2021). The following section will describe the themes from the literature review including support/willingness/confidence, ethical considerations, burnout, perceived role, use of relational harm reduction, and harm reduction barriers and facilitators.

2.14 Support, Willingness, and Confidence

Historically, research has indicated that health care providers overall often have negative attitudes toward caring for individuals affected by substance use (Danda, 2021). This has been evidenced by Punches et al. (2020) who conducted qualitative research in EDs and found that some nurses lacked enthusiasm for participating in naloxone programs (Punches et al., 2020). Similarly, Ford's (2010) quantitative research indicated that some health care providers showed more support for abstinence-based measures over methadone programs or safe consumption sites. However, more recent quantitative studies (Criswell et al., 2024; Michels et al., 2024), published in the United States of America, found that many emergency nurses were willing to distribute naloxone resources and generally were supportive of naloxone distribution for individuals at risk. Authors recommended further education to improve willingness scores and further research on factors influencing willingness (Criswell et al., 2024).

Research has also shown that health care providers reported neutrality towards (Ilievska et al., 2025; Jiao et al., 2024), varying levels of willingness (Jiao et al., 2024), and confidence with harm reduction interventions (Nguyen et al., 2024). This is evidenced by quantitative survey research among ED nurses which indicated that they felt neutral toward safe consumption sites and described some concerns about the sites by agreeing or being neutral toward statements that

the sites created dangerous neighbours and promoted drug use (Ilievska et al., 2025). Most nurses in this study had no or limited experience with safe consumption sites (Ilievska et al., 2025). A mixed methods study found that among ED physicians and nurses, willingness to carry out harm reduction interventions was tied to being prepared and trained adequately, and opportunities to work collaboratively to support patients with ongoing care (Jiao et al., 2024). The authors stressed the importance of including substance use education in nursing curricula to better prepare nurses to engage in harm reduction. Confidence providing methadone maintenance was assessed in a survey study of primary care providers in Vietnam (Nguyen et al., 2024). The authors asserted that clinicians who had methadone treatment experiences reported higher confidence in treatment and less stigma associated with individuals who used substances.

2.15 Ethical Considerations

Some researchers have reported that health care providers have expressed ethical and moral conflict related to harm reduction interventions and programs (Denis-Lalonde et al., 2023; Osinski & Afseth, 2024; Pauly, 2008b; Punches et al., 2020). In particular, qualitative research of nurses' perceptions of naloxone programs has shown that they believed that it might condone substance use, further contributing to the problem (Punches et al., 2020). The nurses in Punches et al. (2023) study thought that their role should be to educate and hinder individuals from using rather than condoning use (Punches et al. 2020). Moral distress was also cited by nurses working in the ED after caring for several individuals who had overdosed (Punches et al., 2020). Similarly, Pauly (2008b) found that although nurses supported harm reduction as a philosophy, they simultaneously identified moral/ethical concerns, including having difficulty determining whether nurses were actually reducing harm at times. Examples of concerns included caring for pregnant women who used substances or caring for patients using substances and refusing

antibiotics, potentially putting the wider community at risk (Pauly, 2008b). On a broader level, some nurses in Punches et al.'s (2023) study believed that naloxone programs in the ED may have been an inequitable use of funds and that patients would not want it or use it. Similarly, participants in another study indicated that repeat users of the system were wasting health care resources and time (Pauly, 2008b).

2.16 Burnout and Feelings of Unappreciation

In addition to ethical considerations, health care providers cited burnout (Haug et al., 2016) and reported feelings of unappreciation related to providing harm reduction interventions (Punches et al., 2020). Haug et al. (2016) reviewed health care providers' posts on social media (i.e., X, formerly known as Twitter) and used a grounded theory approach to construct themes related to their attitudes toward naloxone. A variety of health care providers were included in the study, with nurses representing 13% of posts. Descriptive analysis revealed that the health care providers felt burned out and reported worker fatigue associated with naloxone, with nurses showing the highest levels of burnout, followed by emergency medical services (Haug et al., 2016). Qualitative research has also shown that nurses felt unappreciated after providing care for individuals who overdosed, even though some recognized that the verbal abuse may have been related to withdrawal and the need to access more substances (Punches et al., 2020).

2.17 Perceived Role

In addition to burnout/unappreciation, another theme that emerged from the literature was perceived role (Carlberg-Racich, 2016; Denis-Lalonde et al., 2023; Dieujuste et al., 2021; Punches et al., 2020; Speight et al., 2023). Specifically, some health care providers questioned whether it was their role to provide harm reduction interventions and education (Carlberg-Racich, 2016), perceiving it to be outside of the scope of NPs (Speight et al., 2023) and

questioning whether the ED setting was appropriate for the interventions (Punches et al., 2020). In particular, the physicians in Carlberg-Racich's (2016), qualitative phenomenological study of providers—mostly physicians but included some nurses—working in primary care clinics in locations with high rates of HIV, outlined that many physicians did not perceive harm reduction to be part of their perceived role; rather, they thought that it should be provided by substance use counselors or other staff instead.

Researchers have also used quantitative methods to ascertain ED physicians and NPs perceptions of take-home naloxone programs. Similar to qualitative research, surveys have indicated that practitioners thought that prescribing naloxone was beyond their scope, with researchers calling for the need to reexamine the role of providers in these settings and incorporate the role within education (Dieujuste et al., 2021). Although useful information, only 16% of respondents were NPs, and the authors did not discuss if physicians, physician assistants, and nurses had different perceptions. The study also focused on prescribing naloxone only (Dieujuste et al., 2021). In a more recent study, participants (i.e., physicians, nurses, pharmacists, and social workers) identified the ED as a crucial setting to offer naloxone, though cited several barriers to its facilitation (Badke et al., 2024). Results from another qualitative study informed by critical social theory found that nursing students believed that harm reduction was inherent to nursing practice and was part of their role (Denis-Lalonde et al., 2023).

2.18 Use of Relational Harm Reduction

Another theme that more recent literature has focussed on is the use of relational harm reduction (Creasy et al., 2025) and relationships (Ellefsen et al., 2024; Reed et al., 2023). Authors differentiate between structural and relational harm reduction approaches (Creasy et al., 2025). Structural interventions were those outlined in 1.33, including naloxone, needle exchange,

safer supply and methadone maintenance programs, as well as consumption services. Creasy et al., (2025) indicate that, “harm reduction is also a relational approach to care encompassing principles such as patient autonomy and pragmatism that can be implemented in healthcare teams to improve outcomes for PWH [people with HIV] who use drugs” (p. 2). These authors investigated HIV health care workers’ use of harm reduction interventions in their practice to ascertain their attitudes and experiences using harm reduction. This study included several types of health care providers. Creasy et al. characterized patient-provider interactions as positive and negative, describing how these interactions either met or did not meet harm reduction principles, highlighting missed opportunities to integrate principles and recommending increased harm reduction training. In a qualitative study investigating the experiences of clinicians in providing heroin assisted therapy (HAT), the participants described HAT as a relational approach (Ellefsen et al., 2024). In another qualitative study exploring the experiences of clinicians working in the ED with the distribution of fentanyl test strips, the study participants described the strategies that they used for the implementation, including relational dimensions of harm reduction (Reed et al., 2023). Strategies included being understanding and using open mindedness, citing that patients felt empowered and respected from the experience; in some cases, it aided in developing rapport with their patients.

2.19 Harm Reduction Barriers and Facilitators

The previous section described the experiences and perspectives held by health care providers in relation to harm reduction programs and interventions. Several harm reduction barriers also were identified in the literature review, including individual and system level, as well as some facilitators.

2.191 Individual/Personal Barriers. Researchers have indicated that a major individual or personal barrier to understanding and implementing harm reduction in their practice is the stigma around substance use (Bounthavong et al., 2020; Denis-Lalonde et al., 2023; Forchuk et al., 2023; McCall et al., 2019, 2023; Pauly, 2008b; Shreffler et al., 2021; Speight et al., 2023; Van Hout et al., 2018). For example, authors described health care providers who offered and provided naloxone perceiving and labeling individuals as addicts (Bounthavong et al., 2020). This was not surprising because as described previously, there is a long history of stigma associated with substance use caused by the behavioural or biomedical understanding of substance use.

People who use drugs were not the only ones being stigmatized; they were care providers who choose to work with people who use drugs. Health care providers (e.g., nurses, social workers, and peer support workers) expressing an understanding of substance use and/or had chosen to work in harm reduction with a population impacted by substance use (McCall et al., 2019, 2023) were stigmatized. Similar sentiments were echoed in another qualitative study of primary care clinicians indicating that the participants experienced stigma as buprenorphine prescribers, with one participant reporting being bullied by others who did not agree with her practice (Speight et al., 2023). Fear of stigma, as well as society's understanding of substance use, may impact health care providers' choice to work in harm reduction and should be further explored.

In addition to stigma being an individual barrier, health care providers have reported patients being barriers in and of themselves (Carlberg-Racich, 2016; Van Hout et al., 2018). A phenomenological study, primarily with physicians, identified challenges such as patients not coming to their appointments, not adhering to medication regimes, and not "recogniz[ing] the

problems their use may cause" (Carlberg-Racich, 2016, p. 17). The physicians often reported being suspicious of the motives of their patients (Carlberg-Racich, 2016). Van Hout et al. (2018) conducted focus groups in Ireland among prescribers—primarily physicians—to determine barriers to a methadone treatment program. Similar to Carlberg-Racich's (2016) results, authors identified difficult patient-related factors, including behavioural challenges associated with polysubstance intoxication (Ellefsen et al., 2024) and additional complexity caring for people experiencing homelessness (Van Hout et al., 2018).

2.192 System-Level Barriers. In addition to individual barriers, system level barriers have been identified in previous studies. The following section presents details about lack of education/training, lack of time, and information management as common system-level barriers identified in the literature.

The literature review held qualitative and quantitative studies indicating that health care providers reported a lack of education/training related to substance use harm reduction (Badke et al., 2024; Carlberg-Racich, 2016; Denis-Lalonde et al., 2023; Haug et al., 2016; McCall et al., 2019; Michels et al., 2024; Osinski & Afseth, 2024; Peckham et al., 2018; Speight et al., 2023; Whitfield et al., 2025). Some researchers specified lack of training related to specific harm reduction interventions (Haug et al., 2016; Peckham et al., 2018). Authors reported that health care providers were unprepared and untrained generally to care for individuals affected by substance use (McCall et al., 2019).

Studies with samples of health care providers identified time (Badke et al., 2024; Bounthavong et al., 2020; Carlberg-Racich, 2016; Forchuk et al., 2023; Jiao et al., 2024; Michels et al., 2024; Peckham et al., 2018; Reed et al., 2023); space (McCall et al., 2023; Reed et al., 2023; Speight et al., 2023); complexity of care (Van Hout et al., 2018); and a lack of providers

(Ellefsen et al., 2023; Van Hout et al., 2018) as additional barriers. A phenomenological study conducted with primarily physicians and some nurse participants indicated that the nurses, compared to the physicians, reported fewer barriers to implementing harm reduction interventions and that they were well positioned to be local champions of such interventions (Carlberg-Racich, 2016). The author recommended training to address the barriers and system-level policy changes to provide additional time to address complex problems often involved in caring for individuals impacted by substance use. Van Hout et al. (2018) discussed the lack of harm reduction providers as a system-level barrier. They discussed the need for all general practitioners (GPs) to be trained in the treatment of opioid dependence, including prescribing methadone, and the potential to use pharmacy and NPs in rural areas without GPs.

Finally, researchers have cited information management (Bounthavong et al., 2020) and challenges with lack of access to follow up (Badke et al., 2024) as barriers to harm reduction interventions. Researchers have used qualitative methods among naloxone prescribers to determine facilitators and barriers to prescribing practices, using academic detailing (i.e., integrating best practices around prescribing; Bounthavong et al., 2020). Prescribers also have indicated the need for better integration of information to be able to navigate all of the data needed to prescribe naloxone (Bounthavong et al., 2020).

2.193 Facilitators. In addition to individual and system-level barriers, the literature review revealed facilitators of harm reduction (Anderson et al., 2022; Dieujuste et al., 2021; Pauly, 2008b, Van Hout et al., 2018). Facilitators are described in the following themes: cohesive teams with aligned values, education/training, information management, and other perceptions. Having cohesive teams with aligned values were described by some researchers as important facilitators (Anderson et al., 2022; Pauly, 2008b; Van Hout et al., 2018). Nurses'

proximity to the patients and non-judgemental attitudes were additional facilitators, including pre-existing relationships that nurses had with patients (Anderson et al., 2022; Pauly 2008b). Facility leadership was another important facilitator (Dieujuste et al., 2021; Pauly, 2008b), especially to ensure values were being upheld and nurses had opportunities to raise concerns (Pauly, 2008b).

Education and training were described as facilitators in harm reduction (Bounthavong et al., 2020; Dieujuste et al., 2021; Forchuk et al., 2023; Van Hout et al., 2018). Forchuk et al. (2023) identified education as an important facilitator to address the stigma associated with substance use. Specifically, two studies (i.e., Bounthavong et al., 2020; Dieujuste et al, 2021) described education for prescribing naloxone practices as important facilitators. More broadly, other researchers described the need for all GPs to be trained in methadone prescribing and treatment for opioid dependence, as well as better staff education on available community supports for patients (Van Hout et al., 2018). Similarly, Nguyen et al. (2024) found that perceived work-related support was positively associated with confidence in facilitating methadone treatment.

Researchers of two studies reviewed in the literature (Bounthavong et al., 2020; Dieujuste et al., 2021) described information management as a potential facilitator. The health care providers in the studies indicated that a system generating lists of patients at risk for opioid overdoses or prompting prescribers to facilitate naloxone prescribing would be helpful. Expanding scope of practice and other broad perceptions of health care providers also were discussed as facilitators. One study that identified lack of rural GP as a barrier suggested ways that community pharmacists and/or nurses could be used to better facilitate naloxone prescription in isolated areas (Van Hout et al., 2018).

Other perceptions of health care providers were discussed as facilitators in the literature. For example, the health care providers in McCall et al.'s (2019) study perceived that access to harm reduction provided stability in many of the individuals' lives and was rewarding, impacting their own lives by providing a sense of hope. In Punches et al.'s (2020) study, some health care providers working in the ED indicated that the setting was an opportunity to promote harm reduction interventions. Pauly (2008b) noted that the nurses in their study reported that working in harm reduction involved reducing the physical harms as well as providing an opportunity to reduce the social harms of substance use. This result is consistent with what the nurses in Anderson et al.'s (2022) study indicated about health care being built directly into community substance use and harm reduction resources providing more confidence by nurses in service provision.

In addition to expanding scope of practice, some studies described harm reduction as rewarding to clinicians working in the area. A qualitative study investigating the experiences of health care providers in HAT included the observed harm reduction outcomes, opportunities to provide holistic care, and the positive relationships developed (Ellefsen et al., 2024). This was echoed in another qualitative study of the perceptions of NPs about buprenorphine prescribing, with those who currently prescribe reporting it as rewarding work (Speight et al., 2023).

2.2 Implications for Nursing Practice

The previous section described the results of the review of literature on health care providers' experiences and perceptions working in or with substance use harm reduction. The following section provides details about the implications for nursing practice, including the role of nurses and nursing in the north.

2.21 Role of Nurses

Nurses working in acute, community, and primary care settings often care for individuals who are impacted by substance use and are well situated to provide harm reduction interventions (Abram et al., 2024; Limbu, 2008). The College of Nurses of Ontario (CNO, 2019) is Ontario's nursing regulatory body. The nurses in the context of this dissertation research had licenses to work in the province of Ontario, so it is important to discuss the CNO's role and expectations for competencies in harm reduction. Through legislation, the CNO is "accountable for public protection by ensuring nurses in Ontario practice safely, competently and ethically" (p. 3) and develop entry to practice competencies for the purposes of public protection, practice reference, approval of education programs, registration/membership requirements, legal reference, public information and continuing competence. The CNO made reference to harm reduction in its entry-to-practice competencies, specifically under the clinician role, with the objective stating that a nurse "incorporate principles of harm reduction with respect to substance use and misuse into plans of care" (p. 5). Nurses have had and continue to have an important role in mitigating the harms associated with substance use (CNA, 2017).

Limbu (2008) asserted that community-based nurses were in a good position to implement harm reduction interventions and "act as a 'bridge' between populations in need of treatment and legal, political, and health authorities aiming to help both clients and the community" (p. 213). Harm reduction programs may be the first point of contact for individuals impacted by substance use (CNA, 2017; Deren et al., 2017), and nurses, given their training in care and compassion (i.e., relational inquiry), can build trust by treating them as "patients," not "criminals," as well as engage otherwise hard-to-reach populations and connect them to services (Limbu, 2008). Nurses also can provide education about reducing the harms associated with

substance use by being in close proximity to patients and gaining their trust, which can empower patients to make informed decisions that reduce harm.

2.211 Relational Inquiry. Relational inquiry, the foundation of nursing curriculum and practice, requires that nurses look inward at themselves (i.e., intrapersonal) and at their patients (i.e., interpersonal), and consider the context of the patients and their work. Doane and Varcoe (2020) considered relational consciousness an important component of relational inquiry, noting that "a relational consciousness extends your attention beyond the individual level to the relational interplay occurring at and between the intrapersonal, interpersonal, and contextual levels" (p. 4). At the intrapersonal level, nurses understand what is going on within themselves, but they also need to be mindful of what is going on within their patients. At the interpersonal level, nurses' attention is directed toward what is going on within and between individuals. Context is important in relational inquiry because it involves what is going on around the individuals, that is, what forces and structures have influenced individuals and how have they shaped their intra- and interpersonal responses (Doane & Varcoe, 2020). Relational inquiry and consciousness set the foundation for nurses to use a harm reduction approach that requires them to look within to determine what biases and judgements (i.e., intrapersonal) are held against individuals who use substances; the impact of what they do on patients, and vice versa (i.e., interpersonal); and understand how the environment, as well as political and social structures (i.e., context) impact patients.

2.212 Ethical Nursing Practice. Harm reduction interventions are consistent with ethical nursing practice because they highlight patient autonomy while preserving opportunities to develop trust (Pauly, 2008b). Researchers stated that "nurses provide care that conforms to ethical guidelines along the continuum of prevention and treatment and can provide much-

needed services and interventions for PWUD [people who use drugs]" (Deren et al., 2017, p. 626). More recently, Kameg (2025) indicated that mental health nurses have an ethical duty to not only advocate for but implement harm reduction in their practice. One author suggested the need to develop nursing curriculum to increase nursing students' knowledge of the social conditions that impact individuals who are impacted by substance use and would benefit from harm reduction knowledge (Pauly, 2008b).

Harm reduction approaches are consistent with relational inquiry as well as strengths-based care (Gottlieb, 2014). Practicing strengths-based care means that nurses must develop awareness of their own strengths, weaknesses, and vulnerabilities to provide care that is more intentional, deliberate, and thoughtful (Gottlieb, 2014). The author described nurses' strengths, including mindfulness, humility, open-mindedness, non-judgemental attitudes, curiosity, self-reflection, respect and trust, empathy, compassion, courage, and self-efficacy, all of which are consistent with harm reduction approaches.

2.22 Nursing in the North

The Canadian North has been defined in several ways, and its definition has important social, financial and political implications (Schiff & Møller, 2021). The scope of this project was northwestern Ontario, which falls under the Provincial North, often referred to as the "Forgotten North" (Coates et al., 2015 as cited in Schiff & Møller, 2021). Rationale for investigation into the provincial north in Ontario relate to the health and economic inequities in northern regions compared to rural ones. As described prior, provincial rates of opioid related EMS responses, hospitalizations and deaths are all higher, per capita, in Thunder Bay, ON, compared to the provincial averages. Additionally, there are continued staffing shortages in northwestern Ontario with respect to health services (Ontario Medical Association, n.d.). The nursing shortage is

reflected in the provincial government's Stay and Learn Grant, where students who study in northern regions may be eligible for funding to cover the cost of tuition for human health programs—including nursing—if they commit to stay and work in the same areas post-graduation (Ontario, 2025b). The program provides funding for "underserved and growing communities in Northern, Southwestern and Eastern Ontario [and] responds to labour market needs, including in health care" (Ontario, 2025b, para. 2). The health inequities, including troubling rates of opioid related impacts and human health service shortages in northwestern Ontario, may contribute to additional barriers (e.g., complexity of care, lack of training and resources) for nurses working in these areas, warranting exploration.

2.3 Methodological Limitations and Gaps in the Literature

A major limitation identified in the review of the literature is related to the settings and populations in the various studies. Many of the researchers had interviewed or surveyed health care providers whose main role was in work outside of harm reduction; thus, rich or thick descriptions of nurses' experiences working in harm reduction is lacking and many practitioners in the theme focusing on perceived role questioned whether harm reduction was their role. There is a knowledge gap around how community nurses working in harm reduction build trusting relationships, what it means to "meet people where they're at" in the context of harm reduction, how nurses conceptualize the space of harm reduction and their role within it, how nurses are affected by their work, and what prompts nurses to pursue work in this area. These gaps are justification for the need to examine the experiences of nurses who work specifically in substance use harm reduction, that is, what does it mean to be nurses working in harm reduction contexts or programs.

A methodological limitation of these studies was that more of the research focused on quantitative methods and included health care providers other than nurses. Additionally, this author did not locate any phenomenological studies that explored the lived experience of northern nurses working in substance use harm reduction. In addition, much of the literature was published in urban settings in the United States, with fewer studies in Canada and none identified in the north. There is a lack of qualitative research focusing on the experiences and perceptions of northern nurses working in community substance use harm reduction programs.

2.4 Purpose Statement and Research Questions

The methodological limitations, the lack of qualitative inquiry producing thick and rich description of community harm reduction nurses' experiences, and the gaps in the literature identified above, particularly in the north, warranted further investigation. This study attempted to fill these gaps by focussing on the lived experience of nurses working in substance use harm reduction in a northern setting. This qualitative study followed a phenomenological approach to explore the unique experience of nurses who employed harm reduction approaches and interventions in their everyday work.

The study was guided by several research questions:

Experience/Meaning

1. What are the experiences of northern nurses working in harm reduction programs?
2. What are the contexts of the experience? How do different harm reduction contexts impact/affect the experiences?
3. How are nurses impacted by their work in harm reduction?

Role/Perception

4. How do northern nurses use harm reduction in their practice? What role do nurses play?

5. What are the perceptions of nurses working in harm reduction?

    a) What are their attitudes, beliefs, and values?

    b) What do nurses perceive as their role in harm reduction?

The overall objective and goal of the research was to explore northern nurses' experiences and perceptions of working in substance use harm reduction programs. The utility of this research is threefold. Exploring nurses' experiences and perceptions of working in substance use harm reduction will:

1. Provide an understanding of nurses' experiences that may help provide opportunities to better support nurses who currently work in this area.
2. Produce rich data that have the potential to inform areas in nursing where harm reduction interventions are not currently or as readily being carried out.
3. Help inform future nursing curriculum development to better educate and prepare nurses to work in harm reduction, thus having a wide impact on nurses' practice.

Overall, research exploring northern nurses' experiences and perceptions in harm reduction is needed, given (a) the increasing physical and social harms associated with substance use; (b) nurses' close proximity to patients and harm reduction's goal alignment with the nursing focus on relational inquiry, ethical practice, and strengths-based care; and (c) the missing voice of nurses who work directly in substance use harm reduction.

2.5 Significance of the Study

Researchers have agreed that even though a generalizable theory cannot come out of phenomenological studies, implications for practice can (van Manen, 2014; Wilson, 2015).

Students, nurses, nurse researchers, educators, and employers may benefit from insight into the experiences and perceptions of northern nurses working in community substance use harm reduction. Students and nurses may benefit from the study by having the opportunity to learn how others have experienced working in harm reduction. This learning may help students and nurses feel more prepared in choosing or continuing the path of caring for individuals impacted by substance use. For nurse researchers and employers, the findings from exploring the experiences of community nurses working in harm reduction will build on the existing literature and body of knowledge and may help to develop policies to support their work to better support nurses working in this area. In addition, nurse employers may consider the impact of contextual factors that influence experiences in harm reduction and make efforts to improve employment experiences for people caring for people impacted by substance use and improve the care provided to people impacted by substance use at the same time. For educators, the findings from this work may be used to inform future nursing curriculum development around harm reduction to better prepare nurses to work in the field by highlighting how nurses can best mobilize harm reduction in their practice; thus, having a wide impact on nursing practice.

2.6 Chapter Summary

This chapter summarizes the review of the research literature about the experiences and perceptions of health care providers working in and/or employing substance use harm reduction. The settings, samples, and types of programs found in studies were discussed, as well as literature review themes including ethical considerations, burnout/unappreciation, perceived role, use of relational harm reduction, barriers and facilitators. The role of nurses, relational inquiry and ethical nursing practice were discussed broadly in terms of the parallels between harm reduction and implications for nursing practice. The chapter concluded with an overview of

methodological limitation gaps in the literature, which lead into the purpose statement, research questions and overall significance of the question.

3.0 Chapter Three: Theoretical Framework, Methodology and Methods

Chapter three is an overview of the theoretical framework, methodology and methods used to guide this study. I describe the historical and central tenets of Critical Social Theory (CST) along with its use in nursing research and practice. I also describe its parallels with harm reduction. In addition, I provide details about my own positionality and assumptions of the phenomenon of interest, and the use of phenomenology as the methodological foundation.

3.1 Theoretical Framework: Critical Social Theory

Giacomini (2010) stated that "theories enter qualitative research as the assumptions that underpin expectations, methods, and analyses; they exit research in the form of findings and suggested implications" (p. 4). For the purposes of this research, CST is the paradigm or worldview of this author and thus informed all aspects of the research process. Presented next are explanations of the historical and central tenets of CST, and levels of analysis. I will then use CST's tenets to situate and underpin substance use harm reduction.

Freeman and Vasconcelos (2010) described CST as a process and an outcome merging multiple viewpoints involving evaluative and political activities to understand how things are and move them to where they should be. Philosophically, underpinning CST is the notion that history and context are important to understand social phenomena (Mooney & Nolan, 2006). Broadly, critical social theorists have been critical of the impacts of inequities and injustices in societal arrangements viewing "society as a human construction in need of reconstruction" (Freeman & Vasconcelos, 2010, p. 7). Morrow and Brown (1994, as cited in Browne, 2000) described CST as a "metatheoretical framework (theory about a theory)" (p. 39), which will be discussed further below in the section on how CST will underpin this research.

3.11 Historical and Central Tenets

Historically, CST was derived "out of the theoretical tradition of the Frankfurt School in the 1920s and 1930s, as left-wing intellectuals endeavored to reappraise Marxist theory and move the notion of domination and oppression beyond the realm of economic and class struggles" (Browne, 2000, p. 38). It emerged from analyzing capitalism and the need to modernize understandings of emancipation in the 20th century (Giroux, 1983, as cited in Manias & Street, 2000). In the 1980s, researchers began to question and express concerns with dominant empirical orientations, in particular with their ability to capture the political, economic, social and historical conditions that create power imbalances and oppression that ultimately impact health care and nursing practice (Kendall, 1992 as cited in Browne, 2000). CST indicates the need to look at the historical and sociopolitical contexts of health care (Ray, 1992 as cited in Browne, 2000).

Rather than represent one school of thought, CST includes several different "strands of theory" (Browne, 2000, p. 38). Within modern understandings of CST, there are four main theories that it draws from including the theory of false consciousness, the theory of crisis, the theory of education, and finally the theory of transformative action (Freeman & Vasconcelos, 2010). The theory of false consciousness involves looking at and understanding the social traditions and relations that create and maintain oppression, in particular how individuals in vulnerable situations may fail to recognize how social interactions harm them. The theory of crisis refers to positioning and characterizing the oppression and how dissatisfaction can threaten societal cohesion (Manias & Street, 2000 as cited in McCall et al., 2023). The theory of education refers to the processes and conditions necessary for enlightenment to come to fruition (Freeman & Vasconcelos, 2010). The theory of transformative action, which is emancipatory in nature, references the actions needed to resolve crises (Freeman & Vasconcelos, 2010).

3.12 CST and Nursing

CST as a philosophical and theoretical orientation has become more prevalent in nursing research and practice (Browne, 2000; Fassett et al., 2025; McCall et al., 2023) perhaps because of its emancipatory focus that aligns with the goals and worldview of nursing. Using theory with an emancipatory focus has required researchers to shift into the domain of developing practical useful knowledge that interrupts power inequities and is focused on socially transformative processes towards justice and equity (Manias & Street, 2010). Browne (2000) asserted that CST was an opportunity to bridge the gap between theory and practice to improve health inequities. In more recent nursing literature, researchers employed a CST perspective focused on reflection on practice, which aided participants in understanding the factors that impacted their work in caring for individuals impacted by substance use (McCall et al., 2023).

A central tenet of CST is power, especially who holds it and who does not (McCall et al., 2019). Power involves microaggressions, stigma, marginalization, and racism, concepts discussed previously in relation to substance use. CST is important in nursing because it can be used as a theoretical perspective for nurses to question what types of things are taken for granted, what norms are unchallenged, and what does and does not work (McCall et al., 2019) to uncover hidden meanings (Wilson-Thomas, 1995). In addition, the use of CST in nursing serves as a framework and an opportunity for health care providers to reflect on the current context of what is occurring in how health care is being carried out and how it contributes to inequalities (Mosqueda-Díaz et al., 2014), aligning with the central values of nursing (McCall et al., 2019).

3.13 CST and Substance Use Harm Reduction

Kerber et al. (2020) noted that harm reduction has a foundation in CST, a philosophical approach to understand and address the ways that individuals, societies, and communities are

unjust and oppressive, and the ways that power and social hierarchies promote the "othering" of individuals impacted by substance use. Kerber et al. stated that using CST to guide research could help to shift power dynamics, encourage empowerment and health equity.

CST and substance use-related harm reduction principles, values, and interventions hold many of the same tenets. Freeman and Vasconcelos (2010) stated that "critical social theorists are critical of what they see as pervasive inequalities and injustices in everyday social relationships and arrangements… [and that using CST involves] assessing how things are in order to transform them into what they ought to be" (p. 7). Stevens (1989), a nursing scholar, identified the overarching goal of CST as one that can "facilitate change in the structural conditions that, (a) distort or inhibit communication, (b) limit life options, (c) constrain action and/or (d) impose unequal economic, gender or racial imperatives" (p. 60).

Substance use harm reduction approaches and interventions, as already described, call for nurses to provide value-neutral and non-judgemental care focused on reducing harms rather than on use. They also want nurses to build trust with individuals impacted by substance use to build relationships with them to provide education and connect the individuals to services. To develop trust and provide non-judgemental care, nurses must engage in relational inquiry by understanding their own assumptions, values, biases (Doane & Varcoe, 2020). They also must understand power, norms, and the ways that the social determinants of health, oppression and marginalization lead to health inequities. My worldview is heavily rooted in CST, and this theory was used to underpin this research, in particular relating to, (a) how substance use is understood and (b) the need for harm reduction.

3.2 Methodological Foundations

3.21 Positionality and Assumptions of Phenomena of Interest

I want to preface this section by reflecting on and discussing my personal positionality in relation to the phenomenon of interest and the study. I am a White woman who grew up in a lower/middle-class home. During my adolescence and young adulthood, several close friends became addicted to substances and sometimes suffered accidental overdoses. One friend died from an overdose. I have experienced mental health concerns and addictions. In fact, throughout this dissertation process I have become sober from alcohol, something I struggled with for years. While I recognize I have some lived experience, I have not personally experienced the many hardships that the individuals who have accessed harm reduction programs have. My assumptions about substance use and harm reduction have also been influenced by my own experiences working as a registered nurse (RN) in an acute care hospital and community setting in northwestern Ontario.

When I was still new to the profession, I worked in a very busy acute care hospital as a float nurse trained to several medical units. I later moved into a community nursing position while attending graduate school. After completing a master's degree in public health with nursing specialization, I joined Lakehead University as the simulation lab coordinator and, more recently, as a full-time faculty member in the School of Nursing. In both clinical settings, I cared for individuals with a variety of medical conditions, including patients affected by substance use. My decision to pursue graduate school was heavily influenced by working with other health care providers who were judgemental toward individuals impacted by substance use and the overemphasis on treatment with little consideration for broader determinants of health. My decision to join academia was also influenced by these experiences and by the desire and opportunity to educate the nursing workforce of the future. It was important for me to share these experiences and their influence on how I see the situation and the research process.

3.22 Philosophical Assumptions and Interpretive Framework

Qualitative researchers begin their investigations by making assumptions and then using interpretive frameworks to guide the research (Creswell & Poth, 2017). Specifically, it guides the formulation of research questions and how researchers go about answering those questions (Creswell & Poth, 2017). The interpretive framework is also influenced by a researcher's experiences and training, and my positionality and assumptions of the phenomenon of interest informed my philosophical assumptions. Following are descriptions of the ontological and epistemological beliefs within this interpretive framework.

3.221 Ontological and Epistemological Beliefs. Ontological assumptions refer to the ways in which researchers view reality, and epistemological assumptions refer to what researchers count as knowledge, and how they are justified (Creswell & Poth, 2017). Giacomini (2010) classified ontologies along a continuum of realism and idealism.

My ontological beliefs are grounded in idealism. According to Giacomini (2010):

> Idealism…, holds that we have direct access only to our ideas and subjective experiences, and no empirical access to the world beyond, except through these ideas. It follows that when researchers study the world they necessarily examine only their mental constructs of it. Data do not correspond directly with reality; they are researchers' representations. This holds whether researchers study mental constructs themselves (e.g., cognition in the field of psychology), social constructs (e.g., culture in the field of anthropology) or the natural world (e.g., gravity in the field of physics). (p. 5)

Giacomini (2010) asserted that epistemological beliefs flow from ontological beliefs. Interpretive epistemologies are consistent with the idealist ontology: understanding the world as one of ideas about social phenomena and shared meanings and recognizing the researcher as an important component of the social world.

3.222 Social Constructionism. As the researcher, my worldview is strongly aligned with Burr's (2003) understanding of social constructionism. Burr (2003) suggests that individuals "mentally construct, rather than receive, their ideas of the world" (p. 5). Social constructionism is a theoretical orientation (Burr, 2003) consistent with idealistic ontologies and interpretive epistemologies.

Burr (2003) defined social constructionism in how it:

> …insists that we take a critical stance toward our taken-for-granted ways of understanding the world, including ourselves. It invites us to be critical of the idea that our observations of the world unproblematically yield its nature to us, to challenge the view that conventional knowledge is based upon objective, unbiased observation of the world.
> (p. 2)

Social constructionism acknowledges that study participants' perspectives reveal multiple realities, each a reflection of unique lived experiences (Burr, 2003). Within a social constructivist epistemology, data do not relate directly with reality; rather, they are co-constructed between researchers and study participants (Denzin & Lincoln, 2018) and shaped by the individuals' experiences. With this worldview, I sought to make sense of the world in which the participants lived and worked to rely specifically on their experiences to support their views of the situation.

I recognize that individuals develop subjective meanings of those experiences and knowledge is constructed between individuals. Burr (2003) emphasizes how "the goings-on between people in the course of their everyday lives are seen as the practices during which our shared versions of knowledge are constructed" (p. 3). With this lens, I understand experiences as not fitting into simple straightforward categories but as multiple, varied and complex experiences, instead (Creswell & Poth, 2017).

I also understand that experiences are shaped by context, including cultural norms and historical events (Creswell & Poth, 2017). Norms and historical events are important, given the nature of harm reduction, as described previously. The research questions guided the exploration of the nature of each participant's individualized and subjective reality and experience (Singh et al., 2022). Overall, this work uncovered the structures about the phenomena of interest, as well as the general meaning and experience of working in harm reduction, as experienced by the participants.

3.23 Rationale for Qualitative Inquiry

Creswell and Poth (2017) stated that qualitative research "involves closer attention to the interpretive nature of inquiry and situating the study within the political, social and cultural context of the researchers and the reflexivity or 'presence' of the researchers in the accounts they present" (p. 43). According to Creswell and Poth, qualitative research is conducted in the natural setting (i.e., collecting close-up data in the field where participants live/work/play), highlighting the use of researchers as a key instrument, with context and reflexivity being major features. Also consistent in qualitative research is the focus on the multiple perspectives and meanings ascribed to the participants' experiences of the issue/problem to develop a rich description and holistic account of the complex phenomena under study. Therefore, the focus is to describe "the complex interaction of factors in any situation" (Creswell & Poth, 2017, p. 44).

The research questions in this study required the use of a methodology that allowed for a complex and detailed description. To achieve rich data that are sensitive to the context of the participants, Creswell and Poth (2017) indicated the need to speak directly with people (i.e., via interview), ideally while in their settings (i.e., observations), which also empowers participants to share their stories and experiences. Given the research questions described earlier, together

with my ontological and epistemological beliefs, I used qualitative inquiry to guide this work. The following section provides a more in-depth description of the research methodology of phenomenology that guided this work.

3.24 Phenomenology

van Manen (1990) described phenomenology as a human science and wrote:

> Perhaps the best answer to the question of what is involved in a hermeneutic phenomenological human science research method is "scholarship!" A human science researcher is a scholar: a sensitive observer of the subtleties of everyday life, and an avid reader of relevant texts…as they pertain to his or her domain of interest. (p. 29)

Phenomenology was selected to guide this research because van Manen's approach resonated with me and aligned with the research question's focus on lived experience. Following are a definition of phenomenology; an overview of the origins and philosophical perspectives; and a description of the purpose of phenomenological research, including a rationale for its use in my study. Also included are details about the congruences and conflicts between CST and phenomenology, and a discussion of methodological challenges and limitations.

3.241 Phenomenology Defined. van Manen (1990) defines phenomenology as the "study of the lifeworld" (p. 9) with the aim to gain a deeper understanding of a phenomena or event of interest. The goal, according to van Manen (1990), is to uncover the essence or internal meaning structures of lived experience. Broadly speaking, the researchers' objective is to describe commonalities among individuals as they experience the phenomena, to ultimately describe the universal essence (Creswell & Poth, 2017). The purpose of phenomenology is to understand the human experience by studying the ways that individuals understand and experience their world as meaningful or real (van Manen, 1990).

3.242 Origins and Philosophical Perspectives. Phenomenology has a rich history in philosophy (van Manen, 1990, 2014). Philosophers Husserl and Brentano often have been referenced as the founders of phenomenology (Moran, 2000). By the end of the 19th century, much research focused on exploring the world through a positivist, empirical lens, and it was phenomenology that started to refuse the subject-object dichotomy (Lobiondo-Wood et al., 2018). The following section will describe Husserl's, Heidegger's and van Manen's phenomenology as well as differentiate between the two distinct schools of phenomenology.

3.2421 Husserl's Phenomenology. Edmund Husserl has often been referred to as the founder of phenomenology, being heavily influenced by the work of Brentano (Moran, 2000). Husserl and Brentano have been credited with developing such concepts as intentionality, consciousness, and descriptive investigation of inner perception (Moran, 2000). Husserl was a mathematician, and his work emphasized the reduction and epoché, also known as the "principle of presuppositionless […] that is, the claim to have discarded philosophical theorizing in favour of careful description of phenomena themselves, to be attentive only to what is given in intuition" (Moran, 2000, p. 9).

According to Giorgi (2012), Husserl believed that consciousness is what connects an individual to the world and that "an object is correlated with an act of consciousness and it can be examined in relation to the act with which it is correlated" (p. 9). Husserl's phenomenology calls for an approach to research in which the judgement about what is real is suspended, with reality being linked to one's consciousness of it. Husserl has been credited with the development of epoché, known more commonly now as "bracketing," to acknowledge and reduce researcher bias (Moustakes, 1994).

3.2422 Heidegger's Phenomenology. Heidegger, initially a student of Husserl, rejected the central tenets of Husserl's phenomenology (Moran, 2000), citing "all description involves interpretation, indeed that description was only a derivative form of interpretation" (p. 20), essentially rejecting the epoché, or the ability to "bracket." Heidegger emphasized the interpretation of experience and the meaning of being, rejecting the subject-object dichotomy citing they are interconnected and inseparable (Moran, 2000).

3.2423 Distinct Schools of Phenomenology. There are two distinct schools in phenomenology: interpretive and descriptive (van Manen, 1990, 2014). Matua and Van Der Wal (2015) described key differences related to the focus of the research, outcome/goal of the research, and the level of objectivity thought possible. The authors indicated that the goal of descriptive phenomenology is to strictly describe an experience without consideration of the participants' context (van Manen, 1997, as cited in Matua & Van Der Wal, 2015). The focus of interpretive phenomenology is to achieve a deeper understanding, with focus on the participants' contextual and social reality (McConnell-Henry et al., 2009, as cited in Matua & Van Der Wal, 2015). The outcomes and goals of descriptive and interpretive phenomenology are also different. Descriptive phenomenology aims to uncover pure, first-hand knowledge (Husserl, 1970), whereas interpretive phenomenology aims to enter the participants' world, discover wisdom, while undercovering meaning as described by participants and interpreted by the researcher. This involves shared meaning making, or as Heidegger described it, the "hermeneutic circle" of understanding (Streubert & Carpenter, 2011, as cited in Matua & Van Der Wal, 2015).

Another differentiation involves the level of objectivity that researchers believe they can take in exploring others' lived experience (Matua & Van Der Wal, 2015). Bracketing, or epoché, consistent with descriptions of Husserl, involves researchers setting aside their preconceptions

and biases so that they do not influence their studies (Wilson, 2015). This is common in descriptive phenomenology. Alternatively, interpretive phenomenology involves a researcher accepting "that the person and their 'world' are inseparable and that an investigator, to an extent, shares this same world" (Wilson, 2015 p. 40). Several philosophers have continued and adapted the work from Husserl and Heidegger, in particular van Manen's (1990, 2014) work, which will be discussed and used to guide this research.

3.2424 van Manen's Phenomenology. van Manen (1990, 2014), influenced by Heidegger, describes phenomenology of practice as the "kinds of inquiries that address and serve the practices of professional practitioners as well as the quotidian practices of everyday life" (p. 15). van Manen (1990) also wrote that "to do research is always to question the way we experience the world, to want to know the world in which we live as human beings" (p. 5), which as he explains, to get to know the world is ultimately to attach ourselves to it, to become the world.

In contrast to quantitative research methodologies which aim to conduct research that is generalizable, van Manen (1990) described phenomenology as a "theory of the unique" (p. 7) and more specifically interpretive phenomenology "as a philosophy of the personal, the individual, which we pursue against the background of an understanding of the evasive character of the logos of other, the whole, the communal or the social" (p. 7). van Manen (1990) described phenomenology as being unlike other methodologies in that it aims to gain insightful and comprehensive description of how people, pre-reflectively, experience the world, leading to plausible insights and explanations that can bring us closer to and with the world (van Manen, 1990, 2014, 2017). The phenomenological attitude keeps researchers aware of the ways that

individuals are conscious of and experience the world prior to reflecting on it (van Manen, 2014).

van Manen (1990) describes how phenomenology "aims to grasp the exclusively singular events (identity/essence/otherness)" (p. 27). Essences are the internal meaning structures of lived experiences that can be determined only by involving those who have lived that particular experience. van Manen (1990) also indicated that phenomenology involves both description and interpretation producing meanings that are both rich and include a level of depth.

3.243 Purpose of and Indications for Employing Phenomenological Research. As described by van Manen (2014), "Any and every possible human experience (event, happening, incident, occurrence, object, relation, situation, thought, feeling and so on) may become a topic for phenomenological inquiry" (p. 38). Wilson (2015) described four purposes for conducting phenomenological research, starting with understanding. Wilson noted that phenomenological research can "explicate deeper human aspects of a situation, attending to mood, sensations and emotions, seeking to find out what the actual experience is, what it means to individuals and what the personal implications are" (p. 40). This is consistent with van Manen's (1990) goal of phenomenological research, which is broadly to uncover the phenomena as it is meaningfully experienced by the participants, rather than being focused on that which is factual. This was important in the context of the current study and is consistent with the objective to explore nurses' experiences and perceptions working in substance use harm reduction.

In addition to understanding, Wilson (2015) described uncovering as another purpose, by setting aside assumptions using either bracketing or by using reflection to understand self and interpret our own experiences. This is consistent with van Manen (1990), who asserted that in phenomenological research, data collection involves both gathering experiential material and

analyzing it. Analysis occurs with data collection in the form of reflection. Within the context of this research, reflection was used by the researcher, both reflection in and on action (Doane & Varcoe, 2020), as well as prior to data collection. Reflection prior to data collection was described in the positionality section above. Reflection in action occurred in the research setting, while collecting data. Reflection on action occurred in the form of a researcher diary, described below. To truly uncover the lived experience of working in harm reduction, I had to understand my own biases, assumptions, values, and experiences and how they could have impacted the research process, including collection and analysis.

Wilson (2015) also described explication of experience in order to understand experiences that are otherwise not well understood, to research individuals' perceptions. van Manen (2017) made an important distinction when it comes to the explication of experience, specifically that the "focus is not on textual meaning but on the meaning of the experience …as we live through it" (p. 5). Finally, Wilson (2015) described empowerment, in particular how phenomenology "empowers people and promotes understanding of others by allowing the lived experience to be experienced vicariously" (p. 41). My hope was that by discussing the nurses' experiences in harm reduction, it would empower not only the nurses but also myself as the researcher, as well as future targets of dissemination. As indicated above, much of the harm reduction movement originated from the ground up, rather than from the top down, by activists and health care provider groups, often working unsanctioned. It is through empowerment by those individuals that the harm reduction movement occurred. Empowerment can also occur through the dissemination of research in journal articles, conferences, and presentations at organizations that employ nurses who care for individuals impacted by substance use.

When I reviewed various phenomenological philosophers, van Manen's work resonated with me. This was especially true when he cited Heidegger's original work and wrote "it has been argued that all description is ultimately interpretation" (p. 25). My personal beliefs about how objective I feel researchers can be relate to Husserl's (1970) ideas around bracketing, defined as to, "...take hold of the phenomenon and then place outside of it one's knowledge about the phenomenon (as cited in van Manen, 1990). van Manen writes, "...how does one put out of play everything one knows about an experience that one has selected for study?" (p. 47). This indicates that if we try to ignore everything we know about a phenomenon (i.e., bracket), "...we may find that the presuppositions persistently creep back into our reflections" (p. 47). Because of this, I agree with van Manen that it is more favourable to explicitly state our assumptions, biases, beliefs, and understanding of the phenomenon/event in order to "hold them deliberately at bay" (van Manen, 1990, p. 47).

As discussed previously, much of the literature on health care providers' experiences and perceptions of harm reduction has used quantitative methodologies, often in acute care settings with no literature describing northern nurses' experiences and perceptions. Thus, this research employed van Manen's (1990, 2014) ideas and methodology to guide the research methods and analysis. Prior to delving into the methods, it is important to discuss the potential congruences and conflicts between phenomenology and CST and how they were attended to, as well as other potential methodological challenges and limitations of the proposed research.

3.244 Congruences and Conflicts between Phenomenology and CST. As discussed previously, I used phenomenology informed by van Manen (1990, 2014) as a guide and CST (Browne, 2000; McCall et al., 2023) as an overarching interpretive framework (i.e., worldview), which will ultimately impact the methodology and research process. The first conflict worth

noting is in how methodology and theory are used. van Manen (2014) wrote about a dual between phenomenology and theory, noting that "phenomenology has developed certain methods [i.e., bracketing] that aim to guard against the effects and assumptions induced by theory, science, concepts, values, polemical resources, and the taken-for-granted prejudices of common sense in everyday life" (p. 65). He describes how theory should be used as a foil, not a scaffold. As such, CST was not used as a framework for the development of the findings, but rather the findings are interpreted in relation to CST. Another conflict between phenomenology and CST lies in the purpose of each. Although the use of CST is emancipatory in nature, phenomenologists caution using it to achieve "instrumental action, efficiency, or technical efficacy" (van Manen, 2014, p. 69). However, this does not mean phenomenology has no practical value. In fact, van Manen (1990) highlighted the overlap between phenomenology and critically-oriented action research, suggesting that phenomenology is a critical philosophy of action in that the reflection that occurs in interpretive phenomenological studies not only deepens thought, but also "radicalizes thinking and the acting that flows from it" (p. 154) and that the findings of phenomenological studies move us closer to emancipatory actions. An emancipatory focus is action-oriented, and "A phenomenology of practice aims to open up possibilities for creating formative relations between being and acting, between who we are and how we act, between thoughtfulness and tact" (van Manen, 2014, p. 70).

3.245 Methodological Challenges and Limitations. Phenomenology was the methodology chosen to guide this research and to contribute expanding knowledge about nurses' experiences in and perceptions of substance use harm reduction programs in the north. With the use of any methodology, researchers should consider and attend to methodological challenges and limitations, as described next.

First, as described by van Manen (2014), one of the major challenges with phenomenology is that it seeks to describe the "now" of an experience (i.e., as it was experienced). However, when researchers are asking about the experience, they are, in essence, already too late because the experience has already occurred. van Manen (2014) wrote, "I am the now when I am in the now" (p. 59), posing a major challenge conducting phenomenological research by making it less accessible. To overcome this challenge, van Manen (1990) called for employing the phenomenological attitude, an open and reflective orientation to lived meaning. As stated earlier, although I do not believe that true bracketing is possible in research, consistent with Husserl's phenomenology, I do believe that it is important to reflect on preconceived and evolving understandings of harm reduction and substance use and how this may impact the research process.

Generalization of the findings is generally not the goal with qualitative research, as such researchers should take this into account when considering the goals and purpose of their study. van Manen (1990) described how the goal of phenomenology is not to problem solve to develop 'correct' knowledge, strategies, and effective interventions. Rather, van Manen writes that

> …phenomenological questions are meaning questions. They ask for the meaning and significance of certain phenomena. Meaning questions cannot be "solved" and thus done away with (Marcel, 1949). Meaning questions can be better or more deeply understood, so that, on the basis of understanding I may be able to act more thoughtfully and more tactfully in situations. But in some sense meaning questions can never be closed down, they will always remain the subject matter of the conversational relations of lived life, and they will need to be appropriated, in a personal way, by anyone who hopes to benefit from such insight. (p. 23)

Thus, the goal is to deepen our understanding of the lived experience, and not to generalize the results to wider populations. I attended to these limitations by ensuring that the

research questions and goals are consistent with the methodology, in line with the idea that phenomenological studies are those of meaning rather than factual based with the goal of generalization (van Manen, 1990).

3.3 Phenomenology as Method

> It is the phenomenological and hermeneutical study of human existence: phenomenological because it is the descriptive study of lived experience meaning; hermeneutics because it is the interpretive study of the expressions and objectifications (texts) of lived experience in the attempt to determine the meaning embodied in them. (van Manen, 1990, p. 38)

Although van Manen (1990) described phenomenology as a method without methods, the author did specify six broad steps with important considerations for conducting phenomenological research. In the following section, I use van Manen's six steps to describe the methods that were involved in the research. Using these steps to guide this work is a form of rigour in qualitative research, and other aspects of quality are highlighted in the following sections.

3.31 Investigating Phenomena that Interest us as Researchers (Step 1)

van Manen (2014) stated that phenomenological research starts with wonder, the antecedent to inquiry. Related to developing phenomenological research questions, van Manen (1990) asserted that to conduct phenomenological research, we must both "live" and "become" the question. I have reflected on why I was interested in this topic, how it was deeply rooted in how I thought about health, inequity, justice, in line with CST as my worldview. Related to quality in qualitative research, Tracy (2010) describes the importance of a "worthy topic" in describing criteria for excellence in qualitative research. A worthy topic is one that is relevant,

significant, timely and interesting (Tracy, 2010) and rationalization for the need for knowledge in this area was provided in chapter one.

Additionally, van Manen (1990) described the need to have a phenomenological question, which "explores what is given in moments of pre-reflective, pre-predicative experience– experiences as we live through them" (p. 27). Consistent with van Manen (2017a), it is important to develop phenomenological questions and not assume that phenomenological questions will result from asking unstructured interview questions. The research questions that guided this work are detailed in chapter two.

3.32 Investigating Experience (Step 2)

> "We gather other people's experience because they allow us to become more experienced ourselves" (van Manen, 1990, p. 62).

Investigating experience was van Manen's (1990) second step in conducting phenomenological research. van Manen (2014) described lived experiences as what individuals live through prior to reflecting on them. van Manen (2014) described pre-reflective experience as "the ordinary experience that we live in and that we live through for most, if not all, of our day-to-day existence" (p. 28). The author differentiated between the "the living now" (i.e., the experience as it occurred in the moment for the individual) and "the mediated now," or the reflected presence, which occurs in telling the story. The goal of phenomenological inquiry is to describe the pre-reflective, or the "living now" presence. van Manen (2014) called these our "taken-for-granted experiences as we live through them in natural attitude, without ever bringing them to reflective awareness" (p. 34). To investigate these experiences, I conducted in-depth, semi-structured interviews while attempting to pay attention to craft the questions as carefully as possible with the intention to gear individuals towards pre-reflective experiences. The following

section describes the specific methods involved with investigating experience. Specifically, it will outline the participants, setting, recruitment strategy, and data collection methods.

3.321 Participants. Given the research questions and phenomenological approach, I used purposive sampling to obtain a sample of nurses who worked in and/or employed harm reduction interventions caring for individuals impacted by substance use. According to van Manen (2014), phenomenological studies do not require a minimum number of participants. The author indicates that phenomenological inquiry cannot strive for empirical generalization. Instead, researchers should strive to gain "examples" of experientially rich descriptions rather than a representative sample (van Manen, 1990), consistent with rich rigour (Tracy, 2010), described below. The study sample comprised 18 participants which are further described in the findings chapter.

3.322 Setting. The scope of this project was northwestern Ontario, justified by the lack of research on the topic, as well as the increasing rates of opioid related morbidity and mortality in the area. The participants were nurses who had experience in substance use harm reduction. The setting was primary care addiction and harm reduction programs offered through community agencies and clinics, including ones with safe consumption sites and safe supply programs, and community programs with outreach nursing.

3.323 Recruitment Strategy. It was important for me to ensure that I devoted adequate time and attention to the recruitment of participants that had experienced the phenomena of interest. As Tracy (2010) outlines, this is related to an important criterion for quality in qualitative research, rich rigour. This includes the ability for the study to provide explanations and descriptions that are rich (Tracy, 2010). Identifying key stakeholders was the first step in the recruitment strategy. Through my work evaluating a local harm reduction program and my

attendance at several conferences and webinars on harm reduction, I have developed relationships with many key parties in northwestern Ontario. These included public health units, primary care clinics/medical centres/health teams, jails, and other community agencies. These individuals, as well as their contacts, were important parties to accessing the population of interest. E-mails (see Appendix B) were sent to the important parties, who were asked to identify potential participants that met the eligibility criteria and information about the study (Appendix C, D) including the information letter for review (Appendix E). As an incentive to join the study, individuals who completed the interview were provided a $50.00 gift card to a grocery store in their area. Snowball recruitment (Sadler et al., 2010) was also used during the interviews to identify additional nurses who work and use harm reduction in their practice.

3.324 Data Collection. Data collection occurred from September to November 2023. The data collection methods were audio recorded, semi-structured interviews and a researcher journal. Originally, interviews were planned to take place in the participants' workplaces. However, due to ethical and feasibility considerations raised during the Research Ethics Board (REB) review, interviews were instead conducted in my office or via Zoom, according to participant preference. Phenomenology's main concern is with the participants' lived experience of the phenomena (van Manen, 1990; 2014). Interviewing is a common data collection method in qualitative research (Kahn, 2000) and an essential approach to get at the essence of an experience, consistent with the phenomenological approach (van Manen, 1990, 2014). Interviews were conducted in line with van Manen's (1990) phenomenology. van Manen (1990) indicated that the interview serves two very specific purposes, namely, to gather and explore narrative material to obtain a rich and deep understanding of the phenomena, and as a way to develop a "conversational relation" (p. 66) with the participants. Prior to being interviewed, the participants

had the opportunity to ask any questions they had about the research or their participation. I reminded them that the interviews would be recorded. I also emphasized that because their participation was voluntary, they had the right to withdraw at any time or decline to answer any of the questions without any negative consequences.

Similar to Kahn (2000), the aim of the interviews was that it resembled informal conversations so that participants were comfortable. The interviews were semi-structured in nature and followed an interview guide (Lobiondo-Wood et al., 2018). However, I focused on listening to the participant, rather than strictly dictating the direction of the interview (Kahn, 2000). van Manen (1990) described "the art of the researcher" (p. 98) to be their ability to keep the participant and themselves oriented towards the lived experience in question. This often involves participants becoming invested in the research, providing an opportunity for them to reflect on their experience and to delve deeper into the meaning of the experience (van Manen, 1990). The interview guide can be found in Appendix F. It includes questions surrounding the nurses' experiences and perceptions of working in harm reduction, consistent with the research questions described above.

van Manen (1990) also described the use of a researcher journal as a source of lived experience. The journal helped the researcher reflect on insights gained and patterns identified during the interview process. Common in qualitative research is for data collection and analysis to occur simultaneously (Creswell & Poth, 2017; Lobiondo-Wood et al., 2018). This is consistent with van Manen (1990), who indicated that in phenomenological research, data collection involves gathering experiential material and simultaneously analyzing it.

Analysis occurs with data collection in the form of reflection (van Manen, 1990). I used a researcher journal as a space for reflection and self-evaluation (Kahn, 2000) throughout data

collection and analysis. Like Kahn (2000), I recorded "substantive and theoretical hunches, ideas, insights, and observations" (p. 6). The researcher journal was also used to reflect on how the research process impacted me (Kahn, 2000) including my insider and outsider perspectives. As recommended by Kahn, I journalled not only my relationship with the participants, but also my relationship with the data.

3.325 Ethical Considerations. In addition to data collection methods, there are important ethical considerations in qualitative research. Because the research involved human participants, I applied to Lakehead University's REB for ethical approval to conduct the study which I received. As described by Holloway and Wheeler (1995), qualitative research is often more intrusive than quantitative inquiries and requires sensitivity. Given that thick description was the goal of this research, measures were taken to ensure the anonymity of the participants. I replaced their names with alphanumeric identifiers (P1, P2, etc.) to maintain their privacy and the confidentiality of their interview responses. I also reviewed the quotes included in the final report to ensure that they contained no identifiable participant information. Recordings and transcriptions were stored on a secure, password-protected computer that only I had access to. Other practical considerations that were involved in the REB application include the participants' informed consent to the interview and recording, the right to refuse answering any questions, and to withdraw at any time without consequences.

3.33 Identify the Essential Themes Through Reflection (Step 3)

> Making something of a text or of a lived experience by interpreting its meaning is more accurately a process of insightful invention, discovery or disclosure– grasping and formulating a thematic understanding is not a rule-bound process but a free act of "seeing" meaning. (van Manen, 1990, p 79)

van Manen's (1990) third step in conducting phenomenological research is to identify the essential themes through reflection. Qualitative research involves data collection and analysis that occur simultaneously (Lobiondo-Wood et al., 2018; van Manen, 1990). As Denzin (1978) noted, the overall aim of analysis is a thick description that represents the full and rich meaning ascribed by the participants of their experiences with the phenomena of interest. Thick description is one practice that is consistent with how credibility is achieved in qualitative research (Tracy, 2010).

An encrypted transcription service (real person) was used to transcribe all the interview data. This author reviewed the transcriptions to ensure accuracy. Then the transcriptions were uploaded to NVivo v.15 software that was used for part of the analysis as a way to organize and theme the data. Consistent with the methodology, the analysis was guided by van Manen's (1990) interpretive method of analysis. In this method, reflection is emphasized and described as a way in which authors attempt to grasp the meaning of phenomena. van Manen differentiated between our pre-reflective lived experience with the phenomena and our "reflective grasp of the phenomenological structure of the lived meaning" (p. 77). The author indicated that uncovering the phenomenological structure (i.e., essence of the lived experience) identified above involves "a process of reflectively appropriating, of clarifying and of making explicit the structure of meaning of the lived experience" (p. 77), ultimately attempting to grasp and understand the "pedagogical essence of a certain experience" (p. 78).

van Manen (1990) described the process as complex and multidimensional and wrote, "Reflecting on lived experience then becomes reflectively analyzing the structural or thematic aspects of that experience" (p. 78). Formulating themes is not a rule-bound process, but rather a free act of "seeing" the meaning of the phenomena (van Manen, 1990). Broadly, themes are the

structures of experience, and they provide the researcher with order and control in the research and writing (van Manen, 1990).

Analysis was conducted both thematically and existentially (van Manen, 1990). van Manen (1990) outlined several different approaches to isolating thematic statements: these included the "wholistic or sententious approach … [, the] selective or highlighting approach… [, and the] detailed or line-by-line approach" (p. 92). My process of analysis involved first reading each transcription fully several times. I then used the selective reading approach and asked, "What statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described?" (van Manen, 1990, p. 93). I highlighted those that were substantial. I also used the detailed (line-by-line) approach by asking, "What does this sentence or sentence cluster reveal about the phenomenon or experience being described?" (van Manen, 1990, p. 93).

Phenomenological analysis is not concerned with just coding the data with descriptive tags, but rather identifying insights, interpreting meaning and identifying the structures of lived experience (van Manen, 1990). Reflective writing was used to develop the themes, including moving between individual transcripts/texts and the overall meaning of the phenomenon, reflecting the hermeneutic circle. The goal of analysis was to reveal the lived experience of nurses working in substance use harm reduction. While doing this I made use of the researcher journal to record reflections and connections I was making with the data. I reflected on my own positionality and why I may be viewing and thinking about the data in certain ways. The data was also analyzed existentially (lived relations, lived space, lived body and lived time) (van Manen, 1990). This process took several months and included a lot of deep reflection on the essence of the lived experience, highlighting experiences that reflected the participants lived

meanings. The reflective components of this work are consistent with how Tracy (2010) described sincerity as a criterion of excellence in qualitative research, highlighting reflexivity, honesty, and transparency.

3.34 Use the Art of Writing to Describe the Phenomena (Step 4)

> "The problem of phenomenology is not how to get from text to meaning, but how to get from meaning to text" (van Manen, 2017b, p. 2).

Consistent with van Manen (1990), one of the goals of using phenomenology is to create a phenomenological text, thus phenomenology is a writing activity and also van Manen's (1990) fourth step. van Manen (1990) wrote, "The phenomenological method consists of the ability, or rather the art of being sensitive - sensitive to the subtle undertones of language, to the way language speaks when it allows the things themselves to speak" (p. 111). Essentially, this involves the researcher being attuned to language and a true listener, ready to listen to "the way the things of the world speak to us" (p. 111). van Manen (1990) also emphasized that it is more important *how* the researcher writes, rather than *what* they write, requiring cultivated thoughtfulness.

Phenomenological writing is a complex process that requires an artful approach involving rewriting, rethinking, reflecting, and recognizing to create depth and multiple layers of meaning (van Manen, 1990). To do this, I ensured that I devoted adequate time (6 months) to the writing and rewriting process. Additionally, I repeatedly went back to the existentials (van Manen, 1990), the researcher journal, and reviewed the transcripts to ensure that the writing reflected the participant's experience. I was mindful to use the language that the participant used and included several quotes to represent the lived experience.

3.35 Maintain a Strong Relation to the Phenomenon of Interest (Step 5)

van Manen's (1990) fifth step is to maintain a strong relation to the phenomena of interest, highlighting that the writing must be oriented, strong, rich, and deep. It must be oriented in that whatever approach is used, it must be in line with the phenomenological question being asked. Thus, I returned to the research questions and objectives of this work throughout the study. Richness and depth are what gives the phenomena of interest meaning (van Manen, 1990) and were acquired through the methods described above. Additionally, I was intentional about how I described the experience and took care not to explain the experience theoretically, as this is not consistent with van Manen's phenomenology. Finally, I attempted to keep the phenomena alive by sharing rich descriptions and experiences, while avoiding generic claims.

3.36 Consideration for the Part and Whole in Balancing the Research Context (Step 6)

Finally, van Manen's (1990) sixth step is to balance the research context while considering both the parts and whole. Considering the parts and the whole has to do with the researcher being aware of the overall methodology and how the individual parts (i.e., text) make up the total structure (van Manen, 1990). In discussing balancing the research context, van Manen (1990) emphasized the need to be aware of the ethics and effects of human science research, outline the plan and context of the research project, and considerations for 'working the text'. Related to ethics, I thought about and reflected on how the phenomenological methods may have been transformative for both the participants, as well as myself as the researcher. Related to "working the text," van Manen (1990) described different ways to present and organize the text, including thematically, analytically, exemplificative, exegetically, or existentially, or by inventing a new approach. As a novice researcher also new to phenomenology, I presented the data thematically/existentially, as described above. Overall, it is important to consider the

research context by going back to the research questions and objectives so as to not get side-tracked.

3.4 Chapter Summary

This chapter described the use of theory in research, and it detailed parallels between CST and nursing and harm reduction, which helped to conceptualize and position the phenomena of interest, and detail my personal worldview. It then described the ways that an interpretive phenomenological approach was used to explore what it meant to be a nurse working in substance use harm reduction. Phenomenology was well suited to answer holistic questions of meaning, particularly those involving phenomena that are not as well understood and especially ones concerning the lived experience of people. It was guided by van Manen's (1990) phenomenology method to highlight steps and considerations in the research process. The findings of this study have the potential to enhance nursing practice and knowledge by understanding the experiences of northern nurses working in community harm reduction programs to inform how best to support nurses, opportunities to integrate such learnings into other settings and better prepare nurses to mobilize harm reduction in their practice.

4.0 Chapter Four: Findings

van Manen (1990) wrote that "all phenomenological human science research efforts are really explorations into the structure of the human lifeworld, the lived world as experienced in everyday citations and relations" (p. 1010). The chapter is organized using van Manen's four fundamental lifeworld existentials: lived relationality, lived space, lived body, and lived time. In addition, it is organized thematically and includes the themes and subthemes (see Table of Contents for overview) that came out of the analysis and interviews, representing the lived world of the nurse's experience of working in substance use harm reduction. Each section (i.e., lived world existential) explores the major themes nurses discussed related to that existential and is supported with quotes. Some quotes were adjusted for readability (e.g., removed added words such as "um") when it did not distract from the content and original meaning. Prior to exploring the lifeworld existentials, the participants are described.

4.1 Description of the Participants

Table 1

Description of Participants by Nursing Classification, Setting and Years of Experience (N=18)

Nursing Classifications	**Settings**	**Years of Experience**	
Registered Practical Nurses (N=5)	Consumption treatment services or withdrawal management (N=8)	Nursing Experience	2-22 years (μ=9.55)
Registered Nurses (N=9)	Outreach (N=3)	Experience in Harm Reduction	0.58-12 years (μ=4.19)
Nurse Practitioners (N=4)	Multiple settings (N=7)		

Eighteen nurses working in substance use harm reduction took part in this study. Five were Registered Practical Nurses (RPNs), nine were RNs, and four were NPs. Eight nurses indicated that they were employed in withdrawal management or consumption treatment services, three in outreach, and seven in multiple settings. Years of experience in nursing varied among participants, from two to 22 years (*mean* = 9.55), with 0.58 to 12 years of experience reported working in harm reduction (*mean* = 4.19). To maintain anonymity, gender is not reported.

4.2 Lived Relationality

> "As we meet the other we are able to develop a conversational relation which allows us to transcend ourselves" (van Manen, 1990, p. 105).

van Manen (1990) described lived other (i.e., relationality) as the "lived relation we maintain with others in the interpersonal space that we share with them" (p. 104), highlighting the impression of others and conversational relations. Within this work, many of the nurses' experiences of the work of harm reduction had to do with creating relationships and connections with others. Nurses discussed several ways in which they interacted and built trust with individuals impacted by substance use who were accessing harm reduction services. This section begins with a discussion of the importance of developing and maintaining trust among individuals impacted by substance use. It also explores ways nurses describe establishing trust. These include maintaining commitments, being approachable, maintaining non-judgemental attitudes, and speaking the patient's language. The final sections discuss the importance of respecting autonomy and privacy, as well as how nurses use incentives to create and maintain connections.

4.21 Importance of Trust: Care as Relationally Contingent

All of the nurses in the study discussed the importance of relationship building in their work with individuals impacted by substance use who were accessing harm reduction services. The development of trust was critical and foundational to their work. This is evident in how one harm reduction nurse described the sequence of work, stating that "you do a lot of relationship building work before you even get to any of the health and social service stuff" [P10].

Nursing care and trust development were inherently relational processes for the nurses. Establishing and maintaining relationships with individuals impacted by substance use was often delicate and required more time compared to relationship-building in other areas of care. For example, some nurses shared experiences with wary clients who initially may not have been willing to share details about their situations. This is reflected in how one harm reduction nurse explained:

> They may come up to [location] to get harm reduction supplies one time and not really saying much to you. The next time they might mention, you know, say one or two things about how they're not really in a safe situation but don't want help with it at that point. And then it gets the point where they're telling you like, 'hey, I'm really not in a safe situation. I want to get out of it. I need X, Y and Z to help with that.' And you can be like, okay, we can get you, you know, linked with clothing. We can get you linked with this resource to help you get out of the unsafe situation. [P2]

The nurses noted considerable differences when they believed that their patients had formed trusting relationships with them. As one harm reduction nurse described, "When they feel comfortable with someone, it's so different. Like the difference I've seen in the clients from when I first started to even now, like some of them would never even say hi to me" [P8].

Several nurses also mentioned that patients may not have been trusting right away. A harm reduction nurse with experience with consumption treatment services commented:

> When someone walks in and it's like, 'I've never been here before,' it is kind of a weird space because they don't trust immediately. But they don't want to say they have drugs on them and stuff because they don't know, maybe there's a cop hiding around the corner or something like that. [P16]

The nurses explained that they often cared for individuals who lacked trust in the health care system based on prior experiences and how their work was an opportunity to rebuild that trust. This happened, for example, through nurses volunteering to hold their clients' important medications to ensure they were able to continue treatment. A nurse working in consumption treatment services explained:

> So, I find that it kind of helps repair that lost trust in the medical system, which is huge because a lot of these clients again have a lot of blood borne illnesses. So like HIV, hep C, a lot of them have syphilis… So, being able to have them trust us, ask us for medical care, we try to bridge the gaps as best as we can... we hold a lot of people's HIV and hep C medications because we know they're coming to see us every day to use. So, it's safer for us to have… [the medication] than for them to get them stolen on the streets, because people will indiscriminately take your pills and figure out what it is after. [P13]

The nurses understood how being trusted by one person, being a familiar face, and word of mouth were all integral to developing trusting relationships with others. This is reflected in how one harm reduction nurse explained:

> So, it was very helpful that we were already that familiar face to everyone. And I'd even seen people say their friend that was in desperate need of wound care or something that's happened to them or maybe they have an STI that they've been leaving untreated for a long time, they say, you can go to them, they're okay. So, it's nice to get that word of mouth. [P4]

Through the sharing of their experiences, it was clear that when patients brought in others, it provided strong evidence for nurses of being trusted by the patients. A harm reduction nurse described:

> Or the other one that I really like is when patients come to me and they go, 'I brought my friend. And they're really scared because they don't want to go to the hospital because they've been there before and they've been treated really, really badly. But I convinced them to come see you.' And that for me is just such a mark of praise to just go, yeah, I'm doing something right here because I'm rebuilding trust and reestablishing what it means to provide healthcare to people who've, you know, not had that, or have had the opposite, you know. [P11]

Another nurse described a similar situation indicating trust in both the harm reduction care providers and in what they had to offer carrying over from one client to another:

> So, we offer something called filters with our crack pipe kits. So, I'll see like girls be like oh, come to them. They have, you know, lots of the filters and they have lists of where to get food. So, we have a lot of people that are new to town. They don't know how to access shelter systems or something. Or they'll bring a friend and oh, she has a wound. Could you look at her? Yeah, they're really nice. You can trust them. [P3]

Other examples of nurses 'knowing' they had been able to establish a trusting relationship included their clients sharing with them that they were planning to use substances and asked the nurses to come look for them. As a nurse working in consumption treatment services explained:

> …they'll tell us, I'm going to go use [substances] outside. If you don't hear from me in 10 minutes, come look for me, okay? And they tell me exactly where they're going to be and then they'll come back and say, I'm okay, I'm okay. I'm like, okay, good, good, good which is nice because, you know, they really respect us enough to say that. And they trust us. [P17]

Just as trust takes time to develop, the nurses described how maintaining that trust is paramount; “you cannot break trust with this population. I mean, you shouldn’t break trust anyway. It’s not good practice for a therapeutic relationship. But if you break trust even one time, that's it. You’re done” [P11]. The trust that had been built between a nurse and patient was considered very delicate and fragile and there was substantial risk of a patient not coming back to see a nurse again if they did something to break it. This rested in part on the limited trust in health care providers their clients had to begin with. A harm reduction nurse explained how broken trust could occur quickly:

> I had a client who came up to us reporting he was suicidal and wanted to go to the hospital. And he had run out of his medications, and he couldn’t, couldn’t commit to safety or anything like that and had a plan in place. So, he sat with me. He was agreeable to go to the hospital. I called 911. Police showed up and this was the first time we had heard of this. And he became upset with us yelling that we had called police on him…then he left. [P3]

This nurse commented on the ways that a new policy (i.e., having police attend the calls) impacted the relationship with this patient and how they felt it immediately broke trust. They indicated that a similar situation occurred a week later and the nurse advocated for police to be parked around the corner or even on standby given what the nurse knew about what was going on with the patient and how it would be triggering.

The relationally contingent nature of trust and relationship development when working with individuals impacted by substance use was emphasized. Developing, maintaining, and honouring trust are integral to relationship-building and in caring for individuals impacted by substance use. Connected to the theme of trust is the importance of honouring commitments and being consistent, as described below.

4.22 Honouring Commitments and Consistency

Honouring commitments and consistency were integral to the nurses' work, and to the relational component of their experience. Understanding the importance of trust and how trust can easily be broken meant that nurses understood the importance of honouring commitments regardless of what else their day might throw at them. As one nurse reminisced:

> Sometimes I promise things…. And I really don't have time to do [what I promised] anymore, but I said I would do it, therefore I must do it because you must come back to me or maybe I'll have a friend help me if I can, but if not, then ultimately it doesn't really matter what I want. I have to figure out a way to get it done. Right? [P11]

Especially the nurses who were working outreach in the community, discussed the importance of showing up when and where they say they would because they knew people were waiting for them. Nurses honouring commitments helped in relationship building and in their clients feeling safe to open up. This is reflected in how one outreach harm reduction nurse described:

> And it's like that consistent where they know they can find us at certain spots throughout [the community] on certain days. And it's that they keep coming back and you know, each time it's like they open – they open up a little bit more with you and a little bit more with you. [P2]

This was why participants felt that commitments they made to people impacted by substance use needed to be prioritized. As another nurse explained:

> And even though we can hand out a card, that could be gone missing in an hour or so. So, you make sure to be there on time, and that was very important for the team to actually show up at that exact time. So, if we're [promising that we will be] there from 1:30 to 3:00, we're not going to be showing up at 2:30 just because we have a busy schedule. It definitely takes priority… people would be there waiting at [location], so it just shows them that we care as well, and it's not just based off of our busy schedule. [P4]

Some nurses also felt that their patients had a sense of safety when staff were consistent in being back. One nurse who worked in an isolated community commented:

> Yeah., and they don't have that up there [in the isolated community] that often with the same person coming back. So, like I even get the question are you sure? Are you sure you're coming back? So, like yeah, I guess it's a sense of safety. [P8]

But not only being consistent in returning was important; it was also important for the nurses to be seen as accessible so that individuals knew where to find them even if that meant that nurses needed to set their own preferences aside like one nurse discussed:

> when you're working in these spaces, people get to know where you're going to be. And then they come looking for you in those spaces. So, although I'd like to get out of my office more, this is probably where I get to hang out for the most part because this is where people know where they can find me. Right? [P11]

Maintaining commitments and consistency were key relational practices in fostering trust and building relationships with individuals accessing harm reduction services. Building on this, the following section presents a discussion of the ways that having non-judgemental attitudes, being approachable, and speaking the patients' language facilitated relationship building.

4.23 Non-Judgemental Attitudes, Being Approachable, and Speaking the Patients' Language

Demonstrating non-judgemental attitudes, being approachable and speaking the patient's language served as important relational signals in the nurse's harm reduction practice. Related to non-judgemental attitudes, the nurses emphasized not judging clients for their "lifestyle choices" while recognizing that addiction is not a choice. The nurses knew that they needed to hold non-judgemental attitudes, regardless of the situations that the individuals were in (e.g., using, not using or starting again after a period of not using). One harm reduction nurse explained:

> We'll connect them to a social worker, you know, to other organizations or whatever they need, we'll help them out, especially when they haven't been using drugs for so long and

> all of a sudden they want - and if they want to restart, that's fine. We're not going to sit there and say, no, that's wrong. So, this is a safe space where they can use and they know that if anything were to happen like overdose, because they haven't used in a year, they have us and no judgement [P17].

Participants highlighted the importance of patients knowing that nurses working in this area held non-judgemental attitudes and would even advise their patients of this. The nurses displayed an understanding of the role of non-judgemental attitudes in their care of individuals impacted by substance use and the building of relationships. The nurses often mentioned the contribution of judgemental attitudes to stigma and the breaking of trust. One harm reduction nurse said, “We’re in an epidemic of people who need help. And, obviously, you know, shaming people for not prioritizing certain things is not helping” [P12].

Some nurses recognized the difficulty of always being non-judgemental but at the same time acknowledged the need to reflect on their practice and encouraged self-reflection. This is reflected in how one harm reduction nurse commented:

> maybe somebody comes into the clinic or wherever they're working, and you make a snap judgement, but being able to reflect on it and be like, oh, maybe that wasn't the best way to handle this. How can I do it differently next time so that I am seeing more of the big picture and not just someone who uses drugs or substances, which can be very hard [P2].

Closely related to being non-judgemental, being approachable facilitated the development of relationships. Being approachable meant different things to different nurses. Most commonly, the nurses described being “laid back” or “going with the flow,” behaviours that started with being warm and welcoming and thanking patients for coming in. A harm reduction nurse explained:

> So… we're not going to worry about the fact that you went off the rails and, you know, you haven't been maybe taking your meds, or you haven't been taking all of them, or you

> didn't come to see me when you said you were going to. First and foremost, you're here. I'm so glad to see you. [P11]

The nurses were aware of preexisting power imbalances that often appeared between them and their patients, so they used approaches to try to minimize the imbalance. In fact, one nurse described sharing a personal experience of mental illness with the patient, which the nurse believed the patient had received well. An approach characterized as “blunt” or not “sugar coating things” was evident. This was particularly apparent in efforts to remain non-judgemental toward substance use and wanting clients to be safe in their use (e.g., blunt regarding not sharing needles). The nurses described “not sugar-coating things” as a way to not provide false hope and in essence telling clients that “everything will be fine.”

Nurses often used different language when interacting with individuals accessing harm reduction services, compared to those in other settings, including the use of casual and informal language, including slang, swear words, and jokes in their interactions. This way of speaking, although contradictory to how they were taught in school, emerged as a way of fostering connection and trust. This is reflected in how one nurse described:

> Like, you know, [we’re] not very professional - I mean, we are professional, but, you know, basically we're cool. We joke, we tease, we kind of are like, hey, how's it going? You know, more of a casual conversation. And I feel like… it builds that trust more, which is definitely not what you're taught at all. When I first started, I was like, what do you mean? It's not business casual? What do you mean, I can wear a sweatshirt? This is weird. But then I realized that [with that], the clients kind of realized, hey, you're cool… I feel comfortable coming here. [P12]

Speaking in ways that echoed the patient’s own language was a type of relational signal that helped to build rapport. A nurse commented:

> I'm not going to speak to them as if they're my nursing colleague. I'm not going to speak to them as if they're a surgeon that I'm consulting with. I'm going to speak with them as if I too live their life, you know, you feel more comfortable with that. So, it's just really learning to read them and understanding where they're coming from and why. [P13]

Holding non-judgemental attitudes, being approachable, and speaking the patients' language were important relational signals that facilitated relationship building. The following section focuses on respecting patient autonomy and privacy, another important component to the lived relationality and experience of nurses.

4.24 Respecting Patient Autonomy and Privacy

A major component of respecting patient autonomy had to do with approaching care with a focus on the goals of the patients. Patient-centered goals and priorities were reflected in one nurse's comment, "So, some people will be on a maintenance dose monthly because they don't want to get off. Like that is not their goal so we have to support them with what their decision is" [P8]. The nurses also understood that being paternalistic in their approach was generally not consistent with a harm reduction philosophy. This same nurse described:

> They are going to do it if they want to. I'm not their mother. I'm not their father. Even if I wanted to hold their hand, they may not listen, so they are in control of themselves. I'm there to help them and guide them if they want it. [P8]

In addition, the nurses repeatedly discussed the importance of education while respecting patient autonomy or patient choice, leaving space for individuals to decide what felt right for them in the moment. A nurse remarked:

> You know, for my folks who are sharing drug equipment or maybe working sex trade or both, you know, [I'll ask] has anybody talked to you about HIV preventative medicine and putting you on PReP? Is that something you're interested in? Yeah? Cool. Let's talk about that right now. Oh, not today? Okay. That's also cool. Like, you know, your call. [P11]

The nurses had a willingness and often desire to work with patients, even when their agendas did not align perfectly. One nurse described an approach used while caring for patients:

> The other thing that I always offer people too… I don't know if it's an intervention so much as it's an approach but I tell people to think of me kind of like a waiter at a restaurant. Okay? … these are the list of interventions, the list of things that I could do for you. And I will tell you which ones I think will help you be the healthiest possible, but ultimately you get to pick what you want. I mean, you can pick some of them. You can pick all of them. You can pick none of them and tell me to go fuck myself. I mean, totally up to you…I will continue to work with you. [P11]

The nurses described the importance of allowing the patients to take the lead in their own care. Much of this related back to the importance of being non-judgemental. One stated, "I'm not pushing them to get clean. I'm not pushing them to start treatment. I'm not going to shame them for what they're using or what they're trying to do to cope with their existence." [P13]

Another nurse expressed a similar sentiment:

> So that's kind of how you build that rapport, having that no judgement. You know, like I said, like, if I haven't seen a client in, let's say I've been looking for them actively for weeks and weeks and then they finally come in. I'm not instantly like, why haven't you come in? I'm more like, hey, it is so good to see you. Thank you for coming in. You know, like, hey, did you want me to look at that wound today? No? Cool. [P12]

In regard to the importance of holding non-judgemental attitudes in respecting patient autonomy, some nurses described the importance of having patience in their care, in particular understanding that a patient might not be in a place where it is possible to accept help. One nurse commented:

> just being patient is a good one because sometimes people, you know, you might try to help and maybe they might not be in the space to accept it and they might not wanna talk about that right now. So, it's like, fair enough if you're dealing with some more serious

> things. Patience is a big one. Yeah, just being, yeah, patient, and empathetic to their situation I think is kind of the crux of it. [P16]

Closely related to respecting patients' autonomy was the importance of respecting their privacy. The nurses also saw respecting their patients' privacy as important to developing relationships and connections and thus facilitating their work. Similarly, and tied to privacy, some nurses considered maintaining their clients' anonymity an important component of their work. A common practice mentioned was not requiring patients to divulge information about who they were until if, and when, they were ready. A nurse working in consumption treatment services explained:

> And then just reminding people that, hey, you don't have to give me any information. We're just here to help you. You let us know what you need. And then, you know, thanking them for coming in basically and for making the safe choice. [P14]

The nurses expressed an understanding for why respecting patients' privacy was important in their work, given the nature of harm reduction and possible vulnerability. Another nurse explained:

> And definitely sometimes it's not so easy for someone to come up… sometimes they may not even want us to know their name right away. And sometimes we would have our little ways of saying, hey you look familiar… So, just try to gather details like that, but sometimes it is difficult for someone to open up or, you know, maybe they're unsafe, being unsheltered and whatnot, not wanting to give their name and tell us everything like that. So, it's not required that they give us any of those details at the time. [P4]

The nurses not only respected their patients' privacy but also knew that when clients were comfortable, they often would share more details. This sentiment was reflected in a nurse's interview response who worked in consumption treatment services:

> Well… our site is anonymous, so there is a confidentiality piece. And when they come in, they provide us a code. They don't give us their name or anything like that. And I know…

> once we get more comfortable, then they'll give us their name, which is nice, you know? [P17]

Respecting patient autonomy was an important facilitator in creating connections and establishing and maintaining trust with individuals impacted by substance use who were accessing harm reduction services. The following and final section of the lived relations category provides details about the nurses' experience using incentivization, another important component of how nurses built relationships, rapport, and trust with patients.

4.25 Use of Incentives

Participants mentioned that just the gesture of giving their patients some needed items, helped to build trust, especially when clients were unknown to them. A nurse working in outreach explained:

> And sometimes it would help giving incentives… So, if we had some water bottles and food and some toiletries and stuff just to let them know, you know, it's not bribing whatsoever but just, you know, if you want to come up to the [location] -- especially when it's freezing in the winter -- just come talk to us. Do you need some things from us? We don't want anything from you in return. We're just trying to kind of build a little bit of trust like that. And if they weren't ready to kind of indulge anymore with anything, we could say that these are the [outreach] stops, and here is a card that you can take, do you want to meet us next time, and kind of let them know that we're here for them. Yeah. [P4]

Some nurses used gift cards to incentivize clients to be screened for sexually transmitted and/or other bloodborne infections. The nurses saw incentives as an opportunity for patients to see what other services were available to them in a judgement-free environment. Some nurses described the use of incentives in their practice as a way to build trust and develop relationships with individuals impacted by substance use.

4.26 Summary of Lived Relations

Lived relations, as described by van Manen (1990), are relevant to the interpersonal space shared between people and to the relation taking place in conversations. Developing and maintaining trust with individuals impacted by substance use was critical to establishing and maintaining relationships. The relational tools that the nurses described using to establish connections and to develop, establish, and maintain relationships included being approachable and non-judgemental, speaking the patients' language, respecting their patients' autonomy and privacy, and lastly, the use of incentives as ways to develop relationships. Next, I will discuss the findings related to the lifeworld existential lived space.

4.3 Lived Space (Spatiality)

"In general, we may say that we become the space we are in." (van Manen, 1990, p. 102)

van Manen (1990) described the four fundamental categories as "belonging to the fundamental structure of the lifeworld [that are] productive categories for the process of phenomenological question posing, reflection and writing" (p. 102). Lived spatiality, also referred to as lived space, is a lifeworld existential described by van Manen as more than just physical space, highlighting how individuals feel about their space. As van Manen wrote, "Lived space is a category for inquiring into the ways we experience the affairs of our day-to-day existence; in addition it helps us uncover more fundamental meaning dimensions of lived life" (p. 103). The following sections are discussions specific to the ways that the nurses conceptualized the space of harm reduction and the factors underpinning the conceptualizations.

4.31 Conceptualizing the Space of Harm Reduction

The nurses conceptualized the space of harm reduction as a place characterised by (a) meeting people where they're at; (b) pragmatic thinking (space as pragmatic); (c) advocating (space as advocacy); (d) working in the grey (space as negotiated) and, (e) broad boundaries

(space as expanded). For the nurses these comprised the essence of a harm reduction space. These conceptualizations are detailed in the following starting with what it means to meet people where they are at.

4.311 Meeting People Where They're At. The nurses felt that at its core harm reduction meant "meeting people where they're at." When describing their experiences, the nurses mentioned going to the people, adapting approaches, considering patients' goals and priorities, and being a pragmatic thinker. These subthemes are discussed below in detail.

4.3111 Going to the People (Space as Mobile). Many of the nurses felt that their work in harm reduction was different from previous or other nursing work because much of it involved "going to the people." Several of the nurses described outreach as an important component of their work that involved going to areas where they knew that people would be. A harm reduction outreach nurse provided this description:

> So that's where people can get food and shelter and that kind of stuff. Not overnight shelter, but we'll go there usually a couple of times a week, if not daily, just to check on the people who just don't have the capacity to get to a clinical setting. And we would deliver any type of primary care service that falls under the umbrella of primary care just to people right there. And then if they need blood work, we can do it right there. [P10]

For the nurses, 'going to the people' necessitated being opportunistic. The nurses' ability to provide services immediately was imperative because they risked not seeing the person again. Another nurse said:

> I can tell them, come see me Thursday at 1:00, and they're going to show up Monday at 10:00. Right? … or three Thursdays from now at 4:00, and they'll be like, but I got here and it's Thursday. All right. Well, you're here, my friend. Let's do business. [P11]

The nurses also had a contextual awareness of the importance of home visits, as one nurse described:

> we do have people that enter recovery and going places that we go every afternoon can be triggering for them, so that's why we offer home visits. Yeah and if someone can't be found…we'll go to their house to find them too. Yeah. I think it works. [P3]

The nurses consistently described "going to the people" as an important component of "meeting people where they're at" and how they conceptualize the space of harm reduction.

4.3112 Adapting Approaches to Meet Needs (Space as Adapted). Care was often adapted in response to patient needs, reflecting a responsive and flexible approach in their practice. In particular, one nurse described that they understood the judgement and stigma experiences that many patients have had in other health care environments. This nurse shared a common situation in their practice of patients requiring IV antibiotics. They explained that many community practitioners would send that patient to an acute care facility, but this nurse described a different approach they use if a patient expresses they will not go:

> Well, I'm sorry I can't help you because you should be at the hospital is what most people would do with that, right? But my approach is okay, well what can we do then? Maybe I can get those same antibiotics and give it to you intramuscularly or maybe we can, you know, get some really strong oral stuff or, you know, maybe we can get homecare involved to come and put in a cad pump or something for you for a couple of days. [P6]

Nurses adapted their approach to meet people's needs in relation to both being reached and being able to reach their clients. For example, because they recognized that some of their patients do not have a phone (i.e., for calling or texting), they found other means of communicating. One nurse explained:

> like, a Facebook message because lots of our clients don't have a rolling phone number or they're using a text now number or something like that. But one of the things that we've seen over time is that our folks always seem to find internet access, whether it's the

> library or McDonald's. So, we've just found that that's the most consistent way to get a hold of, like, the more difficult to reach people. [P10]

The nurses often displayed contextual awareness, recognizing the need to adapt their approach to the individuals' unique circumstances for example by having to be:

> a little more crafty with what you have in the community. And we have a great supply of stuff in the [location], but every once in a while, it's like, okay, how can we make this easier for somebody who is living, say, in a tent or, you know, living on the streets? We have to give them dressing supplies, but they don't have everything that we have. So, what can we give them and kind of have that creativity with it? [P2]

The nurses also understood the need to arrange their day-to-day schedules to meet the needs of patients and meeting them where they are at, for example, as one outreach nurse noted:

> So a typical day, a lot of our clients aren't awake in the mornings. So, we do kind of computer work, sending letters, planning our day in the mornings or public health events that we go to. And then in the afternoons, we go to different outreach stops every day. I think that in itself is meeting clients where they are [P3].

In addition to adaptable schedules, many nurses highlighted the need for walk-in availability and structured outreach as important components as one nurse expressed that many clients do not know…

> what end of town they're gonna be staying at… So, they might end up on one side of town if they have somewhere to stay, but then they can't get back to their scheduled appointment the next day. [P16]

The nurses working in outreach understood the needs of their patients and would staff more nurses strategically on their van in certain areas, explaining that they "know some stops are more nurse heavy [requiring clinical skills], so we try to have two nurses at those stops. Other ones are more mental health related" [P2]. The nurses adapted their approaches to meet needs as an important component in their conceptualization of the space of harm reduction. In addition to

"going to the people" and adapting approaches to meet their patients' needs, the nurses often described the importance of working within patients' goals and priorities as an important component of "meeting people where they're at."

4.3113 Prioritizing Patient Goals (Space is Patient Led). Overwhelmingly, the nurses felt that harm reduction involved respecting patients' choices. They often described starting their interactions with patients simply by asking them, "What do you need? How can we make it easier? How can we get you connected to your meds?" [P10], recognizing that much of the nurses' work involved helping patients to achieve goals that they had set for themselves. This nurse commented:

> You have to be able to build relationships so that you can come up with ways to engage with people so you can help them achieve that goal -- whether it's abstinence or whether it's substance reduction or whether it's no change at all other than, you know, it would be really great if I didn't end up with a life-threatening abscess or a bloodborne infection while I'm engaged in my addiction. [P10]

The nurses understood that nurse priorities may not align with patients' priorities, and they were cognizant of the need to respect patient autonomy and disregard paternalistic approaches. Much of this was described by the nurses as having a contextual awareness of the situations that patients were in. For example, one nurse described:

> So oh yeah, just get to treatment. You can do this, you know, we'll support you and everything else. But they're like, that's not my priority. My priority is, you know, being a sex worker to have money for food and addiction. And that's far from my mind right now, and that's to deal with the trauma and everything else. [P2]

The nurses often mentioned patients' goals and priorities as central to their care of individuals impacted by substance use and in their conceptualization of their work within the space of harm reduction.

4.312 Pragmatic Thinking (Space as Pragmatic). In addition to 'meeting people where they're at,' pragmatic thinking was important to their conceptualization of the space of harm reduction. For example, some nurses identified the need to acknowledge the impact of the drug poisoning crisis realistically. One nurse said:

> I guess for me it's just the acknowledgement of the reality of what's going on… And talking to clients a lot too, just like they speak a lot about what it was like before this service opened up and how, you know, they'd be buying used needles off each other and stuff like that. [P12]

The nurse's work was practical and realistic, and they understood the reality of the situations that they encountered. One nurse explained:

> for instance, somebody who's been a chronic alcohol user for many years is unlikely to stop drinking alcohol just because you said, well, your liver is in bad shape, you know. You gotta stop that. Same with people who maybe are using opiates or stimulants, you know. Telling them to just stop is a highly ineffective strategy, although it's one that lots of people try to engage in. [P11]

This nurse also described the use of pragmatic thinking which for some was equivalent to applying a harm reduction approach as being helpful in accomplishing things:

> What I'm finding in my experience is that you can get a lot done if you use a harm reduction approach. I don't have any formal evidence to substantiate this from the [location] when I worked there, but in the [amount of time] that I worked there, I systematically chased down every high-risk HIV person that we knew of living in the city. And they're either all now on treatment or they're dead, unfortunately. But one of the things that it did is we haven't seen a spike in HIV cases lately. [P11]

The nurses explained how "no win is too small" in their harm reduction work and how they continue to offer support. For example, one nurse explained:

> …you never know which time is going to lead to the time that leads to recovery. So we continue to offer, and we continue to see what happened and all this kind of stuff and just it should be right, like, a universal - you don't question why somebody does or doesn't take their heart medication. You try to just encourage them to continue taking it because it's the best thing they can do for their health and in that moment. [P10]

Building on this, a nurse practitioner described the pragmatic way that they prescribed in their practice:

> I often will prescribe medications that will help people to increase their motivation or their confidence, I guess, to make a change. So, let's say you're drinking alcohol. You're not quite ready to make a change but the big barrier to wanting to make that change is because I get such bad withdrawal symptoms in the morning. So, sometimes I'll prescribe something like gabapentin or certain medications that would help to manage those withdrawal symptoms so maybe you're not drawn to roll out of bed and take a drink first thing in the morning or get up in the middle of the night to get a drink. Maybe we can start to introduce some medication with the hopes that eventually you can build that confidence up to make a change. [P6]

The nurses' use of pragmatic thinking, including how they viewed the drug poisoning crisis, realistic expectations, and the celebration of small wins, comprised one component of the ways that they conceptualized the space of harm reduction.

4.313 Advocating (Space as Advocacy). In addition to pragmatic thinking, advocacy was an important component to how nurses view the space of harm reduction. Several nurses described themselves as trailblazers, often seeing their advocacy work as different from what the rest of the health care world was doing and a very needed addition because they in some ways acted as extended…

> eyes and ears for the physicians and nurse practitioners when they're not here to communicate those things. But definitely being a part of a team makes your job so much easier where you can – it's not a 'can't help you with that', you know, or even if

> somebody walked in the door as a walk in and they were all mental health. Here, I don't have to say, oh, that's not us. Right. A lot of places are pretty strict in their mandates, and they would just, they might tell them where they need to go, but they're not going to help them get there. [P15]

The nurses also described a range of referrals that they commonly made, including for needle exchange, rapid access addiction medicine, safe injection, counselling, primary care, and housing. They commented that it was helpful when programs had self-referral if patients indicated not being ready for the nurses to refer them to programs, preserving choice and keeping pathways open.

Harm reduction nursing work was often complex requiring persistence in navigating referrals, with nurses often calling multiple services and/or advocating for patients who had possibly been banned from those services. For example:

> Because, you know, people make bad decisions (laughs) when they're using substances. So sometimes it's calling detox and they're on the banned list, but they're working with us here at [location]... they're telling me they're really ready. This is what's going on… you wish that it'd be easy for people to just pick up the phone and be like I'm ready now, you know? [P15]

Harm reduction nursing experiences involved being strategic to increase their patients' chances of success with referrals because they described having the contacts to set up appointments and ability to give bus tickets. Additionally, it involved advocating for clients being seen even if they had missed their last appointments. The nurses would contact the agency and advise them that they would be sending the patient over in a cab, for example. Nurses also encouraged agencies to send appointment reminders to them to pass along to the patient.

For some nurses, accompanying patients to appointments was part of their work. Going with patients to referred services was helpful and aligned with their view of harm reduction and

advocacy. The nurse could then provide support and advocacy right on the spot for example saying:

> ...they really need this appointment. We're not leaving here. And this needs to be done. And… they didn't necessarily need to know this… it took effort to get here because this person does not have transportation. So, we're proceeding with this appointment today… [P4]

In addition to advocacy at the individual level, the nurses experience involved a broader advocacy including systems and policy navigation that fit with how they conceptualized their work within the space of harm reduction. For example, one nurse described how:

> …when you get on the front line and you're trying to work through the healthcare system with an individual who's experienced discrimination and who's been labeled as drug seeking, there are actually a lot of different barriers. So, a lot of what we end up doing is health, navigation, advocacy, looking at what does this policy look like and how can we adjust it, can we get people started on Suboxone in the emergency department? So just looking at the wider causes that keep people in addiction kind of thing. [P10]

Part of their work involved advocacy at the community and societal levels, related to the purpose and need for harm reduction services. This is expressed in how one nurse described their experience:

> I try to advocate as much as I can when I'm out in the community because I also live close by here. And I mean some of these - a lot of these people are just my neighbours. They're just walking around and I see how horribly sometimes they're treated. And so, I try to advocate for them and say, listen, there's more to this than just like, I hate when people say, oh, they're just junkies, you know, let them die. It's like, oh my God, that blows my mind because they're just humans. How can you say that about a human being? … if someone… had an amputated leg, but you're just going to ignore them and say that they're, you know, like they can't function now. Like, no, it's just the same thing. An addiction is a serious mental health issue and I feel like people don't - are not - they don't

> grasp that. They just see a junkie. And that drives me bonkers because they're more than that. [P17]

The nurses work also involved advocacy at the health care level. A good example of this was given in a previous section, whereby a nurse who was caring for a patient with suicidal ideations, advocated for police to be around the corner/on standby as needed, as to not escalate the situation. In general, the nurses conceptualized the space of harm reduction as advocacy at the individual, health care, community, and societal levels being integral to their work in the space.

4.314 Working in the Grey (Space as Negotiated). In addition to advocacy, the nurses experience at times involved "working in the grey", reflecting the space as negotiated. For example, in regard to…

> people with transportation issues who are on eight milligrams of suboxone doing fairly well, we're able to regularly check in there and…we're supposed to see them for direct observed therapy every single day. And we're, like, that's cool, but they're not going to take suboxone if they can't get there. So why don't we do twice a week pickups and see how that goes? Most providers who don't know anything about suboxone would be, like, you can't do that. And we're, like, but you can. [P10]

One nurse described working in an organization whose values were different from the values that they held in the harm reduction space. This meant they sometimes needed to work in grey zones. This nurse expressed:

> Like so I mean I have a big box of condoms and I have crack pipes in my cupboard here but the organization as a whole, turning a blind eye to it, they may or may not know. I don't tell them that though, right, because it's like I don't wanna put you – I don't wanna be in that situation where I'm told I can't do it. So, I'm okay with that. I will take the slap on the wrist when it comes, if it comes, right, to kind of make sure I'm meeting the needs of people on a day to day. [P6]

Another nurse described an example of working in the grey related to some of their practices not being consistent with what they were taught in academia:

> … the way that we're taught in school is, well, you know, if your patient is, using anything at all, you just discontinue their prescription -- which is all fine and good -- or, you know, they can go to another methadone prescriber. Okay. Where? Oh. Yeah. Well, the methadone clinic is next door. That's super cool, except that it's all appointment based. The appointments are almost all full. And if you miss, like, one appointment, your prescription is canceled. Versus the way I do it. And I don't do it -- as I say, I don't do it for very many people, but the way I do it is, you know what? We're going to write you a prescription for a week. The pharmacy will discontinue your dose if you missed three in a row. But if you miss three in a row and you still want it, you're gonna have to find me. You've got to come back and show up. I'm pretty nice. I rarely have appointments booked. So, you know, just come -- come hang out with me. [P11]

Nurses working at the safe injection site explained that they could often not help to manage smoking-related overdoses in the same way as they could for injectables. One nurse described going into the area to check on the patients:

> Well, we can't help with that [smoking related overdoses] because we don't have an area for people to smoke. So sometimes I'll tell them, like, I don't even care. I'll say, go outside and smoke and we'll come check on you in like five, ten minutes. Oh, okay. Okay. Thank you. Thank you. Because they feel safe and it's like we're not supposed to do that. But, you know, I don't really care. Like, I just don't care. That's what happens when you have an older new nurse. [P17]

This nurse uses the reference “older new nurse” to describe that they have been a nurse for many years but are newer to their work in harm reduction, and it was clear that their experience was important in relation to their experiences in their current work including to those of working in the grey. Past experiences impacting present perceptions and work is further explored in the lived time existential.

The nurses described "working in the grey," such as being faced with working in organizations with conflicting values or having to work outside of the ways that they were taught in school. "Working in the grey" as an important component related to how they experienced the space of harm reduction.

4.315 Broad Boundaries (Space as Expanded). In addition to "working in the grey," the nurses felt that their work within the space of harm reduction had broad boundaries. How they described these boundaries was often related to what area of harm reduction they worked in (e.g., outreach, clinic based, withdrawal management, etc.). The nurses often described their work as involving disease and mental health management, but several nurses described the boundaries of harm reduction as blurred and outside of typical disease and mental health management. Their work involved assisting patients with food, shelter, clothing, and finances as being within the boundaries of what they felt were the space of harm reduction to be, highlighting...

> that harm reduction literally isn't just handing out clean needles or clean pipes or condoms. It is so much broader than that. And that harm reduction can literally mean getting them access to clean clothes. Harm reduction can be having a financial source to have food and shelter and everything else [P2].

Some nurses described being limited to certain interventions in their work because of the setting area. For example, one nurse explained:

> We try our best to provide our clients with as much resources as we can but unfortunately, we are only supposed to do [one specific harm reduction intervention]. So, that means if somebody's coming down off the drugs or alcohol, they come with us. We will monitor them, provide medications while they're detoxing so that nothing bad happens because with alcohol, they can have a seizure and if they're at home doing that, it's very dangerous. [P7]

The nurses often described the boundaries of harm reduction as outside of the typical boundaries of disease management. They also considered these boundaries blurred because of the social barriers often faced by individuals impacted by substance use.

4.32 Factors That Underpin Conceptualizations of the Space of Harm Reduction

The previous subsection described the nurses' conceptualization of the space of harm reduction. Described in this subsection are the factors underpinning these conceptualizations, including the provision of ethical care and understanding vulnerability and why people use substances.

4.321 Ethical Care. The nurses felt that the space of harm reduction involved an ethical approach and that all patients, regardless of situation, were deserving of care with one of the nurses upholding that if…

> …you're going to drink every day for the rest of your life… doesn't mean that you don't deserve other care. It doesn't mean that you don't deserve other supports… In fact, it probably means that you need even more of that stuff, right, to kind of help you until you get to a place where you maybe want to make a change…. Right?" [P6]

The nurses explained that harm reduction works within the realm of recognizing substance use and recovery as a kind of a continuum, and that regardless of people tending to relapse, that people deserve to be alive and to receive care and be treated within the notion that there is always a reason to try.

Paying attention to language use and of using 'person first' language in their practice was an important ethical component to harm reduction. A nurse commented:

> you don't call somebody a diabetic – it's a person with diabetes. You don't call them an addict. You call them a person with an addiction. And it also tries to get away from the negatives. So, instead of substance abuse, you can say substance misuse. You don't say alcoholic. You say person with an alcohol use disorder… if you put it the other way…

> you're defining them by their addiction. Whereas there's a person there so you put the person first. [P7]

Understanding substance use and recovery as a continuum and using person first language meant that the nurses viewed harm reduction as a mindset that worked to dismantle systems of oppression. Some nurses shared that many of the patients they care for are Indigenous. They recognized the impacts of colonization and systematic discrimination and felt that they had a role in addressing the impacts in their work. For example, one nurse said:

> …you can't not talk about like the Indigenous population and historical traumas and inter-generational trauma and how that kind of contributes to what we're seeing today on a much broader scope. [P6]

Another nurse shared:

> One person at a time, one system at a time, one conversation at a time because change doesn't happen in this, like, one big, momentous moment. It happens incrementally time over time, piece by piece. And every time I do something like, every time I take a student and I teach them the way I provide care, that's another voice out in the world, you know, rallying others to the cause, right, and changing it all. [P11]

Related to this, the nurses described harm reduction as a holistic approach encompassing more than physical health, with their work often involving the individuals' emotional, spiritual, and psychological health. A nurse described a situation often seen:

> And I think just having the empathy towards clients and being able to listen to them and not just making those snap judgements of, okay, this is a substance user coming into my clinic and okay, they're just here for a drug seeking…. It's like, no, look at the whole person and figure out like, oh no, they actually have a leg wound that they need antibiotics for. And the pain from that leg wound is causing them to drink more because they can't get prescription medications for it or get it treated and that sort of stuff. And kind of looking at the whole story and not just like one certain part of them. [P2]

The nurses consistently described harm reduction as an ethical approach to care, whereby all individuals were deserving of care.

4.322 Understanding Vulnerability and Why People Use. An extension to ethical care was the ability for the nurses to understand vulnerability and the ways in which vulnerability is tied to the need to use substances. Through their descriptions of the space of harm reduction, the nurses often expressed a compassionate understanding for why some individuals may use substances. They described working with several individuals who lived with both adverse childhood experiences (participants referenced term) and current trauma, including being assaulted and trafficked; posttraumatic stress disorder (PTSD); loneliness; and substance exposure at a young age. The nurses recognized the complexity of factors shaping substance use and that these factors are not straight forward. They are not impacting everyone in the same way.

The nurses understood that individuals often used substances to cope with the conditions of their everyday lives, which may have been impacted by past and current traumatic experiences. One nurse shared:

> if you listen to them for 10 minutes almost all of them are very kind, nice people who have just been dealt a terrible, terrible hand and they're just trying to cope the best way they know how and have been let down by the system for years and years and years so they're at where they're at. [P16]

The nurses discussed vulnerability in relation to understanding why people used and how they understood substance use and addiction. The word “choice” often came up when nurses talked about how they understood addiction, although in the sense that addiction is <u>not</u> a choice and that individuals do <u>not</u> choose this life, rather…

> Addiction comes from somewhere. Mental health comes from somewhere. Nobody asked for these problems. Nobody sets out and goes, you know what? I'm going to go shoot up heroin and smoke crack all day long. That is my goal in life. Not a single person ever starts out with that. Right? [P11]

The nurses asserted that individual people, society, and often health care perceived addiction as something that people did to themselves and that because they put themselves there, they can deal with it themselves. The nurses perceived society largely understanding addiction as an individual failing, which contributed to stigma and perpetuated vulnerability. The nurses also understood the direct impact of stigma on individuals affected by substance use, especially in relation to their experiences accessing health care. They explained that many patients with addictions who were accessing harm reduction services refrained from accessing other forms of health care due to having "had real nasty experiences" [P11] with judgement, stigma, and poor care, which have created the assumption "that all healthcare providers are like that." [P11]. Several nurses described similar experiences of patients refusing to go to hospital with one reminiscing:

> I'm like, dude, you really need IV antibiotics. And we're like, okay, if we can get outreach to help out, would you go? …and they're like, yeah, if someone can come with me, it's like, oh, because they know they're going to be treated horribly. And that's the sad part, right? And some people just need antibiotics". [P17]

Another nurse echoed similarly:

> But there's people with life-threatening wounds or there's people that have been stabbed and they flat out refuse to go to the hospital. If that doesn't say something about how they're treated at the hospital, I don't know what does. [P3]

Nurses shared similar stories and scenarios across multiple harm reduction settings, including how from their experience, acute care facilities at times tended to be hesitant in

treating withdrawal, and how often wait times in emergency departments proved to be challenging for individuals affected by substance use.

The nurses also expressed their understanding of other barriers often faced by individuals accessing harm reduction services due to the complexity of determinants involved with active addiction. For example, one nurse indicated that many of the people accessing harm reduction care live on the streets and that…

> Their priority is staying alive and surviving [un]til the next day. So, their appointment with a health care provider obviously isn't going to be at the top of their list, and we understand that. [P12]

Another nurse expressed a similar sentiment:

> vulnerable because they don't have access to housing. They're vulnerable because they don't have access to social supports… they're kicked out of their housing because they drink or because they use substances. [P6]

That, as one of the nurses explained, makes it important to understand what it means when we talk about vulnerability: It is used as a label but is so much more than that.

In general, the nurses expressed an understanding of vulnerability and the reasons that individuals used substances. This understanding underpinned their conceptualization of the space of harm reduction and their work within it.

4.33 Summary of Lived Spatiality

The lived spatiality existential has to do with how people feel about their space (van Manen, 1990). Within the context of this work, it had to do with the nurses' conceptualization of the space of harm reduction and their work within it. The nurses felt that harm reduction described a space where people had chosen to work to "meet people where they're at," a space where people who are impacted by drug use can expect people who work in harm reduction to

provide needed advocacy and are comfortable with broad boundaries and willing to work in grey zones. Factors that underpinned this conceptualization for the interviewed nurses included that they saw the care they provided as ethical and were able to understand vulnerability and the reasons people used substances.

4.4 Lived Body

The lived body existential, also known as lived corporeality, as per van Manen (1990), "refers to the phenomenological fact that we are always bodily in the world" (p. 103). van Manen (1990) highlights how psychological feelings can be looked at as embodied experiences. The nurses acknowledged that working in harm reduction, while in many ways being gratifying work, also took a toll on and impacted their physical and psychological bodies. Thus, from a phenomenological perspective, that means exploring how the nurses work in harm reduction shaped the world around them. This is reflected in the overarching themes that emerged in reference to lived body; (a) the psychological and, (b) physical experiences of the nurses' work, outlined below. The nurses also described the ways in which they were coping with these experiences, which is discussed in the section 'protecting the body' below.

4.41 Psychological Experiences and Impacts

The nurses experienced many different psychological impacts related to working in substance use harm reduction and discussed several factors that contributed to experiencing the psychological experiences. The psychological experiences and impacts are divided into the subthemes; (a) heavy emotional work and patient loss, (b) worrying, (c) feelings of helplessness, and (d) feelings of fulfillment, presented below.

4.411 Heavy Emotional Work and Patient Loss. Nurses work in this area was often emotionally heavy and described as “heavy on your heart” [P10] because many of their patients share their experiences of trauma both past and present. One nurse relayed a personal story:

> we had like several clients coming in for pretty horrible sexual assaults and it seemed like it was just happening a lot during that period and we have to listen…we had to hear that and you gotta make sure you have somebody that you can talk to [so that] you're not internalizing that because it does affect your mental health seeing what’s going on in the world, in your own community. [P7]

The experience of the emotional work resulted in their need to take a break to protect their own mental health at times. Some found that they were going home completely, emotionally done having nothing left for their family. Realising that this was a sign for them that they needed “to take a step back” [P2]. In addition to supporting their clients when needing to talk about past or present trauma and the ensuing impacts, nurses described the major psychological impact of losing patients. This is described by one nurse:

> it's a tough gig sometimes… I think we can count probably the number of people that we have lost is like above the 150 mark… And those are the ones that, you know, we know of and that we've appreciated over time. [Name] and I have held funerals for people with no family... [P10]

While recognizing that losing patients was a work condition of nurses more generally, some nurses described that working in harm reduction led to more prominent psychological experiences and impacts, potentially given the closeness of the relationships developed often over long periods of time.

The nurses also described harm reduction as heavy work that some become hardened to over time. A nurse described:

> A lot of people just kind of shut those feelings off. They see the same thing over and over again. Even working in the acute care bedside setting, you see people dying all the time. You'll be hardened to that eventually. I feel like we have a lot of our clients who do pass and not to say that you get used to it, but it's not as much of a, oh my goodness this person has passed away. It's still – it's very sad to see that, but it's not as shocking as somebody who doesn't work in that kind of field. [P7]

Heavy emotional work and patient loss contributed to the psychological experiences described by the nurses as part of their lived experience working in harm reduction. Hearing and witnessing traumatic patient stories and experiences, closeness of relationships, and patient loss contributed to these psychological impacts.

4.412 Worrying. In addition to the heavy emotional work, worrying was a constant psychological experience and impact of their work. Nurses expressed worry over a number of things, including that their patients would overdose and die. When nurses could not locate patients, they worried about their safety and wondered what might have happened to them. Nurses also expressed some feelings of worry when their patients needed to access other areas of health care, and worried about how they would be treated in those facilities. Nurses also expressed feelings of worry related to the patient's familial relationships (e.g., abusive home situations or young children at home). Worrying was often ascribed to the complexity of addiction and seeing people in vulnerable situations. One nurse described:

> especially when you see very, very, young people that don't have any sort of family support systems or anything. They don't have parents at home waiting for them to come out of detox. They don't have anybody calling to see how they're doing. That breaks my heart because I worry about where they will be in ten years or five years. Will they even be alive? [P5]

Several nurses described "bringing home their work" as a result of worrying about their patients saying, for example, "sometimes you can't help it, right, because your mind is still kind

of running with something, and whether it's that you're processing something or that you're still coming up with a solution or ways to help people" [P15].

Worrying was a common factor and psychological impact of nurses' experience of working in harm reduction with individuals impacted by substance use. In addition to and maybe also tied to worrying participants described feelings of frustrations and helplessness

4.413 Feelings of Helplessness. Feelings of frustration and helplessness were often associated with not being able to meet all of their patients' needs and sometimes not feeling able to help their clients at all. Nurses felt extreme frustration when they were not able to help, especially in situations when a patient is ready to be connected to a service but there are no beds available at that time for them, for example. One nurse described this type of experience as heart breaking. Another nurse similarly described the frustration like this: "Yeah. It grates on you sometimes for sure. And you have really frustrating days where there's no resources out there and you just want to beat your head against a brick wall. And I feel that totally" [P6].

Some nurses associated these feelings of frustrations and helplessness with wanting to cross the therapeutic nurse-client relationship (participant referred term). For example, one nurse explained:

> I see people that come in and they don't have shoes. They don't have a pair of shoes and they're going to be leaving in a couple of days and they don't have shoes on. Why can't I bring them shoes, you know? Like I don't feel like that should be an issue, but it is. You can't do that. So, that I find that most challenging, I think. [P8]

Feelings of anger and helplessness were commonly associated with the injustices that they see every day. For example, one nurse shared:

> And so, there are days where I cry in my office because it's just so fucking unfair that the deck is so stacked against people and that my resources are limited in terms of what I can do to help. But I also have to hold onto perspective. I can get upset, because I think

> anybody who tells you, oh well, I do these things, so I don't get upset, is just full of shit. If you do this work and if you work in this space, at some point you're going to get upset because there's a lot of injustice, a lot of stigma, and there's a lot of bullshit. That's a quote. [P11]

The nurses mentioned the need to be realistic about their role and what they were able to achieve. One nurse shared:

> …what I would say is every day when I come to work, I have to make a choice that although I'm going to do the best I can all day, sometimes my best is not going to be effective, or it might not meet somebody's needs, or they might just not be in a headspace where they're ready to have that conversation with me. And that doesn't mean that I'm a bad [nurse] or bad person. It might just be that circumstances are not conducive for this yet. [P11]

Feelings of helplessness were a common psychological experience and impact of the work associated with being unable to meet patients' needs, and due to the constant injustice they see in this role.

4.414 Feelings of Fulfillment. Besides the more challenging psychological experiences and impacts of their work, positive psychological experiences, including those most centred around feelings of fulfillment in assisting patients to achieve their goals, were experienced. As one nurse explained: "it is a really fulfilling area to work in because you see those little wins and you're supporting people to reach their goals and help to reduce the risks that are associated with substance use" [P14]. Another nurse echoed:

> And also, it's really nice and rewarding to see clients get sober, which doesn't happen all the time. But, I have this one client in mind that he struggled a lot and he had attempted, I think 3 or 4 times to get sober, but he had always relapsed. But now he's been sober for, I think, about a year now… So, stories like that are really cool and like it kind of shows you the effect and impact that harm reduction can have. Because like, if we weren't around, like he could have overdosed because he had overdosed in the site a few times

> and he could have overdosed and not even had the chance, you know, to recover. So that part of it is nice. [P18]

A nurse described this in relation to an opportunity to show respect to individuals, which in and of itself was rewarding:

> I think that we miss the humanity piece of people that are living with addictions, and they definitely get typecast and they get really crappy treatment in a lot of places. So, I feel like if you're really nice to them, even if you don't do anything, you know, if it doesn't really make a big impact, it does make a big impact because you've shown them respect and you've shown them love, and you've shown them that you know they're worth something, right? And that makes a difference to me. So, I find it super rewarding work personally from a totally non altruistic place. It makes me feel good. I can sleep at night. [P6]

This work provided the nurses an opportunity for constant reflection and growth. For example, one nurse explained:

> Yeah, yeah. I mean, especially with the opioid epidemic, we've lost clients and it's significant, right. Sometimes you work with people for a long time, you know, and so that stays with you. I think it stays with a lot of us in all of our different lines of work, though, right? Like we've all been impacted by something like that. So, there is that emotional piece. But that's also, you know, it's an opportunity for growth and learning. [P15]

The nurses expressed feelings of fulfillment being able to work with a patient population that expressed gratitude for their work. One nurse described:

> And like this is the first population that actually says thank you. Like in long-term care no one really says thank you, in the hospital no one ever says thank you. It's just get me this, get me that. And it's like when someone says thank you, I'm like, oh my God, no, thank you. Because it's like, it's so nice to feel appreciated, you know, and to know that because like, a lot of them will be like, you're like a friend like to us, you know. [P17]

Positive psychological experiences were also expressed by the nurses when patients shared that they felt safe with them. For example, as one nurse shared:

> But it's worth it. And like, I see the difference in the impact that we have on these people's lives and like, for a lot of them we're the only place that they feel safe and we're the only people they feel safe with and it's really important. Like, I, I really see the importance of it and that kind of makes the hard days better. Yeah. It's, yeah, it's touching. [P18]

The nurses' lived experiences of working in harm reduction included a range of psychological experiences and impacts, including heavy emotional work and patient loss, worrying, and feelings of helplessness, as well as positive psychological impacts that included feelings of fulfillment related to assisting patients to achieve goals, showing respect to a patient population often stigmatized, engaging in reflection and growth, working with a population that expressed gratitude, and affording opportunities to provide be a safe space.

4.42 Physical Experiences

Of all the nurses in the study, one reported having been assaulted in their work in substance use harm reduction. The nurse explained:

> I was spit on. Like assault sounds so dramatic, … and obviously our clients have a high probability of being HIV and, like, hepatitis positive. I got it in my mucous membranes. It wasn't just like on my cheek. It was like my eyes and my mouth. So, I went to emerg, and I got - I was put on pep for 28 days, but I'm okay. But I feel like it could have potentially been prevented with… a different [space] setup. [P18]

Otherwise, the nurses described feeling safe in their body in their work. One nurse described: "But for most people they kind of think that like, oh, the clients, you're scary. You know, they're going to get angry. You know, like honestly, like I've always felt safe working in [multiple harm reduction settings]" [P12]. This experience was echoed by another nurse: "I never

feel unsafe. But I know there is obviously safety [considerations], especially when my clients are coming in intoxicated and if there's no one else in the building, right, – I'm a single female… with a big box of suboxone beside me…" [P8].

Some nurses also discussed the societal perception that patients may be dangerous or unpredictable and how that perception could lead to the thought of nurses in this area experiencing physical impacts. The nurses recognized the potential for physical impacts and described the importance of de-escalation in their work. One nurse described:

> …we have a very good system of only having a certain amount of people in making sure, like if there are behaviours, which there are behaviours that's just a reality of most areas, but then basically have a good, good team like approach and de-escalation strategies [P12].

Several nurses shared that they had experienced more physical impacts working in other areas of nursing. This is reflected in how one nurse commented: "So, we kind of laugh about it sometimes, but one of my coworkers was like yeah, I've been like hurt physically and more injured in like [other area of nursing] than I ever have [in this harm reduction setting]" [P12].

Another nurse echoed:

> I've never been physically assaulted [here]. You know, sometimes you have to de-escalate some behaviours, but that's part of the role. I think I had been scared of, you know, physical assaults and verbal assaults more at [other area of nursing] probably just because clients there would be frustrated for whatever reasons… [P14]

The nurses shared that they generally felt safe in their body and work in harm reduction. Societal perceptions of substance use, and addictions may impact how their work is perceived as dangerous, though they do discuss the role and importance of de-escalation training in their work.

4.43 Protecting the Lived Body

The nurses protected their lived bodies from the impacts of their work including through self-care, opportunities for cultural healing practices, supportive group dynamics, reflexivity, and self-honesty.

4.431 Self-Care. Due to the psychological impacts of their work, self-care emerged as a necessary way protect themselves. For example, one nurse commented:

> So, I can go back in and do another day. I can go home, and I can refill my cup. And I can figure out what I need to kind of get myself back in the game, which sometimes looks like time spent by myself for a little bit. [P11]

This nurse described post-shift meditation to move from the nursing role to home life:

> Lately what I've been doing is I go home from work, I lay flat on my bed, and I do a 10-minute meditation with a guided meditation app. And that is enough of a pause that I can kind of go, okay, let's flip the switch. I'm stepping out of, you know, this [nurse] role who's doing harm reduction and who's, like, fighting the good fight for people. And now I'm just going to be at home. And now, I'm going to be with my family. And I'm going to recharge my battery. [P11]

Overall, self-care was important for nurses in managing the psychological experiences of their work and to sustain their ability to continue providing care in this area.

4.432 Cultural Healing Practices. In addition to self-care, opportunities for cultural healing practices were a form of protection from the psychological impacts of their work. For example, one nurse shared, “But we've been really lucky because we've been invited into Indigenous - culture, and we've been allowed to attend sweat lodge ceremonies and do a lot of healing work in that way together” [P10].

Some nurses also discussed opportunities to participate in smudging ceremonies after the loss of an Indigenous patient and how this was healing for them. This is reflected in how one nurse described:

> Just a lot of understanding the culture a little bit more, especially from being a super white [person]. It's good for me to know what's going on and how to provide them with adequate care. So, when we lose clients, especially clients who are Indigenous, we do a smudging ceremony outside and we… discuss our favorite parts about them and what we loved with them… And it's really, really beautiful. [P12]

For some of the nurses, opportunities for cultural healing work were an important part of their experience working in harm reduction and to protect their body from the psychological impacts of their work.

4.433 Supportive Group Dynamics (Shared Embodiment). Protection of the body was often held collectively by the nurses, emerging through relying on one another and supportive group dynamics. Both informal and formal debriefing were important elements to protecting the body. For example, one nurse explained, "With debriefing within the team and that sort of stuff, it's just a lot easier to kind of get through the day and not feel as emotionally heavy at the end of the day" [P2].

Workplaces that made space for debriefing and fostered support were integral to the nurses' sense of protection of their body from the psychological impacts. It was important to the nurses to have a "good group" or a "good team" to be able to lean on and support each other in difficult times. A nurse described an informal group chat with colleagues and its impact on their everyday work:

> It's pretty informal. We have a group chat… we have multiple group chats actually. We have a group chat where we just send each other memes, which is really fun. (laughs). And then we have a group chat that's involving our manager and when things are difficult, we speak about clients in their codes, so nobody knows really who they are except for us. Like, this person had a difficult time because of X, Y, Z. I'm bringing this home, what do you guys suggest that we do? So, we will often brainstorm, problem solving in this chat because it involves everybody, not just people that were available on

> that day. If something bad happens, day of, we will have a debrief… and actually have a conversation like okay, that was hard today. What do we do differently next time or how do we mitigate this or what do we - so, it's good. It's really good compared to the [another area of nursing] where we had absolutely no debrief. This is chef's kiss. It's beautiful. [P13]

Several nurses mentioned supportive team dynamics in terms of needing to step out. This is reflected in how one nurse mentioned:

> So, we always have a terminology of like stepping out. So, like if something's going on that's too much or patients too escalated or something's going on, it's nice. A team approach that we have is like, hey, I'm tapping out for a bit, do you mind jumping in? So, like, that's one thing that we've done is like, that person will instantly be like, yeah, absolutely. No, you know, no questions asked. Just kind of jump in. [P12]

Overall, group dynamics and a supportive team were important experiences that aided nurses in managing the psychological aspects of their work in substance use harm reduction.

4.434 Reflection. In addition to supportive team dynamics, reflection was central in their work to cope with the commonly experienced psychological impacts. As a result of their work, nurses reflected on their own privilege and life circumstances. For example, one nurse commented: “I feel like working in harm reduction, if you hold on to healthy perspective and reflection, you can't help but feel incredibly grateful for your life” [P11]. At times reflection assisted the nurses to make sense of and understand the psychological impacts of their work. For example, a nurse explained:

> If you're going to stick around in this field, you have to find ways to take care of yourself. And the other thing that I often will keep in mind is… it's sort of this concept of the work will not be finished in your lifetime but that doesn't mean that you get to put it down and not do it anyway, even though you're not going to see the end of it. Right? [P11]

Another nurse described needing to reflect on important questions from day to day:

> I think burnout is real. And I think though - from my perspective, the only way to really deal with it is to prevent it. Right? And so just being really aware of where you're at and, you know, did I sleep last night? What's keeping me up? What's stressing me out? And I got my sounding boards, my professional kind of people that I go to kind of help to work through things. [P6]

Nurses often used reflection to keep them grounded in their work and to help make sense of and cope with the psychological impacts of their work in harm reduction.

4.435 Self-Honesty. Closely related to reflection, the nurses often coped with the psychological impacts of their work through being honest with themselves. For some, "a big part of [self honesty] is just kind of checking your pulse," [P6] meaning that a lot of this work started with checking in with themselves. In doing this, several nurses shared that their reflections and self-honesty had led them to at times realize that they needed to take a step back from the work or decrease the time they worked in order to protect themselves and ensure they were able to be there for their families. A nurse explained:

> I did have to take a step back for a while. I have, you know, a child and he was going through some difficulties, and you know, we were losing clients to overdoses or being murdered or this or that, and it took a toll on me. So, I actually did have to step back for a couple of years. And I was just, like, no, I need to do this for my own health. [P2]

This nurse described needing a better work-life balance to be able to better provide for their family. Similarly, another nurse described moving from full-time to part-time work to be able to better manage the psychological impacts of the work:

> It does definitely impact mental, lots of times. I mean I actually…was full-time this past like year and a half and I actually just recently just dropped down to part-time just because it was getting to be a little bit too much. You know, it felt like, like I was there every day always thinking about work. I couldn't leave work at home. You're always

> worrying about, you know, the clients that you have been working with for the last week or whatever. [P9]

Many nurses described needing to be honest with themselves about how the psychological impacts of their work was affecting them and take appropriate action to best care for themselves.

4.44 Summary of Lived Body

The nurses experience in substance use harm reduction was emotionally heavy, shaped by experiences of patient loss, worrying, and at times difficulty of leaving the work behind. The nurses often turned toward practices that offered protection which included self-care, cultural healing practices, supportive group dynamics, reflection, and self-honesty.

4.5 Lived Time

Lived time, also known as lived temporality, was defined by van Manen (1990) as a "temporal way of being in the world [which included the] past, present, and future… horizons of a person's temporal landscape" (p. 104). This section is framed in how the nurses were engaged with the dimensions of lived time through memories of the past, present and thoughts of the future. van Manen (1990) wrote, "Whatever I have encountered in my past now sticks to me as memories or as (near) forgotten experiences that somehow leave their traces on my beings – the way I carry myself … the gestures I have adopted and made my own… the words I speak and the language that ties me to my past…" (p. 104). There were several examples in this work of how the nurses were engaged with the dimensions of lived time and past/present/future. They are categorized in subthemes which are discussed below and include the nurses' motivations to work in harm reduction, what kept them in this work, how working in this area had shifted their perceptions, and where they saw the future of harm reduction. The following section begins by describing the nurses' motivations to work in harm reduction.

4.51 Motivations to Work in Harm Reduction

The influences and motivations [reflecting lived past] that often-led the nurses to pursue work in substance use harm reduction [reflecting lived present] are described. Family histories of substance use, frustrations and challenges in other areas of health care, purpose-driven motivations, and opportunities to give back were important motivators to work in substance use harm reduction and further described below.

4.511 Family History of Addiction and Mental Health Concerns. Many of the nurses discussed their motivation to pursue harm reduction work because problematic substance use had affected their own lives. Some of the nurses shared stories of deep family histories of addiction and mental health concerns, often reflecting on the historical need for services in the community. Examples of these motivators are presented in terms of lived past, present and future (van Manen, 1990). For example, one nurse shared: "My family has a little bit of addictions issues, so it was kind of a soft spot for me [reflecting lived past/present] and, yeah, I definitely see a need in the community [reflecting lived present/future]" [P3]. Another nurse described their personal family history [reflecting lived past] as a motivation to help others [reflecting lived present/future] by explaining that "having some lived experience and family with mental health and addictions [reflecting lived past], I think just kind of helped me a little bit with maybe working as a nurse with people that were living with that [reflecting lived present and future]" [P4]. Another nurse described their motivation as wanting to see substance use from a different perspective as a motivator to work in this area:

> So, it was well, you know, I have lots of family with mental health and addictions [lived past/present]. It would be nice to see it from a different point of view and, you know, be able to have those wins with other people [lived present/future]. [P9]

A nurse expressed empathy as they reflected on their lived past/motivations and how their family situation could have been different:

> So, one is I am the byproduct of two alcoholics, functional alcoholics [reflecting lived past]. So, both of my parents had jobs that they went to. And I always had a roof over my head. And I always had enough food in my belly. So, I didn't live through what a lot of my folks on the street lived through [reflecting lived past]. But I am very much aware that had my parents had different jobs, or had my parents had jobs that were not unionized, the drinking could have become a big issue [reflecting lived past/present]. And then I very much could have lived this exact life [reflecting possible lived future]. [P11]

Another nurse, who described their motivation as a calling to assist with the drug poisoning crisis, shared the experience of friends being personally impacted:

> We are having quite a big substance use problem. Even just like one of my classmates from high school I think overdosed right in my second year of nursing school [reflecting lived past]. So, just a couple factors I think pushed me in that direction [reflecting lived present]. I felt like this was the right route to take. [P7]

Several of the nurses were personally impacted by addiction and mental health concerns that motivated them to pursue work in substance use harm reduction.

4.512 Frustrations and Challenges in other Areas of Health Care. In addition to family histories of addiction and mental health concerns, nurses shared their frustration with other areas of the health care system [reflecting lived past] as a major motivation to pursue work in harm reduction [reflecting lived present]. Subthemes that emerged from the data were (a) burnout, (b) being unable to provide comprehensive care, and (c) treatment of individuals with addictions as motivations.

4.5121 *Burnout.* Nurses shared experiences of burnout in their previous health care institutions. Many of them attributed their burnout to staffing shortages and unpredictable shifts, reflecting their lived past. One nurse explained:

> The [area of nursing] floated me on the floor and made me take a load in a place I was never trained. Anyway, it's the story that many nurses have. It wasn't like out of the ordinary, but I was done. I was like, that's it, I'm done. This is like I'm a horrible nurse, but it's not my fault. It's because of being short staffed. So, I was kind of at my breaking point [reflecting lived past] [P12]

Another described how working in acute care led them to start making judgements around addictions [reflecting their lived past], which was not consistent with their views, and that was the motivation to pursue a setting change, reflecting their lived present:

> I felt myself kind of shifting in [area] where I would start to see them as just a nuisance. And it was like, you know, that wasn't what I was feeling before I went into [area], it was not my thoughts on the opioid crisis [reflecting lived past]. And so, it was like, I'll just take a step back and kind of reevaluate things and, yeah. [P16]

As the nurses reflected on their experiences, they often described burnout [reflecting lived past] as a motivator to pursue their current work [reflecting lived present] in substance use harm reduction.

4.5122 Unable to Provide Comprehensive Care. Similar to burnout, some of the nurses expressed frustration working in previous health care settings and feeling that they could not provide comprehensive care to individuals impacted by substance use. For example, one nurse explained:

> So, I think it was sort of always on my radar. And I think working in the [area] I would get often frustrated with, you know, that I wanted to provide such like comprehensive care to people, but because of the workload and the time constraints that I felt like I could just, you know, it got to a point where I could just provide like basic care to people and couldn't, you know, like sit there and talk to them and like find out what their needs were. And it was just like doing the interventions that were ordered [reflecting lived past]. [P14]

Another nurse described having a similar motivation:

> So, you feel like you're always kind of butting heads with them and then it just kind of leads to a lot of tension in the department and stuff like that [reflecting lived past]. So I think in that sense, I don't know, it was nice to transition away from that and move into a space that had the time and the resources to actually see, to use that sentence again, like meet clients where they're at and not just kind of give them the boot and kind of like [reflecting lived present], okay, here's a taxi voucher, if that'll get you out of here, just go kind of thing. That's what we kind of did in [area]. It was like, here's a sandwich, get out of here [reflecting lived past] [P16]

As the nurses reflected on time, some of them felt that they could not provide comprehensive care to their patients in other areas of health care, reflecting lived past, which motivated them to pursue their work in substance use harm reduction, reflecting lived present.

4.5123 Treatment of Patients. Similar to feeling unable to provide comprehensive care, several nurses reflected on time and indicated that a major motivator to work in this area was because of the ways that individuals impacted by substance use were treated. Nurses who had worked in acute care often reflected on their experiences and expressed major frustrations with being unable to aid patients in need, reflecting lived past. A nurse commented:

> Like in [area] we're taught like just get people out, get people out, get people out. You see people and you know, they're struggling. But the doctor discharged you. See you later, you know. And I hated that part of it, I hated it, I hated it more than anything. And I felt like I wasn't helping people [reflecting lived past]. [P12]

Another nurse discussed similar feelings after discharging patients:

> So, a lot of the times we force them to walk back [to where they came from] which felt like shit. Truly, it felt disgusting. And that was every night shift. Every night shift we had to do this, and we never provided them with any assistance [reflecting lived past]… If these individuals wanted to go to detox, we treated them like they were a burden because

> then our bed would be blocked for longer in the [unit] for people that 'mattered'... which is the most incredibly frustrating thing in the world [P13]

Several nurses expressed not feeling that they were providing adequate care to individuals impacted by substance use, often leaving with feelings of worry and inadequacy in the care they provided. One nurse reflected on their lived past that led them to this work:

> …it just left you feeling kind of crappy at the end of shift sometimes. You just kind of feel like, you know, I would drive out of the parking lot after my shift in [unit] and I'd see the person on the street in the rain that I just discharged and I'm like, oh, that doesn't feel great [reflecting lived past]. Like I don't know where they're gonna go. [P16]

The nurses' stories and experiences towards the treatments of patients reflect their lived past and what led them to this work. They identified challenging past lived time experiences of individuals impacted by substance use having been treated very poorly which was a major motivator to pursue work in harm reduction.

4.52 Reasons to Stay

When the nurses reflected on their time working in harm reduction and what kept them in this line of work, they described the purpose-driven nature of the work and the opportunity to give back as the main reasons to stay, reflecting lived present.

4.521 Purpose Driven. The opportunity to help a vulnerable population of patients who often experienced stigma and marginalization was a major reason for staying in this work. One nurse shared:

> And then what sort of kept me here was seeing people being denied care in really vulnerable situations, or attending an appointment with somebody who really badly needed help, but who was, you'd watch the demeanor of, healthcare professional come in, and the way that they spoke to a person would be, I can't even believe you're getting away with this right now… [reflecting lived present]. And just seeing, the mistreatment

> of individuals with addiction and mental health and just feeling really, no wonder they don't want to exist in these settings because they're just retraumatized over and over again from our healthcare system [reflecting lived present]. And if you ask for help so many times, and what you actually come out with is just feeling really super ashamed and bad about yourself, then there's a good chance that you're not going to continue to try and access that service… [P10]

Opportunities to be a safe space to share and connect individuals to resources was an important reason that kept them in this work, reflecting their lived present. One nurse described how helpful it was to be aware of and have access to resources:

> I think it's really rewarding work... It's having the resources of [harm reduction setting name] has always been a place that I've thought like that it's a great place to work at. And having the access of the rest of the team here… we're pretty full for primary care folks before, but, I could go to them and say, this person needs primary care. You know, these are the risk factors. This is what's going on, and be able to get that [reflecting lived present]. [P15]

Another nurse gave a similar example of this motivator:

> So, to be somewhere where it's like here's some snacks and here's a referral to this place, and yes, you can stay here for a few hours. You can sleep. Like what do you need? You know, let me call this place to see if they have a bed for you, that kind of stuff. It just felt nicer that way to not so immediately feel like the constraints and pressures of an overburdened system [reflecting lived present]. [P16]

A few nurses described their work in harm reduction as a calling and something they were meant to do and felt at home doing. The nurses described their role as difficult but rewarding when they were able to help someone. For example, one nurse said “And then you don't want to leave because as much as there are hard days, there are also days where you're just like, holy shit, I did it [reflecting lived present]” [P11].

In reflecting back in time on what kept them in this area of work, the nurses described the purpose-driven nature of the work, including opportunities to care for a marginalized and stigmatized patient population and provide a safe space while sharing resources [reflecting lived present].

4.522 Giving Back. In addition to purpose-driven work, opportunities to give back was an important reason to stay in this area of work [reflecting lived present]. The nurses used their voice to give back to the community. One nurse remarked:

> And I think the initial piece for me that, what started all of this, I remember thinking oh, I feel like mental health and addiction work would be really hard because I feel like it would be really upsetting for me to have to deal with it all the time after living it [reflecting lived past]. But what I found is actually the opposite is true. It gives me a way to use my voice. And it gives me my own power back because I can help in this equation [reflecting lived present]. [P11]

Another nurse described their own personal history with mental health and addictions and explained that this work was an opportunity to give back to an area that once helped them:

> And it makes me emotional thinking about it, but just a lot of people that help me along the way as well. And I actually just saw a nurse practitioner just yesterday… and she had helped me when I was a teenager [reflecting lived past]. And now we've come full circle that she has seen me working there. And it was just so nice to reconnect with her, and just some things that people had said to me along the way that just really impacted me…So, I think for those people that had that impact on me, I thought it would be amazing to be that person for somebody else [reflecting lived present]. [P4]

The nurses reflected on their reasons for staying in this area of work and having the opportunity to give back to their community as a motivator.

4.53 Shifted Perspectives

In addition to giving reasons to stay in this area of work, there was a shift in their perspectives because of their time working in harm reduction [reflecting lived past/present]. This section describes the nurses' shifted perspectives related to substance use, broadly, and how they perceive individuals with addictions. In addition, the nurses described the shifts in their perspectives related to the complexity of substance use, including how it is identified, who it impacts, and how they see it as a spectrum. Finally, the nurses described ways that their work had led to reflections on their own lives and privilege.

4.531 Perceptions of Harm Reduction and Addiction. The nurses reflected on their perceptions of harm reduction and addiction, with some of the nurses indicating that their prior (i.e., to working in harm reduction) thoughts about harm reduction [reflecting lived past] were much different from their current views [reflecting lived present]. Some of them mentioned not fully understanding or supporting some or all harm reduction approaches prior to engaging in this work [reflecting lived past]. It was through time and their close work with a vulnerable patient population while seeing the impact of the services that some of them came to support and advocate for harm reduction [reflecting lived present]. One nurse remarked:

> I wasn't sure how I felt about that [reflecting lived past], but I totally support it now. I see a need for it. Like our clients are so vulnerable and some of them do reach recovery and do great things and they deserve to be supported and alive until they reach their full potential if, yeah, they're lucky enough. They're just people and so many of them have gone through so many hard things and essentially like children stuck in, trauma and things like that [reflecting lived present]. [P3]

Similarly, another nurse mentioned holding some negative opinions about substance use and harm reduction [reflecting lived past] and how their work and exposure to harm reduction shifted their perspective [reflecting lived present]:

> I think I just had a lot of personal opinions before I ever was exposed to it [reflecting lived past]. That having worked in nursing has really opened my eyes up a lot. It's created more sensitivity for me for people who actually are suffering [reflecting lived present]. [P5]

One nurse detailed a story about the ways that their work in harm reduction had shifted their perspectives related to how they saw patients with addictions:

> I don't think I was judgemental because I cared for every patient the same, but if I had a patient with say like cellulitis from IV drug use, I would almost say it was more of a burden patient than someone that had pneumonia [reflecting lived past]. And now I would totally say it would be opposite… I don't have more compassion for someone with an – like the addict but knowing that there's another component of rather than just pneumonia that you're treating, totally different [reflecting lived present]. [P8]

Time working in harm reduction and with individuals impacted by substance use was a factor that some nurses described as shifting their perceptions and perspectives of harm reduction and substance use.

4.532 Complexity of Substance Use. The nurses work in harm reduction shifted their perspectives away from a basic understanding of substance use to a more complex one. One nurse reflected on their rather simplistic understanding of substance use prior to working in harm reduction, reflecting lived past:

> And, you know, before I worked in the program, it was very much like why don't they just go to treatment? Why can't they just go to detox? I don't get why they're there doing this? [reflecting lived past] [P2]

Also reflecting lived past, another nurse shared how time and experience working in harm reduction shifted their perspective on ways to identify substance use:

> I kind of always thought that – I guess, before that, that people that used drugs would look very obvious and that's a personal opinion, right? I thought the people who were on

> drugs, you know, you'd know. You'd be able to spot it a mile away. You'd be able to spot somebody who started pills or injected drugs. You could see it. You could tell by the way they were dressed, or they were maybe sleeping on the street or something like that. [reflecting lived past]. And that is certainly not the case [reflecting lived present]. [P5]

Similarly, a nurse also explained that through their experience, their perspectives had shifted in how they understood who substance use could impact:

> I still see that to this day, working in detox, it affects so many different walks of life. It affects business professionals, teachers, healthcare providers. It affects everybody. Young people as well. So, if one thing I learned… addiction is definitely something that can affect anybody at any time in their life [reflecting lived present]. And I go back to like nobody chooses to go down that road. Like, yes, we all make a choice to try a drug or something like that, but at the end of the day, nobody chooses to end up with their life falling apart, basically, because of drugs. [P5]

Through their work, an understanding of the complexities of substance use and need for harm reduction services further came into view [reflecting lived past/present]. One nurse described how their experience shifted their perspective of the realities of the experiences of recovery:

> But in the [area of harm reduction], it's definitely trying to look at the person as a person and holistically and recognize that, you know, most people don't choose that life for themselves. They don't choose to become addicted to things. They don't choose to, you know, lose their job and all their, sort of, social structures in preference to being addicted to something. And I'm just sort of recognizing that it's a spectrum. Recovery is a spectrum [reflecting lived present]. [P5]

Through experience, an understanding of the complexity of substance use and the ways that addictions developed gradually emerged. A nurse, working in an isolated community, described the ways that their work in harm reduction led to a better understanding of the influence of boredom on substance use, reflecting lived present:

> I get it… Sometimes when there's nothing to do up there [isolated community], say in an evening, like I've been in bed at 6:00 [PM]. I don't drink. I don't do drugs. Like I'll have maybe a glass of wine once or twice a year. Like do not drink. And I was laying in bed one night at like 6:00 PM and [thinking]... a bottle of wine would be nice right now, and I'm like oh my gosh. A lightbulb went off. I maybe understand a little bit more too why people use substances up here because there's nothing to do. And I don't drink. So, I'm like why am I thinking about a bottle of wine right now?? [P8]

The nurses understood the ways that the complexity of substance use led to challenges addressing not only substance use but also the stigma and inadequacies in the system relevant to the root causes of substance use. This is reflected in how one nurse discussed the ways that their time working in harm reduction had solidified this understanding: "So, seeing those different pictures of things, seeing where there's like inadequacies in the system, all of that has kind of fed into us looking at different ways we can support people. You just notice different things [reflecting lived past/present]" [P15].

As a result of their work in substance use harm reduction, the nurses had a deeper understanding of the complexity of substance use in terms of who it affected and how it is lived.

4.533 Personal Reflections. Over time, the nurses' experiences in harm reduction often put things in their own lives into perspective [reflecting lived present]. Some nurses reflected on their own privilege as a result of their work. For example, one nurse shared a reflection from their work [reflecting lived present and future]:

> Because in reality, I have the easy job. I offer suggestions. I offer treatments. I offer help. But then, I close my computer, and I get in my car, and I drive home to my warm house, to my, you know, bank account with enough money that I can go buy whatever I need in that moment, and there's food, and there's people who love me, and there's nobody who's going to cause me harm. So, I get to step away from it. And so, sometimes that

> perspective is very helpful to go, yeah, this is hard, but I don't have to live half -- even a fraction of what my folks are living through. [P11]

Another nurse shared their perspective:

> I had a client who, it was minus 30, and he spent the night in a dumpster. That's just awful. And then I sit in my car on the way home with my heated seats and heated steering wheel off to my, you know, home and [partner] and everything. [P15]

Working with vulnerable patient populations often had the nurses reflecting not only on their own lives but also on the inequities faced by several individuals impacted by substance use. One nurse said:

> So, I think if anything it kind of gives me that perspective. It's like, man, life is really crazy for a lot of these people and super unfair. And the traumas and cards that they were dealt were just like, yeah, it just makes you really reflect on it. But if anything, it just gives me perspective that, yeah, maybe what I'm dealing with isn't so bad [reflecting lived present]. [P16]

As a result of these shifted perspectives, they became advocates for harm reduction in their community. This is reflected in how one nurse stated:

> It's interesting to see the shift in my perception versus before – from before when I was not in the program [reflecting lived past] to being in the program now [reflecting lived present]. And even some of the things I say to like family or friends, when they start saying like, oh, the encampments and this and that and why don't they just go get housing and stuff? And I was like, oh, it's so much more than that. [P2]

The nurses work resulted in shifted perspectives, in the ways that they perceived harm reduction, addiction, and the complexity of substance use, and resulted in personal reflections on their own lives and privilege.

4.54 Future Directions of Harm Reduction

The nurses shared their experiences working in harm reduction in relation to time and the future directions of where they saw harm reduction going and/or what they saw it needing [possible lived future]. Additional services to manage the drug poisoning crisis emerged as a major concern. As well, the need to advocate for and better educate society regarding not only the ways that people understand substance use but also the role of harm reduction services in communities. Finally, the need to better prepare nurses to work with individuals impacted by substance use and offer harm reduction services.

4.541 Expanding Services. The nurses overwhelmingly emphasized the need for additional resources in substance use harm reduction. The need for safe smoking sites was emphasized, as the nurses recognized the shift from injectables to inhalants. For example, one nurse working in consumption treatment services stated:

> A big thing to me is that our site is set up so that people can consume drugs intranasally, orally, or via injection [reflecting lived present]. A lot of people who are overdosing in the community are smoking substances and we just currently don't have the facility set up to accommodate that [reflection on possible lived future]. [P14]

Another nurse working in the same setting shared:

> I really think that a safe smoking site would be ideal, even if we could just work outside and provide them with a safe area to smoke. That way if you fall and you overdose, I can Narcan you or I can give you oxygen [reflection on possible lived future]. [P13]

The need for better availability of beds and more space was also emphasized [reflecting possible lived future]. The nurses expressed frustration with having to turn people away when resources were not available [reflecting lived past/present]. One nurse commented:

> … where we try and connect people with resources, but they just aren't there. So sometimes we're just like… there's no detox beds and we close in half an hour, so see you

> later. Like that kind of never feels good and always kind of feels like you're just leaving people high and dry. [P16]

Space, too, was a constraint for some nurses, especially during colder days. One nurse working in consumption treatment services commented:

> Sometimes during the winters we get really busy just because we kind of act as a warming center in addition to being a consumption site, so if we had more space [we could help more people - reflecting possible lived future]. Right now, we have a max of seven clients at a time and only four people can use the consumption room, which can fill up pretty quickly when it's really cold outside and you have people living outside. [P16]

Several nurses hoped to see the expansion of harm reduction services to provide better coverage across their area. Again, this reflects the nurses possible lived future if services were expanded to support more people. One nurse commented:

> I hope just in [city] that we can expand it. With [area of town] there's a whole - everyone always says that comes in there they always ask like, "Oh, do you have a place in [area of town]? And it's like no. There's a whole other world over there that we're not addressing and that, you know, we can. Now that I'm in this – like I can recognize clients as I'm walking around town and stuff. I can see people and it's like, oh, they live over on this side of town and they have to bus all over to us if they want something or have an appointment or whatever. Like so hopefully it just expands, and we can get another site.

The nurses asserted that the future of nursing in harm reduction warranted additional resources to better manage the drug poisoning crisis, reflecting a possible lived future. In particular, the nurses working at the safe injection site stressed the need for a safe inhalation site because of the shift in substance use to inhalants from injectables. The future of harm reduction, from the nurses' perspectives, also involves an expansion of care (beds, coverage) to meet what continues to be needed.

4.542 Scope of Practice and Prescribing. Opportunities for expanded scope of practice and prescribing were also emphasized, reflecting a possible lived future. Some nurses shared that they did not always have access to prescriber which can impact their work [reflecting lived past/present]. The nurses described having reliable access to a prescriber as critical when working with a vulnerable, often difficult to locate, patient population. A nurse working in consumption treatment services commented:

> Me and my coworkers have also talked about providing more primary care services and I've seen talks in the CNO about expanding the RN scope to be able to prescribe and stuff. So, I think that would be super helpful. Like in terms of especially just like antibiotics for like a UTI or for like very simple things that can be so quick that would eliminate them having to wait eight hours in emerg or walk in or like eliminate that stigma because obviously like we like to, you know, not a lot of stigma in our facility, so they feel a lot safer. So, I think if we could expand or like work to our full scope and like be able to administer IV antibiotics if need be or like stuff like that. [P18]

Another nurse discussed RN prescribing for contraceptives, noting, “If we could prescribe contraceptives because of a lot of sex work that goes on, almost every female who comes in the door is involved in sex work, so that would be a huge one” [P16].

Potential future opportunities to expand scope of practice from the nurses’ perspectives were explored, reflecting a possible lived future to better meet needs.

4.543 Address Social Determinants of Health and Access to Care. As previously discussed, the nurses understood the broad determinants of health, highlighting the role and impact of the social determinants of health (SDOH) on individuals affected by substance use [reflecting lived past/present]. The nurses consistently discussed the need for resources to better address the SDOH, also reflecting a possible lived future. A nurse noted:

> But I think those are the hardest things and that it would be nice to do more to address, whether it's through our work here or elsewhere, but it's just trying to help more with that. The psychosocial stuff. Right. The lack of housing, the barriers and stuff that are out there for folks. [P15]

The nurses also recognized the challenges and barriers that individuals impacted by substance use experienced accessing acute care. Based on their experiences working in harm reduction [reflecting lived past/present], the nurses described the need for collaboration with acute care settings [reflecting a possible lived future], given the population of interest is often referred to and accessing this area. A nurse commented:

> Also building those pathways between the ER, we've been doing a really good job between ourselves and detox. We have tried with the ER. I think there's more on the horizon and hopefully very soon that will improve those pathways. But, you know, that's work I want to be a part of. Yeah. [P15]

As a result of their work in harm reduction, the nurses described that the future of harm reduction requires better addressing the SDOH and access to care for individuals impacted by substance use.

4.544 Advocacy and Societal Shifts in Understanding Substance Use and Harm Reduction. In addition to addressing the SDOH and access to care, the nurses emphasized the importance of and need for advocacy and societal shifts in the ways that substance use is understood [reflecting lived past/present/possible future]. Possible lived futures are reflected in the next examples the nurse gave about where they see the future of harm reduction and their role within in. Most nurses pointed to the need to address stigma and its effect on individuals impacted by substance use. The need to educate the wider community about what harm reduction entails, and how it works was also central. Additionally, the need to share the experiences of individuals impacted by substance use was emphasized. A nurse commented:

> I'd like there to be more advocating… I think more of these stories need to be told because a lot of people have, that don't work in the field… just have this, you know, they see the people struggling on the streets and oh, there's needles on the ground and this is awful, and they need to leave these encampments. Well, where are they going to go? They're just, every one of our, the people we serve has been through things like you can't even imagine and you know, a lot of it all stems back to residential schools and things like that and generational trauma and I think it's a community's responsibility to kind of look at solutions to prevent such things as not kick them out of the encampments. [P3]

In addition to educating the wider community, the need to educate the health care system about their role and the interventions they provide was emphasized. One nurse remarked:

> And with methadone, suboxone being around for quite some time, that's not really anything new to most people in our community. I think a lot of people are very much against it, and I have heard, like, nursing colleagues be against that too, saying that you're trading one addiction for another. And, you know, once you're on that, like, you're never going to get off of it. [P4]

Sharing their experiences and knowledge more broadly within the health care system also emerged, extending their learnings into other areas of health care. One nurse noted:

> Like for me, it would be going to all the doctors' offices, all the places and you know, teaching them about starting people on suboxone, maintaining people on suboxone in their office. It is not a big deal at all. You know, we'll start them. We'll give them to you. You just need to carry it. It increases our capacity, right, so that we can discharge some of these folks. Anytime anything changes, they want to go off it. They want to change your dose. You're not sure? Call us, send them back. Whatever. Same with alcohol use, right? [P15]

Societal perceptions of their work as enabling came into view, alongside the need to address the commonly encountered misconceptions, as one nurse stated:

> And so I try to educate people outside of here and say, no, there's more to this than what you just see. We're not enabling. We're saving lives [reflecting past/lived present] So, I'm trying, I feel like a lot of people are not educated. They don't really understand, society as a whole. They just don't get it. They just see somebody breaking into a car and getting, you know, whatever change they have. And it's like but where does that come from? They're not doing it because it's for kicks, you know what I mean? A lot of them are doing it for survival. And I try to tell them [it's about] mental health and what's going on with them. It's all about survival. You know, people don't become sex workers just for the hell of it. It's survival. And a lot of them turn to drugs, you know, to sort of ease that pain. And I don't blame them. I don't blame them but people don't grasp that. So, I really take it upon myself. I've actually taken some articles and I put it in the mailboxes of people (laughs) of my neighbourhood [reflecting lived present]. So, I'm like, you know, read. So, I don't know what else to do. [P17]

By reflecting on their time working in harm reduction, the nurses saw the future of their work as involving advocacy and the need to shift societal perceptions of substance use and harm reduction.

4.545 Preparing Nurses for the Work of Harm Reduction. The nurses asserted that the future of harm reduction also involved nurses who are more fully prepared to care for individuals affected by substance use [reflecting a possible lived future]. Several of the nurses described the lack of preparedness and training caring for individuals with addictions as well as substance use in their academic program [reflecting lived past/present]. One nurse said, "They're not providing enough education…That should be a mandatory part of everybody's training, right? Because the way it's been changed is through that education piece. Right" [P15]. Another nurse shared a similar experience in reflecting on their nursing education:

> Very briefly, I think it was one lecture or like half a lecture and like in fourth year community nursing, I think it was in. And I think if I remember correctly, I'm pretty sure it was someone from the health unit who came and talked to us about harm reduction.

> And like the way he kind of explained it was like, oh, yeah, that makes a lot of sense. I think like I remember [them] saying, they're going to do it anyway. So rather than them, you know, injuring themselves more or creating more of an infection or whatever, why not just stop it there and meet them where they're at and give them the clean supplies to hopefully avoid them getting hepatitis. And people say they're a burden on the healthcare system. Well, they're going to be even more of a burden on the healthcare system if they don't get the proper care and if they are using dirty needles and if they're, you know, not getting the harm reduction they need. [P18]

Some nurses identified the need for nursing students to receive hands-on training in addictions and harm reduction. This is reflected in how one nurse explained: “I think every nurse should experience working in harm reduction maybe. Maybe that’s what the nursing students, like, have a placement specific to harm reduction [reflecting a possible lived future]. I know that might be hard somewhere like this because the placements are limited [reflecting lived present]” [P3]. This nurse also shared how experiential learning opportunities are critical to prepare nurses to work in harm reduction and care for individuals impacted by substance use. They commented:

> Yeah, because you can read about it, but you don’t really understand. I think you can read about what harm reduction is but knowing the background of the clients is really, yeah. It’s hard to not love them after and care for them. [P3]

The nurses saw opportunities to better educate and prepare nurses for the workforce by providing more mandatory education on substance use, addictions and harm reduction, and hands-on training, reflecting possible lived futures.

4.55 Summary of Lived Time

Lived time, or lived temporality, according to van Manen (1990), involves the past, present, and future aspects of individuals’ experience. In my study, the nurses’ experiences in terms of lived time were explored, including what motivated them to pursue work in harm reduction; what kept them in the work; ways in which their experiences had shifted their

perspectives of substance use and harm reduction; and where they saw the future of and their role in harm reduction.

4.6 Chapter Summary

This chapter presented the lived experience of eighteen nurses working in substance use related harm reduction in northwestern Ontario. It delved into van Manen's lived world existentials, lived relations, space, body, and time (van Manen, 1990) and explored the main and sub themes related to the nurse's experience in their work.

5.0 Chapter Five: Discussion

The purpose of this phenomenological study was to gain an understanding of the lived experiences of nurses working in substance use harm reduction in northwestern Ontario. The findings expand current understanding of the experiences of nurses working in harm reduction and are framed using van Manen's (1990) lived world existentials: lived relationality, lived space, lived body, and lived time. The four existentials, including their themes, are discussed and situated in the literature.

5.1 Existential 1: Lived Relationality

Six main themes revealed the meaning of the lived relational experiences of nurses working in substance use harm reduction: (a) importance of trust: care as relationally contingent, (b) honouring of commitments and consistency, (c) non-judgemental attitudes, (d) ability to be approachable and speak the patient's language, (e) respect for patient autonomy and privacy, and (f) use of incentives. The essence of what it means to work as nurses in substance use harm reduction was apparent in the nurses' descriptions of their relational experiences, particularly in the importance of trust and other relational aspects of care when working with individuals impacted by substance use.

The ways that nurses described their relationship dynamics, and the development of trust reminded me of a burning fire. See figure 1 below. The image reflects the relationship development between the harm reduction nurse and patient. The fire/flame is the relationship. The fire is initiated by oxygen/air and wood (fuel). The air represents the trust and the wood represents the trust building factors. To build and sustain a fire (relationship), oxygen/air (trust) and fuel (trust building factors) are needed, all further described below. Just as important, the nurses also described how quickly the fire (i.e., relationship) could be extinguished (i.e., by

water), so they were very mindful of the ways that they interacted with patients and maintained their commitments.

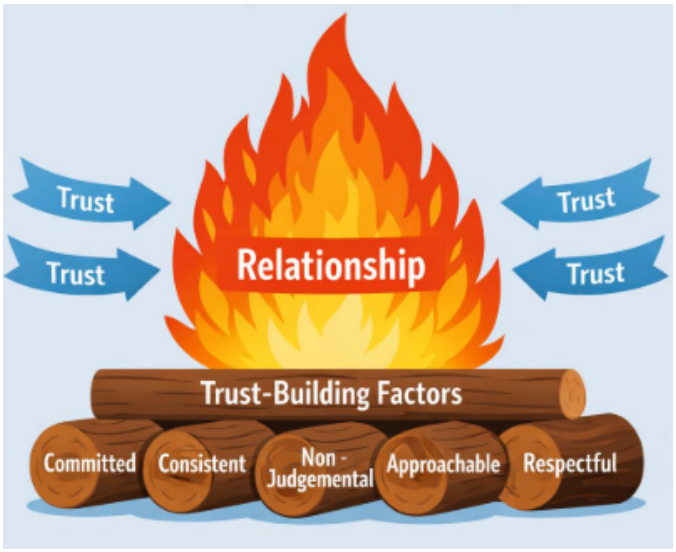

Figure 1: Lived Relationality: Relationship Building (developed by AI)

5.11 Importance of Trust: Care as Relationally Contingent

Within the nurses' harm reduction practice, care unfolded through the development and maintenance of relationships with individuals accessing the services. Nursing care and trust development were inherently relational processes for the nurses. The essence of the nurse's experience is that trust development takes time, is incremental, and especially in this work, is impacted by the patient's experience, reflecting the experience as relationally contingent. It is developed through persistent presence and dependability which allows for risk disclosure and ultimately promotes patient safety. Although it is described further below, trust is closely related to "meeting people where they're at" in how nurses work reduces barriers which builds trust. The harm reduction nurses' role in "meeting people where they're at" is explored below.

The findings related to trust in this present study build on previous work by Hammond and McGee (2024) describing the role of outreach harm reduction nurses, which emphasize the importance of building trust. There were several facilitators of trust, described in more detail

later in this section, that helped nurses develop trust with their patients. The nurses also understood why individuals impacted by substance use lacked trust in the health care system and their role in rebuilding it. They mentioned "word of mouth" as an indicator of the trust developed between them and their patients. Related to the literature, some previous researchers have touched on trust (e.g., Creasy et al., 2025; Forchuk et al., 2023; Pauly, 2008; Reed et al., 2023). Forchuk et al. (2023) investigated the barriers and facilitators to implementing harm reduction for methamphetamine use in the hospital settings. They found that many providers discussed lack of trust as a barrier related specifically to the history of negative experiences that patients had with the health care system. Forchuk et al. discussed the ways that relationship development could enhance trust by acting in a way similar to that of facilitator.

Creasy et al. (2025) described trust as an important component of a positive patient-provider relationship among health care workers caring for individuals who were HIV positive and using substances. Reed et al. (2023) studied the experiences of ED staff with the pilot testing of fentanyl test strips. The authors described how some participants believed that the distribution of the strips helped to foster trust with the clinicians. These findings are similar to the ones in this present study as many of the nurses believed that harm reduction interventions broadly, including providing clean supplies, aided in trust development. In a study with NPs completing buprenorphine prescribing in primary care settings, participants described flexibility in prescribing as an important component of patient provider trust (Speight et al., 2023). Nursing literature often describes the importance of trust in the therapeutic relationship (Gottlieb, 2014). In many of these studies, the researchers did not delve into how trust with patients was developed or how clinicians knew that they were developing trusting relationships with their

patients. Thus, this present study expands our current understanding of how trust is developed among harm reduction nurses and their patients from the nurse's perspective.

Lived relationality, particularly the importance of trust in relationship development, was the essence of the experience of working in harm reduction with individuals impacted by substance use. There were several ways that they built trust in their practices: honouring of commitments/consistency, non-judgemental attitudes, ability to be approachable/speaking the patient's language, respect for patient autonomy/privacy, and the use of incentives. Each way is discussed in the following text.

5.12 Honouring Commitments and Maintaining Consistency

Honouring commitments and maintaining consistency are critical to the development of trusting relationships with patients and this is not a surprise. Nurses understood power differentials between them and the patients, and why relationship building such as honouring commitments and maintaining consistency was incredibly important and necessary when power differentials exist, and in how nurses understood vulnerability. Power differentials between people who use drugs and those who provide care has been explored in the literature (Belle-Isle et al., 2016) and this work contributes to the nursing perspective. The nurses in this study highlighted the need to honour commitments because they understood the delicate nature of the relationship and the development of trust. Part of their work involved honouring commitments (e.g., keeping promises) even when they had other competing commitments or lack of time. Consistency was also a facilitator to the development of trust in that, especially for outreach nurses, they maintained consistency related to where they would be on certain days. The nurses understood the importance and priority of maintaining commitments and being consistent. These examples align with critical social theory (Browne, 2000; McCall et al., 2019) and are

emancipatory in nature and provide opportunities for nurses to rebuild trust and repair institutional harm.

While honouring commitments is an important component of nursing practice curriculum (Doane & Varcoe, 2020), primary literature on the experiences of nurses working in substance use harm reduction specific to maintaining commitments and consistency has been sparse. Research has focused more broadly on the role and commitments of nurses related to social justice (Pauly, 2008a). Maina et al. (2020) discussed that the patients' commitment to recovery enhanced the patient-clinician relationship, though this is discussed in relation to the health care providers' trust in patients. This study suggests that there may be other important considerations, not currently covered in the literature, related to nurses' experiences maintaining commitments and consistency while working in substance use harm reduction.

5.13 Non-Judgemental Attitudes, Being Approachable and Speak the Patient's Language

Adopting a non-judgemental stance, being approachable and speaking the patient's language served as important relational signals in the nurse's practice. Adopting a non-judgemental stance was central to their experience. In particular, this related to not being judgemental of an individual's choice to use substances, and in how they recognized that substance use is not a choice. The nurses highlighted that it was important for patients to know that they were not being judgemental, and they often would tell patients that their care was in a "no judgement" zone. Though they would state it, it was shown through continued care regardless of a patient's decision to continue using substances or to not follow through on plans. A non-judgemental stance is linked to the previous theme of maintaining consistency. Not in the location the patients expected the nurses to be in, but more in how harm reduction nurses are consistent in their response to patients regardless of if they are using or not. This is expressed in

their gestures, tone, facial expressions and presence. It is clear through their experiences that non-judgemental care was inherent to their practice in harm reduction. Some literature on nurses' perceptions of substance misuse (Kratovil et al., 2023) and harm reduction (Ford, 2010) was negative or conflicted (Denis-Lalonde et al., 2022). In one study, nursing students simultaneously believed that harm reduction was inherent with nursing practice, that addiction is complex, but still expressed beliefs around addiction that were incongruent with harm reduction (Denis-Lalonde et al., 2022). Other literature of clinicians working within harm reduction has been more favourable in promoting non-judgemental attitudes (Anderson et al., 2022; Jiao et al., 2024).

Being approachable was also an important component of developing trust and relationships with individuals impacted by substance use. Being approachable was not a single action by the harm reduction nurses, but rather a relational signal. It was related to and built by the nurse's non-judgemental stance, and other factors related to trust more broadly. Approachability was increased when the settings are less institutional and respect patient privacy, further described below. As far as this author is aware, no other primary studies of nurse's experiences of working in substance use harm reduction discuss being approachable. In previous research, approachability among counsellors who work with individuals impacted by substance use has been explored, and it was found that counsellors with lived experience of substance use were perceived as more approachable (Russell et al., 2021). Related to approachability, some nurses in this study used different language when communicating with individuals impacted by substance use, highlighting the use of casual language that included jokes and teasing to build rapport. This way of speaking emerged as a way of fostering connection and trust. Although patient-forward language has been recommended related to how

nurses talk about substance use and the drug poisoning crisis (Collins et al., 2018), to my knowledge, this study is the first that focuses on the way that nurses working in harm reduction used language in this way to build rapport.

5.14 Respecting Patient Autonomy and Privacy

Respecting patient autonomy and privacy were central to the nurses' experiences in harm reduction, with presence and assistance offered to patients generally without requirements or expectations. The nurses understood paternalistic approaches as not being consistent with harm reduction and emphasized patient-centred goal setting, highlighting that their own agenda may not have matched that of their patients. Respect for autonomy is one of the results of non-judgemental attitudes, that leaves space for individuals to decide what is right for them. The way in which the nurses promoted autonomy in this study is consistent with how nurses respected patient choices and decision-making capacity in other work (Pauly, 2008b). Respecting patient privacy was another way that the nurses developed relationships. Given the sensitive nature of substance use, several nurses described the importance of anonymity in their work. Some nurses described working in settings in which patients did not need to divulge personal information until they were ready to do so and perceived this right to be a facilitator in developing trust. Interestingly, anonymity or the promotion of privacy was not discussed in any of the primary studies in the literature review, possibly because the setting for many of the studies (i.e., emergency/acute care) posed additional barriers to the promotion of anonymity. Regardless, respecting patient privacy is described as important in nursing practice generally (College of Nurses of Ontario, 2025), and the nurses in this study often emphasized its importance.

5.15 Use of Incentives

Some of the nurses used incentives in their work to help build connections, including giving out food, water, and gift cards to encourage individuals to access services. The use of incentives was a relational gesture, an opening, which created space to develop relationships and trust. To my knowledge, no other researchers have described the use of incentives by nurses in substance use harm reduction to build trust and relationships with individuals impacted by substance use. A recent study investigated the implementation of incentives in family medicine for opioid use disorder treatment (Ellis et al., 2025). Though this work centered on contingency management knowledge and preferences in program implementation. The use of incentives among nurses working in harm reduction to develop trust could be explored further.

The essence of what it meant to be working in harm reduction was reflected in the nurses' descriptions of their experiences relationally, with the development and maintenance of trust [oxygen/air] being crucial in their work. Several factors influenced the development and maintenance of relationships [fire/flames], including the maintenance of commitments and consistency, non-judgemental attitudes, ability to be approachable and speak the patient's language, respect for patient autonomy and privacy, and the use of incentives [wood/fuel].

5.2 Existential 2: Lived Space

In addition to lived relationality, the nurses described the essence of their experiences related to lived space, that is, how people feel about and perceive their space (van Manen, 1990). Lived space contained two main themes: (a) nurses' conceptualizations of the space of harm reduction and (b) factors underpinning the conceptualizations, as well as sub-themes outlined below.

5.21 Conceptualizing the Space of Harm Reduction

The nurses conceptualized the space of harm reduction, which involved: (a) meeting people where they are at; (b) pragmatic thinking (space as pragmatic); (c) advocating (space as advocacy); (c) working in the grey (space as negotiated), and (d) broad boundaries (space as expanded).

5.211 Meeting People Where They're At. The nurses commonly used the words "meeting people where they're at" to explain how they conceptualized their role in the space of harm reduction. This phrase was the essence of their experience and the lived space of working in harm reduction. Despite the use of the words, "meeting people where they're at" being found commonly in the literature (Bratberg & Kubicsko, 2020; Carney et al., 2025; Denis-Lalonde et al., 2022; Febres-Cordero et al., 2023; Perera et al., 2022), primary research exploring and describing what this entails from a nursing perspective has been scant. In this study, three themes emerged that described how nurses conceptualized "meeting people where they're at": (a) going to the people: space as mobile, (b) adapting approaches to meet needs: space as adapted, and (c) prioritizing patient goals: space as patient led.

5.2111 Going to the People (Space as Mobile). As part of their experiences and conceptualization of the space of harm reduction and "meeting people where they're at," the nurses work often involved going to the people, thus their space was mobile. Many of them described this effort as being different from past or other areas of nursing, citing outreach as an important component of their work. The space in harm reduction work was not just the clinical or office space, it was often described as streets, tents, coffee shops, homes, mobile vans etc. where nurses provide care in people's everyday lives. Going to the people meant going to where the people were physically located, which required the nurses to have a good understanding of the community's composition and needs. The ability to be opportunistic, meaning the ability to

provide care then and there, was important because the opportunity may not happen again. This assertion was similar to one expressed by the participants in Anderson et al.'s (2022) study, in which service providers of a harm reduction service indicated that harm reduction workers working alongside nurses helped to provide instant care (e.g., without requiring appointments) and avoid missed opportunities. Overall, going to the people was an important component of lived space and related to the previous existential, lived relations, in how it shifts power differentials by not requiring patients to come into an institution to be deserving of care.

5.2112 Adapting Approaches to Meet Needs (Space as Adapted). In addition to going to the people, the nurses consistently adapted their approaches to meet needs, reflecting a responsive and flexible approach to harm reduction work and adapted spaced. Examples included rearranging day-to-day schedules, adjusting staffing, and using alternative approaches to contact patients (e.g., Facebook messenger). This is closely related to lived relationality in how it reduces barriers and builds trust. Consistent with other research, a study of NPs conceptions in providing medications and safe supply in primary care found that NPs adapted their practices to meet needs, including those related to novel treatment protocols (Whitfield et al., 2025). Similarly, Glegg et al. (2025) reported a shift in prescriber approaches in response to the COVID-19 pandemic, with many going to the people and adapting approaches to meet needs.

5.2113 Prioritizing Patient Goals (Space as Patient-Led). Prioritizing patient goals was also emphasized in how the nurses' conceptualized their work in the space of harm reduction. The nurses overwhelmingly agreed that harm reduction involved respecting patients' choices, and they described many of their interactions with patients as being goal centred. The nurses generally disregarded paternalistic approaches and respected patient autonomy. This was central

not only to the space of harm reduction but also an important component of lived relations and trust development described prior. Related to lived space, the nurses worked with patients to create a therapeutic space consistent with the patient's goals. This result is consistent with previous research by Glegg et al. (2022), who conducted an environmental scan of harm reduction services and reported that harm reduction sites were flexible in the care provided and included the monitoring of patient goals and health.

5.212 Pragmatic Thinking (Space as Pragmatic). In addition to 'meeting people where they're at', the nurses explained the need to be pragmatic in their understanding of the opioid epidemic, their role within it, and the contextual factors that influenced their pragmatic thinking. The nurses felt that a pragmatic approach helped them to accomplish things realistically. This was somewhat consistent with how Hawk (2017) described pragmatism as a harm reduction principle. The authors described pragmatism as being more related to health care providers' realistic expectations of health behaviours. Some of the nurses in this study did discuss realistic expectations of health behaviours, but more of them discussed pragmatic thinking in terms of being realistic about their role in combating the drug poisoning crisis.

5.213 Advocating (Space as Advocacy). In addition to pragmatic thinking, advocacy was a central essence of their experiences working in and conceptualizing the space of harm reduction. They provided numerous examples of advocacy in their work and often described themselves as trailblazers. The nurses consistently cited the need for persistence and strategy when completing referrals for individuals impacted by substance use. The nurses felt that their work extended beyond their jobs, and many of them indicated that they had advocated at the community, health care, and societal levels. It is through the existential lived relations that relationships and trust are developed that helps nurses make progress towards advocacy efforts

with patients. Additionally, advocacy efforts were often rooted in and fueled by the nurses understanding of vulnerability and power dynamics, consistent with critical social theory (Brown, 2000; McCall et al., 2019). How the nurses described their role in advocacy was consistent with what previous researchers had found among nursing students' conceptualization of harm reduction (Denis-Lalonde et al., 2022). Denis-Lalonde et al. reported on student nurses' desire for nurses to become more politically active. This study did not delve into the role of nurses in system and political advocacy and change, an area that may be of interest to future researchers.

5.214 Working in the Grey (Space as Negotiated). Working in the grey emerged as a negotiated space, where the nurses navigated institutional expectations, policies, professional roles, boundaries and patient realities. Primary research exploring harm reduction nurses' experiences working in the grey has been limited. Similar to this work, Whitfield et al. (2025) conducted a phenomenographical study of NPs' conceptions of their capability in providing safe supply in primary care. Their findings indicated that NPs reported a lot of grey areas in this area of work, though authors did not explore them in detail. Nurses' experiences working in the grey could be further explored because there could be practice and policy implications, especially in northern settings where resources may be more limited.

5.215 Broad Boundaries (Space as Expanded). In addition to working in the grey, the nurses work had wide and broad boundaries, often involving work outside of typical disease management which enabled them to meet social needs. This could be explained by and related to the nurses work in "meeting people where they're at" in going to the people and providing more flexible approaches to care. This is consistent with the findings of Pauly's (2008b) work in which the primary care nurses in the study described their role in harm reduction as reducing social

harms. Some of the other research on boundaries has focused on health care providers setting boundaries with patients (Gray, 2014; Speight et al., 2023). Although the nurses gave some examples of their work within the blurred/extended boundaries, future work could explore these processes in more depth, and whether this is context dependent (e.g., attributed to the northern setting/limited access to resources) or central to the harm reduction nurse role.

5.22 Factors Underpinning Conceptualizations

The nurses overwhelmingly described their work as involving an ethical approach to care, and they shared their understanding of vulnerability and the reasons some individuals may use substances. Alternatively, Denis-Lalonde et al. (2022) found that the student nurses in their study had ethical concerns with providing harm reduction to individuals impacted by substance use. As previously discussed, Punches et al.'s (2020) study of ED nurses' perceptions of naloxone distribution found that the nurses experienced moral distress after providing lifesaving interventions with patients experiencing overdoses, only to feel unappreciated and be met with angry patients. Similarly, Ilievska et al. (2025), who investigated ED RNs' views of safe consumption sites, found that the majority agreed or felt neutral toward them in not only creating dangerous neighbourhoods but also promoting drug use. Important contextual factors impacted the nurses' experiences and perceptions, topics that could be explored in future research. The way in which the nurses described their work in this study as an ethical approach to care, was consistent with previous literature explaining the critical roles of nurses in caring for people who use drugs (Deren et al., 2017; Pauly, 2008b) and in viewing harm reduction through a social justice lens (Pauly, 2008a).

Some of the nurses in this study acknowledged the overrepresentation of Indigenous people in the work that they do. They recognized and discussed the impacts of root determinants

(Loppie & Wien, 2022) including colonization, and intergenerational trauma and described their role in reducing not only substance use harm but also colonial harm. The nurses' perceptions were consistent with how the First Nations Health Authority (2026) defines Indigenous harm reduction, with a focus beyond reducing harm and actions to undo colonial harm. This is also consistent with the findings in the lived relations section, including the work nurses do to reduce power differentials and institutional harm.

The essence of the experience of working in harm reduction had to do with the nurses' conceptualization of the space, in particular, related to "meeting people where they're at". Additionally, the nurse's conceptualization of the space of harm reduction involved pragmatic thinking, advocacy efforts, working in the grey, and the broad boundaries they perceived working within. Factors underpinning their conceptualizations also were discussed.

5.3 Lived Body

Working in substance use harm reduction was an embodied experience, with the nurses describing psychological experiences including heavy emotional work and patient loss, worry, feelings of helplessness, and feelings of fulfillment.

5.31 Psychological Experiences and Impacts

5.311 Heavy Emotional Work and Patient Loss. Because of the familiarity of the relationships developed with their patients, as outlined in the lived relationality section, the nurses felt that their patients could trust them enough to share their histories of trauma. However, at the same time, the nurses were at times psychologically affected by their patients' trauma and had to be cautious about taking it home and internalizing it. The nurses also felt psychologically impacted by the high rates of patient loss. Some of the nurses described becoming hardened to the loss and trauma over time. Research on the heaviness of the workload and the experiences of

patient loss as impacting harm reduction nurses psychologically has been limited. McCall et al. (2019) investigated the experiences of staff at an opiate-assisted treatment facility and found that their study participants also reported experiences of stigma, which they suggested could have contributed to the psychological consequences experienced by staff. Similarly, a few nurses in this study discussed stigma related to their choice of work setting, a topic to be considered by future researchers. Research has shown that nurses experience high rates of burnout broadly (Getie et al., 2025), and the experience of nurses working in intensive care unit (ICU) has been explored related to burnout (Levi & Moss, 2022). Similar to this study, nurses described being overburdened related to the experience of patient loss in their work.

5.312 Worry and Feelings of Helplessness. In addition to the heaviness of the work and high rate of patient loss, worrying was a constant psychological experience and impact of their work. Because of the nature of the work, including the complexity of substance use, vulnerability, and closeness of the relationships developed, the nurses often brought their work home, worried about their patients, and were at times not able to "turn it off." Nursing is a relational profession that often draws individuals who have compassionate and empathetic natures. The nurses in this study often worked with and cared for individuals with histories of trauma and negative past experiences, so it was part of their nature to worry about them. Worry was not described in earlier primary research about nurse's experiences and perceptions of working in harm reduction perhaps because of the settings in which studies had been conducted. It has been looked at among the peer workers (i.e., individuals with lived experience) working in harm reduction where authors report similar psychological impacts (Mamdani et al., 2021; Steenekamp & Barker, 2024), as well as among ICU nurses (Levi & Moss, 2022). The findings

of this writer's study add to the literature on ways to understand the psychological experiences and impacts of the nurse's work that can lead to feelings of helplessness and burnout.

5.313 Feelings of Fulfillment. The experience of working in substance use harm reduction also involved feelings of fulfillment within their role, including opportunities to work with a vulnerable population, show respect, and recognize their own privilege. Descriptions of their work as rewarding were found consistently in previous literature (Ellefsen et al., 2024; Maina et al., 2020; McCall et al., 2018). This work adds to the literature by exploring feelings of fulfillment related to nurses reflecting on their own privilege.

5.32 Physical Experiences

In addition to the psychological experiences and impacts already described, the nurses recognized that their work involved physical risks. However, the nurses generally felt safe in their body in their harm reduction work. The nurses' sense of safety in their body may be attributed to the respect and appreciation that patients had for staff, the closeness of relationships developed, and their familiarity with the space. They felt that there was a misconception among the public that all patients accessing harm reduction services would be aggressive and that nurses working in this area would experience ongoing physical impacts. Many of the nurses described experiencing more physical events in other areas of nursing than in their work in harm reduction. The misconception likely relates back to societal misunderstandings of substance use and harm reduction, along with the stigma associated with use. Forchuk et al. (2023) reported that concerns over harm reduction interventions and resultant safety issues were a barrier to implementation in the hospital setting. These perceptions and/or experiences could be context specific.

5.33 Protecting the Body

The nurses protected their bodies from psychological harm by engaging in self-honesty, reflexivity, and self-care, as well as cultural healing practices. The nurses also described the importance of supportive group dynamics in protecting themselves.

5.331 Self-Honesty, Reflexivity, and Self-Care. Self-honesty, reflexivity and self-care were strategies that helped the nurses to manage the psychological impacts of their work and prevent burnout. By using reflexivity and self-honesty, it came into view for some nurses of their need to take a break from their work that was a form of self-care. Self-reflection has been shown to aid NPs working in harm reduction to be more flexible with treatment protocols, manage expectations, and acknowledge their own growth in their practices (Whitfield et al., 2025). Reflexivity, a skill discussed and taught in nursing school curricula, has been identified as consistent with relational inquiry (Doane & Varcoe, 2020). Maina et al. (2020) recommended that health care providers engage in self-care to prevent burnout and relieve work-related stress. Additionally, Furlong et al., (2025) emphasize that nursing schools should cover topics in self-care and self-compassion, given the barriers nurses face in caring for individuals impacted by substance use.

5.332 Cultural Healing Practices. Some of the nurses engaged in cultural healing practices which were a way to protect their bodies from psychological impacts. Some nurses attended sweat lodges and smudging ceremonies not only to learn more about some patients' culture but also to honour and grieve the patients whom they had come to know and care for. Cultural safety has long been taught in nursing curricula as an integral component of relational inquiry (Doane & Varcoe, 2020). This study adds to the literature by exploring nurses' opportunities to engage in cultural healing and its effect on their psychological health. It is

common knowledge that nurses facilitate healing, but this work also shows how nurses can heal from the work.

5.333 Supportive Group Dynamics (Shared Embodiment). Supportive group dynamics also protected the nurses from the psychological impacts of their work related to the heavy work and trauma that patients shared with them, the closeness of the relationships that developed, and the patient losses that they experienced. Having supportive teams meant having colleagues who understood what they were going through, having a place to debrief after difficult situations, and having staff understand when they needed to take a minute. Protecting the body in this way through supportive group dynamics, was held collectively by the nurses on the team, reflecting a shared embodiment. Teamwork and dynamics were identified by the health care providers in Anderson et al.'s (2020) study as facilitators of their work but was not further explored. Thus, this study expands current understanding of the ways that supportive group dynamics impact psychological health for nurses working in the harm reduction field.

The existential of lived body had to do with the ways that the experience of working in harm reduction impacted the nurses' bodies. The nurses often turned towards practices that offered protection including self-honesty, reflexivity, self-care, and cultural healing practices. Supportive group dynamics, as a shared embodiment, was also described.

5.4 Existential 4: Lived Time

Lived time, according to van Manen (1990), refers to the ways of being in the world temporally that comprise past, present, and future landscapes. van Manen further described the impacts of previous experiences on individuals that include gestures, language used, and the ways that they carry themselves. Motivations to work in harm reduction, reasons to stay, shifted perceptions, and the future direction of harm reduction are explored below.

5.41 Motivations to Work in Harm Reduction

Some of the nurses shared deeply personal stories of family histories of addiction and mental health challenges that led them to pursue work in harm reduction, reflecting lived past. Through these direct experiences, they saw the impact of the drug poisoning crisis, with some of the nurses describing themselves as having a "soft spot" for this area of health care, reflecting lived present. Having these experiences was a major motivator for them to pursue work in harm reduction, and it impacted the nurses' perceptions of substance use and their compassion for people struggling with addiction. These findings are similar to a qualitative study of nurses, mainly in hospital settings, which found that personal experiences (i.e. a family member with a history of substance use disorder) impacted their perspective (Kitt-Lewis & Adam, 2024). Though the researchers in this study indicate that it was apparent many nurses had not previously reflected on these impacts on professional practice. That was not the case in this present study; it was apparent that nurses had reflected on this in how it was a main motivator to pursue work in this area. Quantitative research among nurses in hospital settings also found that nurses were more motivated and willing to provide care to those affected by substance use when they had personal experiences (i.e. family members with a history of use; Mahmoud et al., 2021).

In addition to sharing family histories of addiction and mental health challenges, some of the nurses in this present study expressed frustrations and challenges in other areas of health care where they were employed, including burnout related to staffing shortages, unpredictable shifts, and an awareness that they could not provide comprehensive care in harm reduction. The nurses also described the general treatment of patients in their previous work settings as often not aligning with their values and often resulting in feelings of inadequacy. An interesting finding is that the psychological impacts of the nurses work in harm reduction were emphasized, yet when

burnout was experienced in other areas of nursing it served as a motivation for many to pursue this area of work. This could be understood in terms of the alignment in the nurses' personal and professional values which could help to sustain them in their work. To this researcher's knowledge, this study presents new knowledge on what motivates nurses to work in substance use harm reduction. Nurses may be drawn to this area of work because of previous work and life experiences.

5.42 Reasons to Stay

In addition to what motivated them to work in harm reduction, the nurses gave other reasons to continue in the work, which included being purpose driven and having opportunities to help vulnerable populations who often experienced stigma and marginalization by health care providers, reflecting lived past and present. The nurses were able to use their voice to give back to the community. Their reasons aligned with their descriptions of the lived space of harm reduction and their conceptualization of their role within it. The findings of this study contribute to additional knowledge in an area that appears to not currently be covered in the literature.

5.43 Shifted Perspectives

Time working in harm reduction shifted the nurses' perspectives of caring for individuals impacted by substance use, reflecting lived past and present. Prior to entering their work in harm reduction, not all of the nurses had completely supported all harm reduction interventions. Over time and through their experiences, their views and understanding of harm reduction had shifted. Through their work of navigating the space of harm reduction, the nurses understood the complexity of substance use and the need for harm reduction interventions to address the individuals' complex needs. The nurses described shifted perspectives in the ways that they identified substance use, who it could impact, the realities of recovery, and even the ways that

addictions developed. This study adds to the literature on how lived time working in substance use harm reduction shifted perspectives for many of the nurses.

5.44 Future Directions of Harm Reduction

The nurses envisioned the future directions of this area of health care, reflecting possible lived futures. These included opportunities to expand services and scopes of practice, better address the SDOH, and better prepare nurses to work in this area. Researchers have supported the expansion of harm reduction services (Dieujuste et al., 2021; Michels et al., 2024; Reed et al., 2023). Some nurses in this study also wanted opportunities to expand their scopes of practice related to harm reduction, including the ability to prescribe antibiotics and contraceptives, which was often described as a barrier to nurses without a reliable prescriber available.

Previous researchers have reported inconsistencies (Jiao et al., 2024) and uncertainties (Anderson et al., 2017) related to health care providers' practice when working in harm reduction. The College of Nurses of Ontario (CNO) (2025) defines scope of practice as the "activities that nurses have the legislated authority to perform" (p. 3), noting that employers can limit, but not expand, it. The CNO (2019), which also outlined entry to practice competencies for RNs, indicated that the RN role "incorporates principles of harm reduction with respect to substance use and misuse into plans of care" (p. 5).

For the nurses in this study, the future directions of harm reduction involved being able to better address SDOH and improve access to harm reduction, including opportunities to collaborate with acute care facilities. Pauly (2008b) suggested that there has been little action on SDOH by nurses. Future research could explore ways that nurses can better address SDOH in their work in harm reduction. Finally, the nurses also described the need to better prepare nurses to work in harm reduction. Most of the nurses in this study indicated that they had received

limited or no training and/or opportunities prior to working in harm reduction. The nurses supported the development of nursing curricula focusing on harm reduction principles and providing opportunities for student nurses to integrate theory into practice. This suggestion was consistent with literature indicating substance use curriculum is minimal (Gagnon et al., 2020) and that students reported not feeling prepared to provide care to individuals impacted by substance use and having been offered limited opportunities to integrate harm reduction theory into practice (Denis-Lalonde et al., 2023).

This section explored lived time, particularly the nurses' motivation for pursuing work in harm reduction [reflecting lived past], reasons for staying [reflecting lived past and present], and the future directions of harm reduction [reflecting possible lived future].

5.5 Recommendations

This work, which was an exploration of nurses' experiences and perceptions of working in substance use harm reduction, was framed using van Manen's (1990) lifeworld existentials of lived relationality, lived space, lived body, and lived time. Implications for practice, practice recommendations, and research gaps of this work are discussed in the following text.

5.51 Implications for Practice

The findings of this work may impact patient care broadly as it:

- Highlighted important components of relationship and trust building that are foundational to creating a safer health care environment.
- Described implications for the nurse-patient relationship dynamic (e.g., considerations for approachability and speaking the patient's language).
- Aimed to gain a better understanding of nurses' conceptualization of the space of harm reduction and their role within it.

- Aimed to better understand psychological impacts of the nurse's work and ways that nurses protect themselves.
- Aimed to better understand what draws nurses to work in harm reduction and ways that their work shifts their perspectives.
- Explored what nurses see as the future directions of harm reduction.

This work reflects the voices and experiences of eighteen nurses working in substance use harm reduction, all of which worked in northwestern Ontario. Implications for practice within northern contexts include:

- The psychological experiences described by the nurses may be related to the higher rates of drug related harms, as well as reduced access to resources and structural inequities in the north.
- Smaller, tight-knit communities may shape the relational aspects of care, as many nurses felt they were "part of the community," which may influence their experiences.
- The nurses recognized the overrepresentation of Indigenous people in accessing harm reduction services, highlighting the importance of supporting nurses' learnings around Indigenous harm reduction, cultural safety and advocacy.
- The broad boundaries of the nurse's harm reduction work may be shaped by resource availability, gaps in services, structural inequities, and to the need to address complex patient needs.

5.52 Practice Recommendations

The findings from this work may help inform organizations that employ nurses who work in harm reduction, and/or nursing curriculum, including:

- Considerations about workload and continuity of care to ensure that nurses can build relationships and keep commitments.
- The importance of better supporting nurses to develop practices that support harm reduction through in-services and mentorship.
- The importance of providing space for flexibility in practice to adapt approaches to meet needs and review or implement policies to accommodate flexibility and "working in the grey."
- The importance of making space for the work that nurses are doing outside of typical disease management to facilitate addressing SDOH.
- Supporting nurses so their approach to care matches the individuals they are caring for (e.g., language used with patients and understanding the lived experience with the person).
- Providing time and space for debriefing and opportunities to create connections and better relationships with each other (team building).
- Providing opportunities for nurses to reflect on practice and opportunities to support nurses' learnings around Indigenous harm reduction and political advocacy
- Exploring opportunities for RN prescribing and supporting nurses to work to full scope of practice.
- Developing nursing curricula so that nursing students can reflect on their own values, beliefs, assumptions about addiction and harm reduction, and provide them with experiential opportunities to integrate harm reduction philosophy and principles into practice.

5.53 Potential Future Research Areas

The findings of this work have identified some potential future areas of research, including exploring:

- How nursing curriculum teaches and integrates substance use harm reduction.
- Curriculum related opportunities to support nursing students in developing values/attributes consistent with harm reduction.
- The impact of organizational goals, missions, visions, and values on the ability of nurses to work in harm reduction.
- Nurses' perceptions of and role in system and political advocacy and change.
- Ways to improve societal attitudes toward and perceptions of harm reduction.

5.6 Limitations and Challenges of the Study

I followed a phenomenological approach to investigate the lived experiences of 18 nurses working in substance use harm reduction. This work reflected the experiences of the nurses in the study and might not reflect all nurses' experiences working in substance use harm reduction. Participants comprised five RPNs, nine RNs, and four NPs, with eight nurses indicating that they were employed in consumption treatment services or withdrawal management, three in outreach, and seven in multiple settings. One limitation of the study was being unable to investigate gender differences in the nurses' experiences. Few men work as nurses in harm reduction, so reporting gender could have risked identifying participants and removing their anonymity. The setting for the study was northwestern Ontario. To maintain participant anonymity, the geographical locations within northwestern Ontario are not disclosed.

As described previously, I teach in a local university nursing program. As such, I did know some of the participants from previous work experiences, but not in a supervisory or

instructor role. Another limitation of this study was my level of experience as a novice researcher following a phenomenological approach. To mitigate this limitation, I closely followed van Manen's (1990) phenomenology of practice and consulted with my committee.

5.7 Revisiting Research Questions

- *What are the experiences of nurses working in harm reduction?* This is reflected in the findings, including in how the nurses experienced the phenomena of interest, their work in harm reduction as outlined in the lived world existentials of relationality, space, body and time.
- *What are the contexts of the experience? How do different harm reduction contexts impact/affect the experiences?* This question was somewhat answered in how nurses of varying harm reduction contexts (settings) described their experience but was often difficult to explicate as several nurses reported working in multiple areas of harm reduction and drew from different settings when describing their experiences.
- *How are nurses impacted by their work in harm reduction?* This question was answered in how nurses described the psychological and physical impacts of their work (see lived body), as well as how they coped with the impacts (see protecting the body).
- *How do nurses use harm reduction in their practice? What role do nurses play? What are the perceptions of nurses working in harm reduction? What are their attitudes, beliefs, and values? What do they perceive as their role?* These questions were answered in how nurses described the relational aspects of their care including the importance of developing trusting relationships with individuals impacted by substance use (see lived relations), as well as how they conceptualized the space of harm reduction (see lived space) and where they saw the future of nursing's role in harm reduction (see lived time).

5.8 Conclusion

The purpose of this dissertation was to explore the lived experiences of nurses working in substance use harm reduction in a northern setting. van Manen's four lifeworld existentials were used to frame the findings of lived relationality (i.e., care as relationally contingent highlighting the importance of relationship and trust development and maintenance), lived space (i.e., conceptualizations of the space of and their role within harm reduction), lived body (i.e., harm reduction work as an embodied experience and how nurses protected the body), and lived time (i.e., what motivated the nurses to pursue and stay in this work and what the nurses saw as future directions of harm reduction).

The essence of the nurses' experiences was discussed in relation to the ways that the nurses understood trust development and its relationship to creating and maintaining connections. How nurses conceptualized the space of harm reduction, including the experience of "meeting people where they're at" and the factors underpinning these conceptualizations were explored. Details about the ways that harm reduction work was an embodied experience, including how nurses were psychologically and physically impacted by their work were presented, along with ways in which the nurses protected their bodies. This study also involved an exploration of the ways that the nurses came to pursue work in harm reduction, what influenced them to stay in this work, and what they saw as the future directions of harm reduction.

This study offered recommendations at the practice level, identified implications for practice in the northern setting and areas of research for future consideration. Practice recommendations that arose from the data included organizational considerations of nurses' workload, flexibility, continuity, training, debriefing, team building, and scope of practice.

Northern specific implications for practice included how higher drug related harms, reduced access to resources, and structural inequities may impact the psychological experiences of nurses. The broad boundaries of the work may be shaped by resource availability and complex social needs. Additionally, smaller, tight knit communities may shape the relational aspects of care. Finally, providing opportunities to support nurses' learnings around Indigenous harm reduction, cultural safety and advocacy was highlighted.

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Appendix A Search Strategy

To uncover literature on nurses' experiences and perceptions of working in substance use related harm reduction, several databases including CINAHL, Emcare, PSYCHinfo and Pubmed were searched with the following terms: nurs*, harm reduction, needle, naloxone, safe consumption, safe injection, perception, view, experience, perspective, role, responsibility, and attitude. See table 2 below for search strategy and number of results. In addition, an additional search was conducted to identify any new relevant literature from 2022-2023 (table 3) and again from 2023-2025 (table 4).

Table 2. Search Strategy

Search	Database	Search	Number of Results	Applicable Results
1	Pubmed	((nurs*[Title/Abstract]) AND (harm reduction[Title/Abstract] OR needle[Title/Abstract] OR naloxone[Title/Abstract] OR safe consumption[Title/Abstract] OR safe injection[Title/Abstract])) AND (perception*[Title/Abstract] OR view*[Title/Abstract] OR experience*[Title/Abstract] OR perspective*[Title/Abstract] OR role*[Title/Abstract] OR responsibilit*[Title/Abstract] OR attitude*[Title/Abstract])	321	15
2	CINAHL	AB nurs* AND AB (harm reduction OR naloxone OR needle OR safe consumption OR safe injection) AND AB (perception* OR view* OR role* OR perspective* OR attitude* OR responsibilit* OR experience*)	221	13 (5 duplicates)
3	PSYCHinfo	AB nurs* AND AB (harm reduction OR naloxone OR needle OR safe consumption OR safe injection) AND AB (perception* OR view* OR role* OR perspective* OR attitude* OR responsibilit* OR experience*)	108	Duplicates only
4	Emcare	AB nurs* AND AB (harm reduction OR naloxone OR needle OR safe consumption OR safe injection) AND AB (perception* OR view* OR role* OR perspective* OR attitude* OR responsibilit* OR experience*)	224	Duplicates only

Table 3. Updated Search 2022-2023

Search	Database	Search	Number of Results	Applicable Results
1	Pubmed	((nurs*[Title/Abstract]) AND (harm reduction[Title/Abstract] OR naloxone[Title/Abstract] OR needle[Title/Abstract] OR safe injection[Title/Abstract] OR safe consumption[Title/Abstract] OR safe supply[Title/Abstract])) AND (perception[Title/Abstract] OR experience[Title/Abstract] OR view[Title/Abstract] OR role[Title/Abstract] OR responsibilit*[Title/Abstract] OR use of[Title/Abstract] OR perspective[Title/Abstract]) OR attitude[Title/Abstract] Full Text Years: 2022-2023	45	1
2	CINAHL	AB nurs* AND AB (harm reduction OR naloxone OR needle OR safe injection OR safe consumption OR safe supply) AND AB (experience OR perception OR role OR view OR use of OR perspective OR responsibilit* OR attitude) Full Text Years: 2022-2023	16	0
3	PSYCHinfo	abstract(nurs*) AND abstract(harm reduction OR needle OR safe injection OR safe consumption OR safe supply OR naloxone) AND abstract(perception OR role OR view OR experience OR perspective OR use of OR responsibilit* OR attitude) Years: 2022-2023	27	0
4	Emcare	(nurs* and (harm reduction or naloxone or needle or syringe or safe injection or safe consumption or safe supply) and (perspective* or perception* or view* or role* or responsibilit* or attitude* or experience*)).ab	12	0

		Years: 2022-2023		

Table 4. Updated Search 2023-2025

Search	Database	Search	Number of Results	Applicable Results
1	Pubmed	((nurs*[Title/Abstract]) AND (harm reduction[Title/Abstract] OR naloxone[Title/Abstract] OR needle[Title/Abstract] OR safe injection[Title/Abstract] OR safe consumption[Title/Abstract] OR safe supply[Title/Abstract])) AND (perception[Title/Abstract] OR experience[Title/Abstract] OR view[Title/Abstract] OR role[Title/Abstract] OR responsibilit*[Title/Abstract] OR use of[Title/Abstract] OR perspective[Title/Abstract]) OR attitude[Title/Abstract] Years: 2023-2025	151	14 (unable to access 1)
2	CINAHL	AB nurs* AND AB (harm reduction OR naloxone OR needle OR safe injection OR safe consumption OR safe supply) AND AB (experience OR perception OR role OR view OR use of OR perspective OR responsibilit* OR attitude) Full Text Years: 2023-2025	145	6 (all duplicates)
3	PSYCHinfo	abstract(nurs*) AND abstract(harm reduction OR needle OR safe injection OR safe consumption OR safe supply OR naloxone) AND abstract(perception OR role OR view OR experience OR perspective OR use of OR responsibilit* OR attitude) Years: 2023-2025	44	4 (all duplicates)
4	Emcare	(nurs* and (harm reduction or naloxone or needle or syringe or safe injection or safe	108	10 (9 duplicates)

		consumption or safe supply) and (perspective* or perception* or view* or role* or responsibilit* or attitude* or experience*)).ab Years: 2023-2025		

Appendix B Script for Email or Telephone Conversation with Stakeholders

Department of Health Sciences
955 Oliver Road
Thunder Bay, ON
P7E 5E1

Hello _____ [stakeholder name],

Thank you for taking the time to talk with me today [if via phone].

My name is Amanda Ruck and I am a nurse and student in the PhD in Health Sciences program at Lakehead University. My PhD supervisor is Dr. Rebecca Schiff and we are conducting a qualitative study entitled “Nurses’ Experiences and Perceptions in Substance Use Related Harm Reduction: A Phenomenological Study.” The overall objective and goal of the research is to uncover northern nurses' experiences and perceptions of working in substance use related harm reduction. We are using a qualitative approach to explore the unique experience of nurses who employ harm reduction philosophy and interventions in their work.

The reason I am reaching out to you today is to ask for your help by sharing the two attached items (recruitment e-mail and poster) with individuals who meet the eligibility criteria below. Their participation would involve an appropriate 1-hour time commitment in the form of an interview. If interested in participating, those individuals will reach out to me directly via e-mail and I will share the information letter with them and schedule the interview. Interviews can be either in-person or via zoom, whichever is more convenient for them. Participants will receive a fifty-dollar grocery gift card for their participation.

In order to be eligible to participate, individuals must:
1) Be a Registered Nurse, Registered Practical Nurse or Nurse Practitioner;
2) Be employed in Northwestern Ontario;
3) Work in the field of substance use related harm reduction (e.g., safe injection site, safe supply, needle exchange program, outreach, managed alcohol program, treatment, harm reduction education etc. or use harm reduction principles in their daily practice).

Please let me know if you have any questions about the study or eligibility.

Thank you for your consideration.

Kind regards,

Amanda Ruck, RN, MPH(N), PhD(c)
Rebecca Schiff, PhD

Appendix C Recruitment Email for Stakeholders to Send to Potential Participants

Department of Health Sciences
955 Oliver Road
Thunder Bay, ON
P7E 5E1

Dear potential participant,

My name is Amanda Ruck and I am a nurse and student in the PhD in Health Sciences program at Lakehead University. My PhD supervisor is Dr. Rebecca Schiff. We would like to invite you to participate in a research study entitled, “Nurses’ Experiences and Perceptions in Substance Use Related Harm Reduction: A Phenomenological Study.” The overall objective and goal of the research is to uncover northern nurses' experiences and perceptions of working in substance use related harm reduction. We are using a qualitative approach to explore the unique experience of nurses who employ harm reduction philosophy and interventions in their work.

Your participation will assist us to develop a better understanding of the experiences and perceptions of nurses who are involved in this work. This research may have the potential to better support nurses in this area, inform areas where harm reduction interventions are not as readily being carried out, and inform nursing curriculum.

If you agree to participate, you will be interviewed by myself, Amanda Ruck, either in-person or on zoom (whichever is more convenient for you). To learn more about participating in this research, please review the recruitment letter attached to this e-mail and contact me directly via e-mail if you are interested in the study or have any questions.

Your participation in this study will be confidential and not impact your employment or relationship with Lakehead University.

As a token of our appreciation for your time you will receive a fifty-dollar grocery gift card for your participation.

Thank you for your consideration.

Kind regards,

Amanda Ruck, RN, MPH(N), PhD(c)
Rebecca Schiff, PhD

Appendix D Recruitment Poster

ARE YOU A NURSE WHO WORKS IN SUBSTANCE USE RELATED HARM REDUCTION?

WE WANT TO HEAR FROM YOU!

Research Title: Nurses' Experiences and Perceptions in Substance Use Related Harm Reduction: A Phenomenological Study

You are invited to participate in a study to understand nurses experiences and perceptions who work in substance use relation harm reduction.

Your participation is confidential and you may withdraw from the study at any time. Participating and/or withdrawing from the study will not impact your job in any way. You will receive a fifty-dollar grocery gift card for your participation in the study.

This study is approved by the Lakehead University REB, Romeo # 1469960

Are you eligible?

- Nurse (RPN, RN or NP)
- Working in Northwestern Ontario
- In the field of substance use related harm reduction (e.g., safe injection site, safe supply, needle exchange program, naloxone program, outreach, managed alcohol program, treatment, harm reduction education etc. or you use substance use related harm reduction principles in your daily practice)

Details/Participation

- Interview (in person or via zoom)
- Approximate 1 hour time commitment

If you are interested in participating, please contact:

- Amanda Ruck, RN, MPH(N), PhD(c)
- Email: aruck@lakeheadu.ca
- Ph: (807) 343-8110 ext. 8393

Lakehead UNIVERSITY

Appendix E Letter of Information and Consent Form

Letter of Information and Consent Form for Nurses to Participate in Interviews

Dear Potential Participant:

You are invited to participate in a research study entitled, "Nurses' Experiences and Perceptions in Substance Use Related Harm Reduction: A Phenomenological Study", by participating in a semi-structured interview.

Your participation in this research is voluntary and will involve approximately a 1-hour time commitment if you agree to participate. Your identity will remain confidential. Before you decide whether or not you would like to take part in this study, please read this letter carefully to understand what is involved. After you have read the letter, please ask any questions you may have.

PURPOSE
The overall objective and goal of the research is to uncover northern nurses' experiences and perceptions of working in harm reduction programs. This qualitative study will follow an interpretive phenomenological approach to explore the unique experience of nurses who employ harm reduction philosophy and interventions in their everyday work.

The principal investigator of this study is Amanda Ruck, PhD candidate in Health Sciences at Lakehead University. Amanda's committee and co-investigators include her supervisor, Dr. Rebecca Schiff (Associate Professor, Health Science, University of Northern British Columbia; and committee members Dr. Helle Møller, Associate Professor, Health Sciences, Lakehead University and Dr. Deborah Scharf, Associate Professor, Psychology, Lakehead University).

WHAT INFORMATION WILL BE COLLECTED?
The principal investigator will collect information in the form of a semi structured interview. Interviews will be audio recorded and involve questions around your experience as a nurse who works in substance use related harm reduction, as well as your perceptions of harm reduction and your role.

WHAT IS REQUESTED OF ME AS A PARTICIPANT?
Semi-structured interviews will take place in person at your workplace and will be audio recorded with principal investigator who will ask the questions. Your participation is completely voluntary and interviews are expected to take approximately 1 hour. The researcher will take

notes; however, interviews will be audio recorded so that the researcher can review the data later. Responsibilities of the participant are to answer the questions as they feel comfortable.

WHAT ARE MY RIGHTS AS A PARTICIPANT?
You are under no obligation to participate and are free to withdraw at any time without prejudice to pre-existing entitlements. Your decision to participate will not affect your status/employment with your organization.

WHAT ARE THE RISKS AND BENEFITS?
The opportunities that are created through this project are for you to contribute to our understanding of harm reduction by providing your lived experience voice. If you choose to participate, you will receive a $50.00 gift card. There are no direct risks to participating in the study and we do not anticipate that participants will experience emotional distress.

HOW WILL MY CONFIDENTIALITY BE MAINTAINED?
During the interviews the researcher will ask your name and use your initials to identify you in the notes. However, confidentiality will be maintained as only the principal investigator outlined above will have access to this study data.

WHAT WILL MY DATA BE USED FOR?
The intent of this research study is to publish the study findings as part of a PhD dissertation in Health Sciences at Lakehead University as well as in the form of academic journals, conferences, and presentations. Data will be de-identified/anonymized with no identifying information present.

WHERE WILL MY DATA BE STORED?
All data will be stored electronically on the research staff's password protected computer at Lakehead University for a minimum of 5 years following completion of the research.

HOW CAN I RECEIVE A COPY OF THE RESEARCH RESULTS?
Research participants interested in accessing the research results can e-mail aruck@lakeheadu.ca to request a copy.

WHAT IF I WANT TO WITHDRAW FROM THE STUDY?
At any time during the interview you may withdraw from the study by telling the researcher you are no longer interested in participating and all data collected (notes) will be shredded and audio recording deleted. If you already participated in the interview and decide to withdraw, you may contact the research team by calling (807) 343-8030 or by emailing aruck@lakeheadu.ca. Again, there are no limitations to withdrawing from the study and it will not impact your position.

RESEARCHER CONTACT INFORMATION:
Mrs. Amanda Ruck
Dr. Rebecca Schiff
Dr. Helle Møller
Dr. Deborah Scharf

Lakehead University
955 Oliver Road
Thunder Bay, Ontario
Canada

Please note: There are no conflicts of interest with any members on the research team.

RESEARCH ETHICS BOARD REVIEW AND APPROVAL:

This research study has been reviewed and approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team, please contact Sue Wright at the Research Ethics Board at 807-343-8283 or research@lakeheadu.ca.

Consent Form for Potential Participants

By signing below, I agree that:

- I have read and understand the information contained in the Information Letter
- All of my questions have been answered

By signing below, I understand:

- The risks and benefits to the study
- That I can withdraw from the study at any time and may choose not to answer any question
- That the data will be securely stored at Lakehead University for a minimum period of 5 years following completion of the research project
- That the research findings will be made available to me upon request
- That I will remain anonymous

By consenting to participate, I have not waived any rights to legal recourse in the event of research-related harm.

Full Name (please print):_____ Date:_____

Signature: _____

Research participants interested in accessing the research results, please email aruck@lakeheadu.ca to request a copy.

Appendix F Interview Guide

Demographic & Other Questions

1. Name.
2. Job title.
3. Additional qualifications (e.g., PHCNP)
4. How long have you been a nurse? (Year graduated)
5. How long have you worked in/with harm reduction?
6. Current place of employment?
7. How long have you worked at your current place of employment?
8. Where did you obtain knowledge of harm reduction philosophy/interventions?

Interview Questions

- Question 1: How would you describe substance use harm reduction? Probing question:
    a. What are the boundaries?
- Question 2: Can you describe your experience working as a nurse in this area? Probing questions:
    a. Can you describe your role as a nurse in harm reduction?
    b. What constitutes harm reduction in your experience?
    c. Why do you think this is your role?
    d. Can you describe further.
    e. Can you provide an example?
- Question 3: Based on your experience, can you take me through a typical day of how you use harm reduction (philosophy and interventions) in your nursing practice. Probing questions:
    a. What guides your practice in harm reduction?
    b. What harm reduction interventions do you use in your nursing practice?
    c. Are you aware of any interventions not currently being used that you think would be helpful?
- Question 4: How do different harm reduction contexts impact/affect your experience? Probing questions:
    a. How is your program structured and how does it support or impact your work?
    b. Who do you work with on the daily?
    c. What supports are in place?
    d. What cultural factors are important?
- Question 5: What is the most challenging part of working in harm reduction or while promoting harm reduction interventions? Probing questions
    a. Why do you think you found it challenging? What contributed to this?
    b. Any ideas around what would make it less challenging?
- Question 6: Is there more that you think you could/should be doing in your role? Probing question:
    a. Are there interventions you're aware of not currently being carried out?
    b. Can you provide an example?
- Question 7: How are you impacted by your work in harm reduction? Probing question:

    a. Have you been influenced in how you think about harm reduction and caring for individuals impacted by substance use?
- Question 8: What led you to this type of work? Probing questions
    a. Often there are additional challenges to working with this population, why did you choose to work in harm reduction rather than another setting?
- Question 9: How do you think using/promoting harm reduction impacts patients? Do you see the benefits? Probing questions:
    a. What factors contributed to your understanding of the benefits?
    b. Can you describe further?
    c. Can you provide an example?
- Question 10: What attitudes, beliefs and values do nurses need to work in harm reduction? And why? Probing question:
    a. Can you provide an example?
- Question 11: How is harm reduction conceptualized?
    a. By the patients you care for?
    b. By your nurse colleagues that don't work in harm reduction?
    c. By your non nurse colleagues/friends/family?
    d. By the health care system?
    e. By the political system?
- Question 12: What do you think students should be taught about harm reduction?
- Question 13: Are there any other experiences of working in harm reduction that you'd like to share? Or anything else important that I did not ask about?