Addressing Drug-Related Harms: The Roles of Community Health Nurses

by

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Abstract

Background. In Manitoba, drug-related harms such as drug poisonings, fatalities and emergency presentations have increased significantly, especially over the course of the COVID-19 pandemic. Other harms include blood-borne infections, stigma and discrimination, and legal harms. Community health nurses are well positioned, in theory, to address these harms in their practice. However, little is known about their perspectives and specific roles and practices in addressing drug-related harms.

Purpose. The purpose of this study was to explore community health nurses' perspectives and their roles in addressing drug-related harms. Their views and experiences with drugs were explored along with their thoughts of the "drug problem" and the current responses to the problem, including government and healthcare responses.

Design. Sally Thorne's qualitative research method of interpretive description was the methodology chosen for this study.

Sample and setting. Participants included licensed nurses (i.e., RNs, RPNs, and LPNs) working in the community, including public health nurses, primary care nurses and nurses working in addictions services recruited from various community organizations in Winnipeg.

Methods. Data was collected using semi-structured interviews and field notes. Interviews were conducted virtually using Zoom videoconferencing technology. Thematic analysis guided by the Framework Method was used to analyze data.

Findings. The findings showed that community health nurses predominantly view the "drug problem" as a social issue rather than an individual one. They stress the importance of addressing root causes of drug-related harms within the context of social determinants of health. Despite this perspective, community health nurses continue to provide mainly individual level care with minimal community or systems level interventions. This misalignment is associated with moral distress. A number of systemic and organizational barriers that limit their ability to perform system level roles were identified.

Conclusions. Community health nurses are well-positioned to address drug-related harms in their practice. However, the majority of their work is comprised of individual level care which fails to address underlying inequities experienced by their clients. Efforts are needed to support community health nurses to perform upstream or system-level roles.

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Preface

I would like to begin by situating myself and my way of being in the world. I am a young white French and English-speaking Franco-Manitoban female adult with ancestors from Québec and France. Socially, this has afforded me privilege within society. I have grown up and lived most of my life in Winnipeg, Manitoba on Treaty 1 territory and homeland of the Métis Nation. This is where I completed a Bachelor of Nursing degree at the Université de Saint-Boniface, a French university. Shortly after graduating in 2015, I moved to Selkirk, Manitoba to work at the Selkirk Mental Health Centre in the Acquired Brain Injury program. While working at the Centre, I noticed growing trends in drug-related harms, such as anoxic brain injuries. I decided to delve further into the topic of drugs and drug-related harms while pursuing a Master of Nursing degree. Eventually this led to the exploration of community health nurses' roles in addressing drug-related harms. I have always been drawn to the community health nursing field and the idea of "thinking upstream". Currently, I do not work in the community setting. This affords me the opportunity of having an outsider lens.

Chapter One: Introduction

Drug-related harms have become a major public health concern in Canada (Illegal Drug Task Force [IDTF], 2019). A noticeable rise in opioid poisonings and deaths have unfolded in the province of Manitoba (Government of Manitoba, 2017; Government of Manitoba, 2019b, 2019c; Canadian Centre for Policy Alternatives Manitoba [CCPAM], 2019). The use of illegal drugs such as crystal methamphetamine also increased (Addictions Foundation of Manitoba [AFM], 2017; CCPAM, 2019; IDTF, 2019). These trends have greatly impacted our community with many individuals and families experiencing harms, such as the loss of a loved one. In 2020, the COVID-19 pandemic only worsened these trends in Canada (Government of Canada, 2021).

Community health nurses (CHNs) are often the first point of contact with the healthcare system for people who use drugs (PWUD) (Jones & Arms, 2018; Limbu, 2008; Nikowane & Saxena, 2004; Pauly, 2008b) providing a unique opportunity for engagement and trust building. Further, according to the Community Health Nurses of Canada (CHNC) *Professional Practice Model and Standards of Practice* (2019), CHNs work at multiple levels to support population health through practice standards such as health promotion, prevention and health protection, evidence informed practice, professional relationships, capacity building, and policy engagement regarding access and health equity. However, there is little empirical evidence exploring the perspectives, practice, and roles of CHNs in Canada specific to addressing drug-related harms, and the barriers and facilitators to fulfilling the theoretical role of the CHN in this arena. Additionally, little is known about how CHNs understand the "problem" of drug-related harms, from which their interventions to redress drug harms arise.

In this thesis, the term "drugs" will include all illegal psychoactive drugs as well as non-prescription drugs. However, it is important to note that the legality of a drug has little

importance when caring for PWUD. In most cases, the term "drug poisoning" will be used in place of "drug overdose" as this type of harmful event usually occurs unintentionally as a result of a toxic drug supply. Calling it an overdose event would place blame onto the individual for knowingly taking too much of a drug when this is typically not the case. Therefore, this term is avoided. The term "drug problem" was used purposely during interviews to elicit responses and reactions of participants about their perspectives of the so-called "drug, opioid, or meth crisis". These same terms are also seen throughout the text. CHNs will include all nurses (i.e., RNs, RPNs and LPNs) working in the community, including public health nurses, nurses working in primary care, and addictions services. This chapter will begin by describing drugs and drug-related harms followed by a discussion of the current context of drug use and drug policy in Canada and Manitoba. This discussion around context is important as it has an influence on shaping CHNs' roles. Lastly, the problem statement and purpose of the proposed study will be explained, and research questions will be outlined.

Drugs and Drug-Related Harms

Drugs are brain function altering substances that can alter an individual's mood, perception, behaviour, and cognition when introduced into the body by ingestion, inhalation, injection, or absorption (Canadian Public Health Association [CPHA], 2014). They have existed for centuries and have been used by humans for a variety of medical, spiritual, cultural, religious, social, or personal purposes (CPHA, 2014; Health Canada, 2018). For example, pharmaceutical drugs used as prescribed for pain or ceremonial use of illegal drugs like ayahuasca (CPHA, 2014). A Canadian study found that people used drugs to manage pain, alleviate mental health issues, foster social experiences and pleasurable embodied experiences (Ivsins & Yake, 2018). Drug use occurs along a spectrum of use from beneficial to problematic and harmful (CPHA,

2014). In 2016, it was estimated that a quarter of a billion people used illegal drugs, although only 11.6% considered their drug use problematic (Global Commission on Drug Policy [GCDP], 2017). In fact, most drug use will not cause harms to the health or well-being of the people who use them (GCDP, 2017; Health Canada, 2018; Marshall, 2018; Winnipeg Regional Health Authority [WRHA], 2016). However, drug use can be problematic and harmful. Problematic drug use occurs when people use drugs despite the harmful consequences (CPHA, 2014; IDTF, 2019). Drug-related harms are discussed further below.

While PWUD may not consider their drug use problematic, there are many physical, psychological, social, and financial harms associated with drug use (CPHA, 2014). These harms can be directly or indirectly related to the drug itself. Direct harms include drug poisoning and death whereas indirect harms include blood-borne infections (e.g., Human Immunodeficiency Virus [HIV] and Hepatitis C Virus [HCV]), stigma and violence (Health Canada, 2018; McCall & Pauly, 2019; Vearrier, 2019). Notably, stigma may prevent PWUD from accessing services and negatively affect the quality of care that is provided to them (Pauly, 2008a, 2008b). PWUD can also become dependent to drugs or develop a substance use disorder and are at risk of incarceration or criminal charges when in the possession of drugs (Canadian Nurses Association [CNA], 2017a; Vearrier, 2019). Engaging in unsafe activities under the influence of drugs, such as driving a motor vehicle can also put them at risk of harms (Health Canada, 2018; IDTF, 2019).

More importantly, historical, political, social, cultural, and economical structures or conditions embedded in society can contribute to harms of PWUD (McCall & Pauly, 2019; CPHA, 2014; CCPAM, 2019; Marshall, 2018). The historical trauma and continued intergenerational impacts of colonization, systemic oppression, and marginalization of

Indigenous peoples in Canada have resulted in significant health inequities when compared with the non-Indigenous Canadian population (Health Canada, 2018; Hunt, 2015). These inequities include factors such as poverty, unstable housing, physical and sexual violence, and lower educational attainment (Hunt, 2015). Some groups of people such as those with mental illness, those experiencing poverty or those of gender or sexual minorities are also at risk of experiencing more harm due to underlying social and economic factors (Health Canada, 2018). Furthermore, society's response to drug use contributes to profound harms experienced by PWUD (CCPAM, 2019; Marshall, 2018; WRHA, 2016). For example, criminalization and drug use stigma profoundly affect life opportunities, social inclusion, and health among PWUD (CCPAM, 2019; Public Health Agency of Canada [PHAC], 2020). From this perspective, harms are largely influenced by the social context around drug use (Rhodes, 2009).

Canadian Context: Drug Use and Harms

In Canada, cannabis, cocaine, crack cocaine, heroin, hallucinogens, amphetamines, opiates, and ecstasy are commonly used drugs (CNA, 2017b; Health Canada, 2018). In addition, prescription drugs like morphine, methadone, oxycodone, and benzodiazepines are commonly diverted and used without a prescription or medical direction (CNA, 2017b; Health Canada, 2018). The *Canadian Tobacco, Alcohol and Drugs Survey* revealed that 15% of Canadians reported using at least one of the following drugs: cannabis, cocaine, crack cocaine, speed, ecstasy, hallucinogens, or heroin indicating an increase from the survey in 2015 which was at 13% (Government of Canada, 2019b). The survey also reported that the prevalence of non-prescription drug use for those aged over 15 was 22% which was the same as results in 2015. Although these findings are informative, they still do not provide a clear picture of drug use trends and drug-related harms in Canada (CNA, 2017b). Since 2013, Canada has been

experiencing increased hospitalizations and emergency department visits involving opioid use (Canadian Institute for Health Information [CIHI], 2018). Between January 2016 and December 2019, there were 15,393 apparent opioid-related deaths in Canada (Government of Canada, 2020a). For these reasons, this has been termed the "opioid crisis" (CIHI, 2019; CNA, 2017b; Health Canada, 2018), a crisis that is now worsened by the COVID-19 pandemic (Government of Canada, 2021; Maynard & Jozaghi, 2021).

Illegally manufactured fentanyl and its analogues are largely to blame as they have been detected in many opioid-related deaths; however, prescription opioids are also to blame (Bardwell et al., 2017; CIHI, 2019; CNA, 2017b; United Nations Office on Drugs and Crime [UNODC], 2021). Canada is the second highest consumer of prescription opioids in the world (CIHI, 2019; Health Canada, 2018). This increases opportunities to divert or use prescribed drugs inappropriately. Notably, opioid poisonings are more likely to occur in a household where someone has been prescribed opioids (CIHI, 2019). Methamphetamine use has also become a major public health concern in Canada with harms related to injuries and poisonings (Canadian Centre on Substance Use and Addiction [CCSUA], 2019; McFaull et al., 2020). The 2021 World Drug Report indicates that the market for methamphetamine continues to expand in North America along with increased mixing of drugs contributing to increased stimulant-related deaths (UNODC, 2021). Fischer et al., have termed the increased use and harms related to opioids and psychostimulants as the "twin epidemic" (2021). They argue that the response to psychostimulant harms has been limited when compared to the response to the "opioid crisis." Although it should be noted that there are a number of local projects in Canada aiming to reduce the harms of methamphetamine, including two projects in Winnipeg, Manitoba (Government of Canada, 2022). In addition, guidelines developed by Hopkins & Mushquash for opioid and

methamphetamine use disorder treatment for residential and community-based treatment centres that serve Indigenous peoples are under review (CRISM, 2022). High use and reliance on benzodiazepines are also common in Canada, a trend that can be attributed to the lack of coverage for non-medical health services such as mental health and counselling services (Murphy et al., 2016).

Drug markets are rapidly changing and becoming more accessible through different avenues, such as the Darknet (UNODC, 2019). According to the 2021 World Drug Report, access to drugs through the online market has become much easier (UNODC, 2021). Notably, drug use trends and harms have evolved during the COVID-19 pandemic due to public health measures that were implemented to reduce the transmission of the virus. Border closures have disrupted drug trafficking making the drug market even more unpredictable and unsafe for PWUD, ultimately increasing the risk of harms (Nguyen & Buxton, 2021; CCSUA, 2020). This disruption has led to decreased availability of drugs along with increased costs and adulteration of drugs, resulting in changed drug use patterns among PWUD (Nguyen & Buxton, 2021; CCSUA 2020, Ali et al., 2021). In addition, a number of health and social services were impacted by public health measures, resulting in decreased accessibility to services such as harm reduction (Nguyen & Buxton, 2021; Wilkinson et al., 2020). Public health measures such as social distancing and self-isolating have also prevented PWUD from accessing services and forces them to use alone (Nguyen & Buxton, 2021).

In summary, drug-related harms have become a pan-Canadian issue (IDTF, 2019). Drug use is found across all sectors of the Canadian population (CNA, 2017b) and almost all people can experience problematic drug use (IDTF, 2019). However, socially and structurally

disadvantaged people are disproportionally affected by drug-related harms. The CNA (2017a) states that:

> Gender, ethnicity, age and socio-economic status affect a person's susceptibility to the harms of substance use. Indigenous people are particularly vulnerable to the harms of substance use and, for women and youth, these harms include higher incidents of HIV infection and violence. (p. 12).

These social inequities are exacerbated by current Canadian drug policies (CNA, 2017b; CPHA, 2014). Historically, it is argued that most drug laws were developed on the basis of fear and racism or for ulterior economical and political reasons (CPHA, 2014). Furthermore, the approach used to control drugs was enacted through criminalization where lower class people who used drugs were labelled as criminal addicts (Boyd, 2021). Boyd (2021) further articulates that drug policy remains gendered and racialized, particularly among women, Indigenous peoples, and people of color in Canada. In her book, *Racialized Policing: Aboriginal People's Encounters with the Police*, Elizabeth Comack (2012) also discusses racialized policing within a broader societal context where police oversee the "reproduction of order" which is raced, gendered, and classed (p.57). Consequently, certain spaces, such as inner-city communities, tend to be viewed as places where crimes and violence are more likely to occur and are therefore subject to heavy policing practices. Canadian drug policies will be examined further below.

Canadian Context: Federal Drug Policy

In Canada, the federal government provides leadership and funding to address drug-related harms (Health Canada, 2018). Drugs are regulated under federal law by the *Controlled Drugs and Substances Act* which issues instruction and regulation over the production, trade and possession of drugs (CPHA, 2014; Health Canada, 2018). Examples of illegal drugs include

cocaine and crack, crystal methamphetamine (meth), heroin, magic mushrooms, ecstasy, phencyclidine (PCP), lysergic acid diethylamide (LSD), gamma-hydroxybutyrate (GHB), Ketamine, bath salts and illegally manufactured Fentanyl (Government of Canada, 2017). The *Opium Act* of 1908 was the first Canadian federal drug law intending to suppress opium use, ultimately setting the foundation for Canadian drug legislation (CPHA, 2014; Malleck, 2015; WRHA, 2016). Some argue that this legislation was introduced due to social tensions and racism at the time of its implementation (CNA, 2017b). Boyd argues that opium users were targeted, particularly Chinese Canadian men, who were criminalized during this time (2021). Many current drug laws continue to reflect these earlier times and are not often driven by current evidence (CPHA, 2014; WRHA, 2016). The legalization of cannabis is an exception.

In October of 2018, cannabis was legalized, demonstrating a small movement toward less restrictive drug policy. Additionally, provincial prescribing of pharmaceutical-grade opioids in British Columbia during the COVID-19 pandemic shows promising advances in the provision of a safe supply for PWUD (Krausz et al., 2021; Nguyen & Buxton, 2021; Boyd, 2021). Nonetheless, drugs continue to be primarily managed with a prohibitionist approach (CPHA, 2014; Fischer et al., 2016). Some have labeled this the “war on drugs” or “tough on drugs” approach (CDPC, 2012; Norman, 2001; WRHA, 2016). Evidence has shown that this approach does not deter drug use or drug-related crimes (CDPC, 2012; CHPA, 2014; WRHA, 2016). Rather, it fuels the black market and increases the risk of drug poisoning and death of PWUD (CDPC, 2012; CPHA, 2014). Illegally manufactured drugs are not regulated, making for an unsafe supply for consumers. Without quality control, drugs are cut with adulterants and their composition, potency and purity is not known (CPHA, 2014; WRHA, 2016). Criminalization also contributes to ongoing marginalization of PWUD (CPHA, 2014). Fortunately, at municipal

and provincial levels, some provinces and cities have turned to public health-oriented approaches (CPHA, 2014; Fischer et al., 2016). These approaches aim to prevent and reduce drug-related harms while promoting health equity and combatting stigma and discrimination of PWUD (CPHA, 2014; CCSUA, 2014). For example, Vancouver has been successful in developing a number of harm reduction initiatives such as Insite, a supervised consumption facility (CPHA, 2014; CNA, 2017b) and Manitoba was successful in implementing a take-home naloxone distribution program (Bozat-Emre et al., 2018; IDTF, 2019). MySafe vending machines that dispense medical-grade opioids, an alternative to toxic street drugs, have also become available in British Columbia, Ontario and Nova Scotia (Bains, 2021). Agencies in Winnipeg are currently working towards implementing this project as well (Dr. G. Poulin, personal communications, April 29, 2022). Every province West of the Maritimes has implemented supervised consumption facilities except Manitoba (Government of Canada, 2020b). Currently, there are no open applications in Manitoba for a supervised consumption site (Government of Canada, 2020b). However, a community agency in Winnipeg is preparing an application for a proposed site (Dr. E. Pijl, personal communications, April 29, 2022). Nonetheless, much more work is needed to address drug-related harms in Canada.

Manitoba Context: Drug Use & Harms

Currently, limited data is available concerning drug use and drug-related harms in Manitoba. However, reports have indicated increases in opioid-related poisonings and deaths, methamphetamine use and injection drug use (CCPAM, 2019; IDTF, 2019). The province began reporting trends related to opioid misuse and poisonings in 2016 and more recently expanded surveillance to all substances. Notably, costs of substance use in Manitoba were estimated to be up to 1.4 billion dollars in 2014 and expected to rise in the future (Canadian Substance Use Costs

and Harms Scientific Working Group, 2018). Costs are calculated based on the following categories: healthcare, criminal justice, loss of productivity and other direct costs (Canadian Substance Use Costs and Harms Scientific Working Group, 2018). This is largely due to the "opioid crisis" which has impacted the whole nation (CIHI, 2018). Reports in Manitoba have shown that EMS responses to drug-related incidences are increasing at an alarming rate (IDTF, 2019). Many of these calls have involved crystal meth or opioid poisonings (CCSUA, 2019; AFM, 2017; IDTF, 2019). Moreover, rates of sexually transmitted infections, such as syphilis and congenital syphilis, have increased and may be associated with increased unprotected sexual activity among those who use methamphetamine (House of Commons, 2019). According to the Manitoba Sexually Transmitted and Blood-Borne Infections Strategy (2019), hepatitis C virus (HCV), hepatitis B virus (HBV) human immunodeficiency virus (HIV), and syphilis are the most concerning infections spread through blood in Manitoba (Government of Manitoba, 2019a). More recently, drug-related harms in Canada, including Manitoba, have shown to increase during the COVID-19 pandemic. A more detailed discussion of epidemiological trends related to drug use and drug-related harms can be found in Chapter 2.

Manitoba Context: Provincial Drug Policy

In Canada, provinces and territories are responsible for providing services that address drug-related harms (CPHA, 2014; Health Canada, 2018). In Manitoba, policy documents and statements deliver contradicting messages about its drug strategy and which strategies are being prioritized (CCPAM, 2019). According to CCPAM, empirical evidence and research are sometimes neglected or refuted by the provincial government. This has been demonstrated by the government's resistance toward some harm reduction services, such as supervised consumption sites (CRISM, 2017; CCPAM, 2019). Notably, Manitoba's commitment to harm reduction

strategies were analyzed to be stronger at the regional level than the provincial level in 2017 (CRISM, 2017). There also remains a large focus on increasing policing efforts to deter criminal activity related to the drug trade (CCPAM, 2019; IDTF, 2019; WRHA, 2016). This approach worsens inequities and it is often racialized spaces that are heavily policed (Comack, 2012; WRHA, 2016). Furthermore, mainstream drug policy and treatment models within the healthcare system continue to be disempowering for PWUD and often place blame on individuals for their behaviour, ignoring the broader influence of social context (CCPAM, 2019). Moreover, treatment and support services for problematic drug use are fragmented and difficult to access in a timely manner (CCPAM, 2019; IDTF, 2016; VIRGO, 2018). This leads to inappropriate use of other services such as EMS, police, and hospitals (IDTF, 2016). It is also important to note that some services are publicly funded while others are privately funded. Provincially funded organizations may not be providing sufficient or effective programming (IDTF, 2019) while at the same time, community-based organizations in Manitoba struggle to receive government funding in order to have the capacity to deliver services (CCPAM, 2019).

At the municipal level, the Winnipeg Regional Health Authority (WRHA) has endorsed the principles of harm reduction in their position statement which acknowledges that drug-related harms are influenced by the social and structural conditions and that choice is only one factor influencing health outcomes. It is known that inequalities continue to affect Indigenous communities in Manitoba and that non-Indigenous peoples disproportionately benefit from current laws, structures, and systems (CCPAM, 2019; WRHA, 2016). WRHA's position statement acknowledges that harms are disproportionately experienced by Indigenous peoples and that culturally appropriate and Indigenous-led services are needed (WRHA, 2016; IDTF, 2019). The WRHA and other organizations such as the Manitoba Harm Reduction Network and

the Addictions Foundation of Manitoba continue to advocate for policies and regulations that reduce harms to PWUD.

Statement of the Problem

PWUD may experience a number of harms. Some of these harms come from the drug itself (i.e., direct harms) while most harms are derived from the social context around drugs (i.e., indirect harms). There are a number of social determinants of health (i.e., poverty, homelessness, unemployment, lack of social support) that influence these harms (CPHA, 2014). More importantly, certain groups of people experience more harms than others. Notably, the effects of colonialism as well as historical and intergenerational trauma increases the likelihood of drug-related harms in Indigenous peoples, including a higher rates of problematic drug use (Nutton & Fast, 2015; Pride et al. 2021) and higher risk of drug poisonings in First Nations people compared to the non-First Nations population (CCPAM, 2019; Interagency Coalition on AIDS and Development [ICAD] & Canadian Aboriginal Aids Network [CAAN], 2019; Health Canada, 2018; WRHA, 2016). In addition, other marginalized groups such as those with mental illness, those experiencing poverty and those of gender or sexual minorities are at risk of experiencing more drug-related harms (CCPAM, 2019; Health Canada, 2018). People who have experienced adverse childhood experiences are also more likely to struggle with drug-related harms (Chandler et al., 2018). In Manitoba, people living in inner city neighbourhoods experience higher rates of poverty (CCPAM, 2019). These marginalized groups are disproportionately affected compared to the rest of Manitobans. Even so, drug use continues to be viewed and researched as a problem of individual behaviour (Marshall, 2018). Marshall (2018) states that most research related to drugs uses quantitative research methods where locally situated qualitative research is needed to inform our response to drug-related harms.

CHNs are keenly positioned to support the health of PWUD and redress drug-related harms at multiple levels. According to the CNA, nurses care for PWUD in various settings such as community health centres, hospitals, prisons, and the community (CNA, 2017b). In this study I focused on the community setting and included nurses working in public health, primary care, and addictions and outreach services. Nurses working in the community are well-positioned to provide services to PWUD because they are often the first point of contact (Jones & Arms, 2018; Limbu, 2008; Nikowane & Saxena, 2004; Pauly, 2008b). In theory, CHNs have roles in supporting health and wellbeing of individuals, families, groups, communities, populations, and systems through various standards of practice (CPHA, 2010, CCHN, 2019). Currently, there is limited knowledge concerning the roles and perspectives of CHNs in addressing drug-related harms in Manitoba.

Purpose of the Study

The purpose of this study was to have a better understanding of CHNs' attitudes, beliefs, experiences, and perspectives of drug-related harms, and their roles in addressing drug-related harms including barriers and facilitators. CHNs in public health, primary care, and addictions services from a large urban region of Manitoba were the key informants for this exploration.

Research Questions

1. What are CHNs' perspectives on drug use?
    - What were CHNs' thoughts about drugs before starting their nursing career?
    - What were CHNs' own experiences with drugs and how did this shape their current views?
    - How do CHNs' perceive the "drug problem" or key issues around drugs?
2. What are CHNs' current roles in addressing drug-related harms in their practice?

- In what ways do CHNs currently address drug-related harms?
- What are the factors that are facilitating/inhibiting CHNs' role(s) in addressing drug-related harms?
- How has the COVID-19 pandemic impacted these roles?

3. What are CHNs' visions regarding their potential role(s) in addressing drug-related harms?

Chapter Two: Literature Review

In this section, a review of the literature is presented. An electronic search of the scholarly literature was completed in CINAHL and PubMed; Google was used to search for grey literature. The review included English-language sources (i.e., peer-reviewed journal articles, published and unpublished reports, and a thesis), from 2000 to 2022. Search terms included the following: drugs or substances; illegal drugs or substances; illicit drugs or substances; drug users; drug abusers; drug addicts; drug or substance use or abuse; drug-related harms; addictions; opioids; opioid-related harms; stimulants; methamphetamine; Manitoba; Government of Manitoba; community-based interventions or approaches; population-based interventions or approaches; public health interventions or approaches; interventions; strategies; best practice; community health nursing; community health nurse; public health nursing and public health nurse. Reports specific to Manitoba were located in the Manitoba Collaboration Data Portal. The Addictions Foundation of Manitoba (AFM) also provided documents and insight.

First, epidemiological trends in Manitoba are discussed. This will consist of drug use trends, demographic trends, and existing drug-related harms in Manitoba. The next section focuses on community and population-based approached to addressing drug-related harms. Lastly, what is known about the role of the CHNs in addressing drug-related harms is described.

Epidemiological Trends in Manitoba

Several data sources were used to identify drug use trends and drug-related harms in Manitoba. However, it is challenging to develop a clear picture of drug use trends and drug-related harms in Manitoba due to some of the limitations of these data sources. For example, some of these key sources focus on substance use in general, including alcohol and cannabis, not just illegal drugs, or non-prescription drugs. In addition, one of the key sources, the Addictions

Foundation of Manitoba (AFM) is mandated to collect data for those PWUD who utilize their services and therefore does not cover all PWUD. The following discussion should be read with these caveats in mind.

Drug Use in Manitoba

Data from AFM shows that alcohol remains the primary problematic substance reported by adults (AFM, 2021; AFM, 2018a). Other reported problematic substances include cannabis, amphetamines, cocaine, crack cocaine and opioids. In youth, cannabis was most often reported to be the primary problematic substance, others being alcohol, amphetamines, cocaine, sedatives, hallucinogens, and ecstasy (AFM, 2021; AFM, 2018c). Importantly, AFM has indicated that reported primary drug use of methamphetamine increased from 2014 to 2017 and past year injection drug use doubled from 2011 to 2017 (AFM, 2017). There is no clear evidence explaining these increases, but the cost of the street drug has decreased, and its availability has increased in Manitoba (CCSUA, 2019; AFM, 2017). Additionally, emergency department visits related to methamphetamine showed a monthly increase from 2013 to 2017 (AFM, 2017). More recently, the Illegal Drug Task Force of Manitoba (IDTF) has reported an increase in drug use in Manitoba, especially methamphetamine (IDTF, 2019). They report that 15% of opioid-related deaths from 2014 to 2017 involved methamphetamine (IDTF, 2019). These findings coincide with an international report that identified a rise in methamphetamine use in North America (UNODC, 2019). The UNODC's international report also indicates that cocaine use has remained popular in North America. According to the CCSUA (2019), it is still the most commonly used stimulant used by clients accessing AFM services. According to Manitoba government reports on substance use, alcohol, cannabis and stimulants were among the top three substances resulting in hospitalizations in the first quarter of 2019 (Government of Manitoba,

2019c). In addition, the top five substances submitted to Health Canada for analysis in 2018 were: cocaine, cannabis, methamphetamine, fentanyl, and oxycodone (IDTF, 2019).

According to the UNODC's international report (2019), opioid use and prescription of opioids remain high in North America. The report suggests that the availability of opioids for medical use is much higher in the United States and Canada compared to other countries like Africa and Asia. Consequently, opportunities for diversion are increased. Oxycodone, hydrocodone, morphine, hydromorphone, codeine, fentanyl, and tramadol are commonly diverted prescription opioids (UNODC, 2019). Fentanyl is commonly implicated in reported drug poisoning events (CRISM, 2017; Bozat-Emre et al., 2018; Government of Manitoba, 2019d). Fentanyl or fentanyl analogs (such as carfentanil) are often cut into street drugs without the users' knowledge (CCPAM, 2019; Government of Manitoba, 2017). Fentanyl is up to 100 times more potent than morphine and carfentanil is 100 times more potent than Fentanyl (Government of Manitoba, 2017). Benzodiazepines, cocaine, alcohol, and methamphetamine have also been found in toxicological findings after opioid poisonings (Government of Manitoba, 2019d). Methamphetamine was detected in 15% of opioid-related deaths between 2014 and 2017 (IDTF, 2019).

Further current data on non-prescriptive drug use in Manitoba is limited. The *2012-2013 Manitoba Youth Health Survey Report* indicated that 21% of students reported using an illegal, prescription or over-the-counter drug to get high in the past year and 15% reported using an illegal, prescription or over-the-counter drug to get high in the past month (2014). Details on which drugs were used are not included. One study found that the injection of Talwin and Ritalin, a declining trend in Winnipeg providing insights to the lived experience of adjusting to drug market shifts (Marshall, 2018).

Demographics of PWUD

Some notable differences in drug use exist in relation to gender, age geographic, ethnocultural and socioeconomic trends. For example, more men than women have accessed AFM services in 2017-2018 (AFM, 2018a; AFM 2018c). This trend has continued in their most recent annual report (AFM, 2021). Opioid-related poisonings and deaths are also higher in men, except in northern Manitoba where women experience more poisonings than men (Government of Manitoba, 2019d). Women also receive more opioid prescriptions and experience more emergency department visits and hospitalizations for opioid poisonings (Government of Manitoba, 2019d). Government reports on problematic drug use indicate that more men are hospitalized and that more women visit the emergency department for drug poisonings (Government of Manitoba 2019a; Government of Manitoba, 2019c). Needless to say, both men and women experience complications from drug use.

Age related-trends show that young adults (18-35 years) and middle-aged adults (36-55 years) experience higher rates of opioid poisonings, but opioid-related deaths and hospitalizations are higher in those aged 45 to 64 (Government of Manitoba, 2019d). The latter category also receives more opioid prescriptions (Government of Manitoba, 2019d). AFM's data showed that young adults and middle-aged adults accessed their services the most in 2017-2018 (AFM, 2018a). Data from AFM's 2018-2019 reports continued to show that young adults and middle-aged adults access their services the most (AFM, 2019a). New Manitoba government reports on problematic drug use show that those aged 25 to 29 are the largest proportion hospitalized for drug use and that those aged 15 to 19 are the largest proportion visiting the emergency department for drug poisonings (Government of Manitoba, 2019b; Government of Manitoba, 2019c). Moreover, more drug-related deaths are seen in those aged 30 and over

(Government of Manitoba, 2019b; Government of Manitoba, 2019c). In other words, many adults are affected by drug use, but it appears that more complications occur in older adults. Further age-related trends regarding youth are lacking.

In relation to socioeconomic trends, many adults accessing AFM services reported lower levels of income and education (AFM, 2018a). This trend has remained unchanged in their 2018-2019 report (AFM, 2019a). It is important to note that individuals with higher levels of income or financial support often pursue private and out of province services. Many also reported experiencing problems at work and home as well as health and mental health problems (AFM, 2018a). Some also reported experiencing legal issues (AFM, 2018a). In addition to these trends, AFM's most recent report shows that almost 40% of their adult clients reported having financial issues in the past year and 12% reporting unstable housing (AFM, 2021). Many youth accessing AFM services reported experiencing adverse life events and the majority were involved with Child and Family Services (AFM, 2018c). A large number of youth accessing AFM services in 2019 continue to have some involvement with CFS (AFM, 2019c). Many also reported to be experiencing mental health problems and were also affected by someone else's substance use (AFM, 2018c). These trends have also continued among youth accessing AFM services in 2019 (AFM, 2019c). Furthermore, a Manitoban study found a relationship between bullying victimization and illicit drug use in students between grade 7 and 12 in Manitoba (Turner et al., 2018). They speculate that drugs are used as a coping mechanism to manage emotional pain related to the experience of bullying victimization (Turner et al., 2018).

Geographic trends indicate that the largest concentration of suspected opioid poisonings events in Winnipeg occur in Downtown Winnipeg and Point Douglas (Government of Manitoba, 2019d). Individuals accessing AFM services are also mainly from Winnipeg (CCENDU, 2015)

followed by those living in the Prairie Mountain Health Region (20.1%), Northern Health Region (11.7%), Interlake-Eastern Health Region (9.9%) and Southern Health Region (9.2%) (AFM, 2018b). Updated statistics continue to show that most people accessing AFM services are from Winnipeg, followed by Prairie Mountain Health (19.7%), Northern Health Region (12.3%), Interlake-Eastern Health Region (9.3%) and Southern Health Region (9.1%) (AFM, 2019b). It should be noted that an increasing number of services other than AFM are becoming available in regions outside of Winnipeg. Recent Manitoba government reports on problematic substance use indicate that substance use-related hospitalizations and emergency department visits for drug poisonings are highest in the Northern Health Region and that most substance use-related deaths occur in the Northern Health Region and Prairie Mountain Health Region (Government of Manitoba 2019a; Government of Manitoba, 2019c).

Regarding ethnocultural trends, it is known that disparities in health exist between Indigenous peoples and non-Indigenous peoples in Canada. Systemic oppression and intergenerational impacts of colonization have put Indigenous peoples at increased risk of experiencing mental health issues or problematic drug use which contributes to ongoing challenges within Indigenous communities (Health Canada, 2018). In addition, racialized groups (i.e., Indigenous peoples, Black Canadians, and other racialized communities) are disproportionately represented in the criminal justice system and criminal charges often involve drugs (People with Lived Expertise of Drug Use National Working Group et al., 2021; Health Canada, 2018). Among PWUD, these groups also experience more stigma and discrimination and other health inequities (People with Lived Expertise of Drug Use National Working Group et al., 2021). A survey of people who inject drugs in Canada, including 181 participants from

Winnipeg, found that 42.2% of their participants identified as Indigenous (Tarasuk et al., 2020). Further information regarding ethnocultural trends is lacking.

Drug-related Harms

Drug use is defined as problematic when an individual continues to use the substance regardless of harmful effects or negative consequences (CPHA 2014; IDTF, 2019). AFM offers treatment services to individuals experiencing problematic substance use or substance use disorder. Between 2007 and 2012, a total of 31, 477 individuals from Winnipeg accessed AFM services. A total of 46, 670 individuals accessed AFM services throughout the province between 2013 and 2018 (AFM, 2018b). Their newest report indicates that they had 14,545 admissions in 2020-2021 (AFM, 2021). This does not account for those individuals accessing other treatment services across Manitoba. It is important to note that the majority of services are still provided by AFM.

Drug Poisonings and Deaths

The most recent government reports show that all substance use-related deaths are rising in Manitoba (Government of Manitoba, 2019b; Government of Manitoba, 2019c). In 2019, there were 7 substance-related deaths reported between January 1st and March 31st and 9 substance-related deaths reported between April 1st and June 30th (Government of Manitoba, 2019b; Government of Manitoba, 2019c). However, cases are still under review for 2019. Reports for 2020 and 2021 have yet to be reported.

Each Canadian province submits data relating to opioid and stimulant-related harms to the Public Health Agency of Canada (PHAC). Data reporting on opioid-related harms began in 2016 while data on stimulant-related harms began in 2019. In Manitoba, there were 88 opioid-related deaths in 2016, 106 in 2017, 93 in 2018, 62 in 2019 and 22 in 2020 (PHAC, 2021). There

were 81 stimulant-related deaths in 2019 and 25 in 2020 (PHAC, 2021). Data for opioid and stimulant-related deaths for 2021 are not yet reported. The following trends were reported on opioid poisonings: 123 hospitalizations in 2016, 161 in 2017, 108 in 2018, 84 in 2019, 126 in 2020 and 31 in 2021 (January to March only) and there were 737 EMS responses to opioid poisonings in Winnipeg in 2017, 592 in 2018, 774 in 2019, 1543 in 2020 and 358 in 2021 (January to March only) (PHAC, 2021). Reporting on stimulant-related poisonings showed the following trends: 66 stimulant-related poisonings in 2016, 82 in 2017, 64 in 2018, 58 in 2019, 56 in 2020 and 11 in 2021 (January to March only) (PHAC, 2021).

Blood-borne Infections

PWUD are at risk of drug-related harms such as HIV/AIDS, Hepatitis C and other infections related to injection drug use (Pauly, 2008b). Sharing needles increases the risk of contracting blood-borne infections such as HIV and HCV. A rise in injection drug use has coincided with the rise in methamphetamine use (AFM, 2017). People who inject drugs are at increased risk of contracting these infections if they do not have access to sterile equipment. The number of new HIV cases in Manitoba increased by 25% between 2014 and 2016 and the number of new HCV cases also increased in 2016 (i.e., 460 cases in 2016, 387 in 2015 and 349 in 2014) (IDTF, 2019). Notably, higher rates of sexually transmitted and blood borne infections (STBBIs) are seen in the Northern and Winnipeg health regions (Government of Manitoba, 2019a). It is important to note that these statistics do not accurately reflect blood-borne infections contracted from sharing needles. Although, according to the *Tracks survey of people who inject drugs in Canada (2017-2019)*, it is estimated that 11.3% of new HIV cases are attributed to injection drug use (Tarasuk et al., 2020). In Phase 4 of this study, 181 of 2, 383 participants were

from Winnipeg. According to the studies findings, 10.3% tested positive for HIV, 64.2% had HCV antibodies (history of infection) and 36.9% had HCV RNA (current infection).

Legal Harms

PWUD may become involved with the criminal justice system due to current drug policies. The Winnipeg Police Service reported an increase in meth possession and increased amounts of methamphetamine are being seized every year (CCSUA, 2019; IDTF, 2019). There has also been a notable increase in crime attributable to increasing methamphetamine use and associated drug trade violence (CCSUA, 2019; IDTF, 2019). According to Statistics Canada (2019), methamphetamine offenses have increased drastically since 2008. Data also showed that cocaine possession charges increased from 2016 to 2017 (IDTF, 2019). The CCENDU reported that 42% of individuals utilizing treatment services were involved with the legal system in 2010, 2011 and 2012 (CCENDU, 2015). Notably, a large number of youth reported having criminal charges (CCENDU, 2015; AFM, 2018c). Criminal charges and incarceration worsen the circumstances of PWUD. For example, criminal records can affect a person's ability to find employment (CDPC, 2012; WRHA, 2016). People who are incarcerated are also at increased risk of contracting blood-borne infections such as HIV due to high rates of needle sharing in prisons (Bonnycastle, 2011; CDPC, 2012; CPHA, 2014; CNA, 2017b; Stone et al., 2018). PWUD may have no choice but to get involved in illegal activities as a means of survival (CPHA, 2014; GCDP, 2017). Sadly, current drug policies make it difficult for PWUD not to get involved with the legal system.

Stigma and Discrimination

PWUD often experience stigmatization and discrimination (CPHA, 2014). Systemic stigma reinforces public stigma (PHAC, 2020). For example, repressive drug laws reinforce

societal prejudices and fears around drug use. PWUD may be labeled as "drug seekers" or "difficult" within the healthcare system (Health Canada, 2018; Ivsins & Yake, 2018; Pauly, 2008b). Consequently, the quality of care provided to PWUD is affected (Pauly, 2008b). For example, PWUD may receive inadequate pain management (Ivsins & Yake, 2018). This can also lead to internalized stigma (i.e., self-stigma) which can lead to isolation and shame (Health Canada, 2018; PHAC, 2020). In turn, PWUD may engage in risky behaviours such as using drugs alone or refraining from accessing services (CPHA, 2014; Government of Canada, 2019a; Pauly, 2008b; WRHA, 2016). Furthermore, data from the provincial Take-Home Naloxone program revealed that PWUD were reluctant to call 911 during drug poisoning events despite the introduction of the *Good Samaritan Drug Overdose Act* in 2017 (Bozat-Emre, et al., 2018). Within society, there is a large focus on drug use as a moral issue of individual behaviour (CCPAM, 2019; Marshall, 2018). This perspective supports a victim-blaming ideology and ignores larger societal issues at hand. It is often these societal views and responses that cause the most harm to PWUD (Marshall, 2018; WRHA, 2016). These indirect harms are often not the focus of research.

Community and Population-based Approaches to Addressing Drug-Related Harms

A public-health-oriented approach aims to promote health, protect health and prevent disease, injury and death at the community and population level with a large focus on addressing underlying social determinants of health and health inequities (CPHA, 2014; WRHA, 2016). This would include interventions that improve social, economic, and policy context that surrounds drug use and create conditions for harms. The literature was reviewed within the context of a public health approach to addressing drug-related harms. The findings are discussed below using categories that are typically used to describe community-and population-based

interventions or strategies (i.e., levels of prevention). It should be noted that some strategies could be considered an example of more than one category. It should also be noted that much of the literature focuses on prevention of drug use rather than prevention of drug-related harms. This study focuses on the prevention of drug-related harms such as stigma and discrimination, violence, legal system harms (e.g., incarceration and criminal records), blood-borne infections, problematic drug use or substance use disorder, drug poisonings, and death.

Primordial Prevention

Primordial prevention aims to prevent the emergence of risk factors that lead to disease (Porta, 2014). This level of prevention involves addressing the root cause of drug-related harms, including problematic drug use. Primordial prevention commonly addresses the structural and social determinants of health. Root causes of problematic drug use are often related to underlying issues and inequities such as poverty, gender, race inequity and trauma (CPHA, 2014; CCSUA, 2014; CCPAM, 2019; Health Canada, 2018; IDTF, 2019; Maina et al., 2021; Rogers et al., 2022; WRHA, 2016). Notably, this would include racism, discrimination or historical trauma experienced by Indigenous peoples and other racialized communities (CCPAM, 2019; Health Canada, 2018; Nutton & Fast, 2015; Pride et al., 2021). Low socioeconomic status and homelessness are also associated with drug use (CNA, 2017b; CCPAM, 2019; IDTF, 2019). In addition, PWUD are more likely to have experienced adverse childhood experiences (Chandler et al., 2018; Maina et al., 2021) and often continue to experience different forms of trauma due to ongoing marginalization (Pauly & Browne, 2015). Mental health issues are also strongly associated with problematic drug use (IDTF, 2019; CPHA, 2014; Simon et al., 2021). It has been argued that drugs might be used by people to cope with adverse life experiences and stress (CNA, 2017b; Ivsins & Yake, 2018; Wang et al., 2018). Some examples of primordial

prevention approaches to reducing problematic drug use and drug-related harms include equity-oriented interventions such as culturally safe approaches, Truth and Reconciliation, the Housing First Initiative, the Icelandic Model, and policy approaches. Each approach is discussed further below.

Culturally Safe Approaches. Culture is a dynamic process that shapes our views and identities. It is shaped by race, gender, religion, ethnicity, socioeconomic status, sexual orientation, and life experience (RNAO, 2015). Cultural safety was developed by Indigenous nurse scholars in New Zealand in order to address racism in healthcare (McCall et al., 2019; Urbanoski et al., 2020). It moves beyond concepts of cultural competency and sensitivity by recognizing power imbalances, systemic discrimination and colonialism within healthcare and their impact on healthcare delivery (Baba, 2013; Urbanoski et al., 2020). It recognizes that our own culture and views affect the client-nurse relationship (McCall et al., 2019; RNAO, 2015) and the influence of political, social, economic, and historical conditions on health (Urbanoski et al., 2020). It also involves challenging inequities in healthcare (Baba, 2013) to address current gaps in services experienced by marginalized groups, including PWUD (Pauly & Browne, 2015). Cultural safety competencies from the Aboriginal Nurses Association of Canada include postcolonial understanding, culturally safe communication, inclusivity, and respect (Baba, 2013). Educating and training healthcare professionals around cultural safety and its competencies is an important primordial strategy. It can also be used at the tertiary level in order to create safe spaces when caring for PWUD.

Truth and Reconciliation. The Truth and Reconciliation calls to action aim to redress the legacy of residential schools and advance reconciliation in Canada (Truth and Reconciliation Commission of Canada, 2015). Calls to action include some of the following: addressing issues

around child welfare to keep Indigenous families together, eliminating educational and employment gaps experienced by Indigenous peoples, preserving and strengthening Indigenous languages, addressing health inequities experiences by Indigenous peoples and undertaking justice system reform to better address the needs of Indigenous peoples and ensure equity in the legal system (Truth and Reconciliation Commission of Canada, 2015).

Housing First Initiative. PWUD make up a large portion of people experiencing homelessness due to difficulty finding and maintaining housing (CCPAM, 2016; Milaney et al., 2021). The *2011 Winnipeg Street Report Survey* found that prior to becoming homeless, people were discriminated by their landlords for the following: drug use, mental illness, source of income, ethnicity, gender, physical disability, and sexual orientation (CCPAM, 2016). PWUD who are also experiencing homelessness are at increased risk of drug-related harms when compared to the general population (Milaney et al., 2021; Miler et al., 2021). Combatting homeless is a key primordial prevention strategy. Unfortunately, some housing programs or shelters enforce conditions such as abstinence from drugs to have access to their programs (CNA, 2017b). Housing First is a program that provides housing to people experiencing homelessness with the fundamental view that access to housing is a human right (CCPAM, 2016; CNA, 2017b). In other words, PWUD do not have to maintain abstinence to have access to housing. It aims to keep people with the highest needs housed (CCPAM, 2016). Once people are housed, the program fosters community integration by connecting people with other services as needed (CCPAM, 2016; Health Canada, 2018). Some of these housing-based programs also offer supervised consumption spaces and overdose prevention (Bardwell et al., 2017; Nowell & Masuda, 2020). Milaney et al. (2021) and Bardwell et al. (2017) also highlight the need to provide housing services alongside harm reduction. Authors agree that a range of services such

as integrated care, harm reduction, case management, housing interventions, peer support, and outreach should be available for PWUD who are also experiencing homelessness; however, there is no "one size fits all" approach when caring for this population as their individual needs are unique (Miler et al., 2021).

Icelandic Model. The Icelandic Model is a long-term approach to preventing substance use in adolescents that is grounded in classic theories of social deviance from sociology and criminology which theorize that deviant acts will only become common behavioural patterns under certain environmental or social circumstances (Kristjansson et al., 2020a; Sigfusdottir et al., 2020). These circumstances include lack of sanctions, low investments in positive values and lack of opportunities to participate in positive and prosocial development (Kristjansson et al., 2020a). In other words, environmental, and social context shapes and influences our behaviours. The Model is population focused rather than individual focused (Sigfusdottir et al., 2020). Collaboration and local input are critical to its success (Kristjansson et al., 2020b). Emphasis is placed on community engagement and collaboration to produce environmental and social changes, and implement locally tailored interventions to maximize the odds of healthy choices among adolescents (Kristjansson et al., 2020a; Kristjansson et al., 2020b). The Model has shown to be highly effective in reducing substance use in Icelandic adolescents and is currently being implemented in other countries such as Chile (Sigfusdottir et al., 2020). However, it is important to note that what has been done in Iceland may not be effective or appropriate in other countries.

Drug Policy Approaches. In many countries, drug policies are predominantly based in the prohibitionist approach. This approach is heavily reliant on the criminal law; however, there is no evidence that this approach reduces drug use or drug-related harms (CDPC, 2012). Ivsins & Yake (2018) point out that prohibition and drug policy have created boundaries for what is

considered acceptable and unacceptable. For example, one kind of drug use (e.g., alcohol) is considered more acceptable than another (e.g., smoking crack). Moreover, it condemns PWUD for their behaviours, leading to stigmatization (CDPC, 2012; Ivsins & Yake, 2018; Kleinman & Morris, 2021). Kleinman & Morris (2021) also point out that criminalization disproportionately affects minorities and people who are structurally disadvantaged, often exacerbating inequities. It could be argued that the prohibitionist approach is one of the root causes of drug-related harms as it has had a large influence on our response to drug use and reduces life opportunities in communities. The CDPC (2012) pushes for drug policy approaches which involves changing drug laws and policies into evidence-based approaches that respect human rights. This would lead to more attention and funding to be focused toward the heart of the drug issue and root causes of problematic drug use (e.g., trauma, mental illness, homelessness, dislocation, and stress) (CDPC, 2012).

Primary Prevention

Primary prevention includes health promotion and disease prevention activities to decrease risk factors and increase protective factors to prevent disease (Porta, 2014) In this paper, this would involve a number of interventions that prevent drug-related harms, including harm reduction and policy approaches, such as decriminalization and legalization. Risk factors include ready availability of drugs, drug use among peers or family, lack of parental support or supervision, low quality of family relations, family disruption, problematic economic conditions (e.g., loss of employment), low perception of harm in society and individual risk factors (e.g., mental health problems, ineffective coping, risk-taking behaviour traits, aggressive behaviour, academic failure, abuse or trauma, ACEs) (Health Canada, 2018; Renstrom et al., 2017; Santo et al., 2021). A Canadian study by Maina et al., (2021) found that early exposure to drugs in

communities where drug use is normalized were significant risk factors for drug use among Indigenous peoples. On the other hand, protective factors include the following: reduced availability of drugs, parental monitoring, academic competence, effective policies, strong neighborhood attachment, health family and peer relationships, good external support system and good individual attributes such as positive temperament, effective coping skills and self-control (Health Canada, 2018; Renstrom et al., 2017). Guiding frameworks involving primary prevention include those that address social determinants of health and health inequities such as the Population Health Promotion Model (RNAO, 2015).

A common primary prevention approach related to drug use harms involves raising awareness and educating the public about drugs (CPHA, 2014; Salmond & Allread, 2019). However, a number of educational approaches such as those that are solely knowledge-based or fear-based, as well as mass media campaigns are known to be ineffective (Scottish Government, 2016; UNODC & World Health Organization [WHO], 2018). Primary prevention also involves engaging youth in recreation programs and other positive social activities and increasing employment opportunities (IDTF, 2019). Strategies often target youth who are more likely to engage in risky behaviours like initiation or experimenting with drugs (Lassi et al., 2015; Turner et al., 2018; UNODC & WHO, 2018). Strategies may include teaching self-regulation which can increase distress tolerance, improve one's capacity to manage emotions and reduce impulsivity (Pandey et al., 2018; Russell et al., 2019). Improving cognitive processes associated with self-regulation (e.g., executive functioning and inhibitory control) can decrease the likelihood of developing maladaptive behaviours as seen in addictions (Russell et al, 2019). They also include evidence-based and locally tailored prevention programs in schools (Lassi et al., 2015; Welsh et al., 2018).

In the education system, preventing bullying in schools and teaching youth healthy coping skills is important (Turner et al., 2018). Programs that support families are also effective in preventing problematic drug use in youth. For example, positive parenting programs can increase resiliency in children and decrease the likelihood of mental health or problematic drug use in the future (Chen et al., 2019; UNODC & WHO, 2018). Addressing mental health disorders is also an important strategy to decrease the likelihood of drug use and harms (UNODC & WHO, 2018). Community-based (Galai et al., 2018; Palombi et al., 2019) and peer-based initiatives (MacArthur et al., 2015) have also been effective in preventing drug-related harms. For example, community-based grassroots efforts in rural Minnesota were effective in engaging community members to address opioid-related harms (Palombi et al., 2019). Finally, primary prevention also involves prescriber education and guidelines for safer prescription of drugs, such as opioids (Kolodny, et al., 2015; Kovitwanichkanont & Day, 2018; Salmond & Allread, 2019).

Harm Reduction. According to Harm Reduction International (2020), "Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws". Harm reduction interventions are shown to be effective in reducing drug-related harms (Pauly, 2008a; Vearrier, 2019). Harm reduction strategies include needle and syringe exchange to prevent transmission of blood-borne infections (e.g., HIV and HCV) from sharing needles and naloxone distribution to prevent opioid poisonings and death (Drucker et al., 2016; Health Canada, 2018; Stancliff et al., 2015; Sue, 2021; Vearrier, 2019). There is also evidence that the involvement of peers in harm reduction work extends the reach and effectiveness of services as they are experts themselves in harm reduction and trusted by PWUD (Chang et al., 2021; Greer et al., 2021; People with Lived Expertise of Drug Use National Working Group et al., 2021). Supervised consumption sites or

safe injection facilities, such as Vancouver's Insite, are another example of harm reduction (Drucker et al., 2016; Health Canada, 2018; Sue, 2021; Vearrier, 2019). Safe inhalation facilities have also been suggested for people who smoke crack cocaine (Bourque et al., 2019; Voon et al., 2016). In these facilities, trained workers are able to intervene during drug poisoning events to prevent death (Drucker et al., 2016; Stancliff et al., 2015). Buchheit et al. (2021) examined the use of an anti-motion alarm system in a public restroom, an intervention revealed to alert staff and improve responses to potential drug poisonings. Safe spaces that provide shelter, food, and a place to sleep are also important in reducing harms (IDTF, 2016; Milaney et al., 2021).

Another key strategy to reducing harms involves addressing drug use stigma (Health Canada, 2018). Stigmatizing language used within the healthcare system and the media leads to discrimination of PWUD (Health Canada, 2018). Many terms (e.g., drug abuser, addict, junkie) lay blame on the person and drive prejudices in the public (PHAC, 2020). Using non-stigmatizing language is an effective strategy in combatting stigma which demonstrates respect by using "people first" terminology (Health Canada, 2018; PHAC, 2020). Reducing drug stigma is also viewed as a harm reduction strategy.

Drug checking is another harm reduction approach that can reduce drug-related harms. Research shows that PWUD can make informed decisions regarding drug use and future drug purchases when they know the composition of their drugs (Sue, 2021; Wallace et al., 2021). Drug sellers have also been shown to utilize drug checking services in order to reduce harms and maintain trust with their clients (Betsos et al., 2021). Ensuring PWUD and drug sellers have access to drug checking services is an important public health approach to reducing-drug related harms (Bardwell et al., 2019; Measham & Turnbull, 2021). Another approach to checking drug composition involves urine toxicology screening. Pilot projects in British Columbia, Edmonton

and Montreal monitored drug use trends and urine toxicology data and found that a number of people were using Fentanyl unintentionally (Biggar et al., 2021). These approaches can be used to monitor the illegal drug supply within communities.

During the COVID-19 pandemic, a number of harm reduction services were decreased or suspended globally (Schofield et al., 2022). Some harm reduction programs remained open, as they believed closing these services would result in greater loss of life than remaining open (Roxburgh et al., 2021); other programs increased access to harm reduction supplies and pivoted their service delivery to decrease risk of COVID transmission (Frost et al., 2021). Innovations were needed to deliver harm reduction services to PWUD. For example, some programs increased access to harm reduction supplies through home delivery and vending machines, increased flexibility of access to opioid agonist therapy (OAT), including initiation of OAT over the phone, increased access to naloxone, and implemented phone check-ins or virtual options in order to supervise drug use when using alone (Frost et al., 2021; Wilkinson et al., 2020).

Lastly, harm reduction as an overarching perspective or approach involves reducing adverse health, social and economic consequences associated with drug use (Denis-Lalonde et al., 2019; IDTF, 2019; Vearrier, 2019; WRHA, 2016). It considers social and structural conditions that influence harms (Iammarino & Pauly, 2021; WRHA, 2016). Strategies include advocating for policies and regulations that reduce harms to PWUD as well as promoting health equity (WRHA, 2016). The approach also involves meeting people where they are at (Sue, 2021; Lightfoot et al., 2009; PHAC, 2020; RNAO, 2015). This means PWUD are met with compassion and feel less judged, thereby increasing their willingness to access services (PHAC, 2020; CDPC, 2012). The approach is supportive rather than punitive (Pauly, 2008a). It also affirms that PWUD are primary agents of change in reducing drug-related harms (CDPC, 2012; Pereira &

Scott, 2017). There is a significant amount of evidence supporting harm reduction as a philosophy and strategy (Sue, 2021). However, harm reduction has also been criticized for doing very little to address social determinants of health (CNA, 2017a; Drucker et al., 2016; Iammarino & Pauly, 2020; ICAD & CAAN, 2019; Pauly, 2008a; Porter, 2020). Some scholars have noted the conceptual tension between harm reduction as medicalized interventions versus a social movement (Denis-Lalonde, 2019; Goodyear, 2021; Jiao, 2019). As harm reduction has become increasingly institutionalized and politicized, this tension has also been observed in the implementation of harm reduction strategies (Nowell et al., 2020).

Decriminalization and Legalization. Decriminalization and legalization are potential drug policy approaches that address drug-related harms. Decriminalization allows people to use illegal drugs without being criminally charged (CCSUA, 2018; Greer et al, 2022; Vicknasigngam et al., 2018). Portugal decriminalized personal use of drugs and increased access to treatment services which has led to positive results. Evidence shows that drug use did not increase and that drug-related harms and deaths decreased (Greenwald, 2009). Unfortunately, decriminalization does not address the unknown and potentially dangerous potency of illegally manufactured drugs (CCPAM, 2019).

Another policy approach is legalization. This approach allows people to legally possess and use a drug (Nowell, 2021; Rieder, 2021; Vearrier, 2019). Obtaining legal drugs through stores or dispensaries can reduce harms associated with using illegally manufactured drugs of unknown contents, potency, and purity (Sue, 2021; Vearrier, 2019). However, Rieder (2021) cautions against full legalization and proposes a safe supply specifically for PWUD. In order to address the “opioid crisis”, Emerson and Haden (2021) propose a medical access model where physicians can continue to prescribe opioids for pain and opioid use disorder (OUD) and a non-

medical access model where PWUD can purchase legal opioids with authorization in a safe and regulated manner. Physician prescribing of these medications to prevent withdrawal from OUD is controversial to some (Lam, 2021; Petrasko, 2022) but heralded as an important next stem in harm reduction by many researchers (McNeil et al., 2022). In a safe supply approach, opioid products are labelled appropriately to ensure consumers are sufficiently informed of harms and benefits to make an informed decision that aligns with their preferences and tolerances (Emerson & Haden, 2021). A qualitative study in Vancouver examined the effectiveness of hydromorphone distribution programs and found them to be effective in decreasing drug-related harms (Ivsins et al., 2020). Safe supply access models and distribution programs like these can greatly decrease the harms related to the dangers of the illegal drug supply (Csete & Elliott, 2020). In addition, decriminalization and legalization can both decrease incarceration, decrease societal costs for drug enforcement and reduce racial injustices and marginalisation of PWUD (Vearrier, 2019). There is also evidence that this approach can decrease the stigma around drug use (Vicknasigngam et al., 2018).

Secondary Prevention

Secondary prevention aims to detect and prevent progression of disease or injury (Porta, 2014). This involves screening individuals for problematic drug use (Salmond & Allread, 2019). Screening, Brief Intervention and Referral to Treatment (SBIRT) (Babor et al., 2007) and Screening and Prescription Drug Monitoring Program (PDMP) are examples of secondary prevention (Salmond & Allread, 2019). Multiple prescriptions from different practitioners can be detected through PDMPs (Kolodny, et al., 2015; Kovitwanichkanont & Day, 2018).

Secondary prevention also involves increasing access to expert pain management (e.g., non-medical modalities) and mental health services (e.g., psychosocial therapies) (Salmond &

Allread, 2019). Opioids are effective in treating pain but also produce euphoria which can increase the risk of dependency and lead to opioid use disorder (Pergolizzi et al., 2020; Peterkin et al., 2022). Best practices in prescribing indicate that alternative pain management methods should be considered and offered (Health Canada, 2018). Lastly, identifying and supporting local peer and community-based networks are important strategies that can prevent the progression of problematic substance use and other drug-related harms in our communities (Salmond & Allread, 2019).

Tertiary Prevention

Tertiary prevention aims to prevent further harms related to drug use. Tertiary prevention strategies include opioid substitution therapy, trauma- and violence-informed care and therapeutic counselling and psychotherapy to support recovery for people with problematic drug use or substance use disorder. These strategies are discussed further below.

Opioid Substitution Treatment. Some interventions aim to reduce harmful consequences associated with drug use without necessarily stopping use (PHAC 2020; ITDF, 2019; Health Canada, 2018; Vearrier, 2019). This includes opioid substitution treatment with Methadone or Buprenorphine for people with opioid use disorder (Drucker et al., 2016; Health Canada, 2018; Kolodny, et al., 2015; Peterkin et al., 2022; Salmond & Allread, 2019). However, treatment retention is poor, therefore, researchers argue that collaborative approaches to address opioid use disorder and concurrent mental illnesses are needed (Harris et al., 2021). Heroin-assisted treatment services have also been utilized in some European countries (Drucker et al., 2016; Tweed et al., 2018). Moreover, Olanzapine is an antipsychotic that can be used to treat methamphetamine-induced psychosis to prevent an individual from harming him/herself or others (CCSUA, 2019).

Trauma- and Violence-informed Care. For people who have experienced trauma, drug use is often a way to deal with its lasting effects (Herron & Venner, 2022; Rogers et al., 2022; Skewes & Blume, 2019). Trauma also produces neurological changes in the brain that have long-term consequences such as substance use disorders (Chandler et al., 2018). A trauma- and violence-informed care approach acknowledges the notion that people may have experienced trauma or violence in their lives which can have a profound affect on development and behaviour (Chandler et al., 2018; Pride et al., 2021). While resolving traumatic experiences is not the immediate goal of the therapeutic encounter, further harm is prevented by creating safe spaces and using a compassionate and strength-based approach while focusing on building resiliency and coping strategies (Menschner & Maul, 2016; Shier & Turpin, 2017). A victim-blaming ideology is avoided by placing more emphasis on understanding what happened to the individual rather than focusing on what is "wrong" with the individual and why they act a certain way (Shier & Turpin, 2017). Four key principles of trauma-informed care include trauma awareness; emphasis on safety and trustworthiness; opportunity for choice, collaboration and connection; and strength-based and skill building (RNAO, 2015). This approach is a key strategy in caring for PWUD.

Therapeutic Counselling and Psychotherapy. According to Salmond & Allread (2019), treatment of problematic drug use or substance use disorders also includes non-medical modalities such as motivational interviewing or other behavioural or psychosocial therapies. Mutual support groups are other options available in most communities (Salmond & Allread, 2019). A recovery-oriented approach has also gained traction in Canada. It is an approach that involves long-term support of people in recovery (CCSUA, 2017; RNAO, 2015). Recovery is an ongoing process that is client driven (Inanlou et al., 2020; RNAO, 2015). A person's recovery

journey is influenced by internal and external resources (Inanlou et al., 2020). Overarching themes include dignity, hope, resilience, relationships and creating meaning in life (RNAO, 2015). In brief, the path to recovery is different for everyone. Therefore, many treatment options should be made available in order to address all individual needs (Health Canada, 2018).

Roles of Community Health Nurses in Addressing Drug-Related Harms

According to the Community Health Nurses of Canada [CHNC] (2019), CHNs provide services to individuals, families, and their communities. Their role often involves addressing determinants of health to promote good health and prevent disease (CHNC, 2019). Achieving social justice and addressing health inequities is also a key part of the community health nursing role (CHNC, 2019; CPHA, 2010). This involves strong leadership and advocacy (CPHA, 2010). In the following sections, primordial, primary, secondary, and tertiary prevention roles, and activities of CHNs, related to drug-related harms, will be discussed further. It should be noted that, in some cases, a particular role or activity could be considered an example of more than one level of prevention.

CHN Roles: Primordial Prevention

To begin, CHNs have an important role in addressing basic needs of people in their communities (Nikowane & Saxena, 2004). Sometimes their roles and responsibilities go beyond nursing when addressing these needs (Self & Peters, 2005). They work in collaboration with other providers and refer clients to social services for assistance with housing, income, employment, food security or mental health (Jones & Arms, 2018; Lightfoot et al., 2009; Pauly, 2008b; Self & Peters, 2005). Importantly, CHNs have a role in advocating for healthy public policies that have an impact on housing and income and other conditions that affect social determinants of health (CNA, 2017b; CPHA, 2010; Falk-Rafael & Betker, 2012; Gagnon et al.,

2019). This also includes advocating for healthy, safe, and supportive environments in their communities (CPHA, 2010; Falk-Rafael & Betker, 2012). To influence policy change, CHNs may have to organize protests, meet with politicians, write letters, join committees, and form partnerships or coalitions with groups who share similar goals (Falk-Rafael & Betker, 2012). Furthermore, CHNs have a role in building capacity and empowering populations, such as PWUD. For example, CHNs have been involved in community-based projects to give voice to marginalized populations (Paivinen & Bade, 2008). Another example is a CHN who became politically active alongside a group of community members to help them secure affordable housing (Falk- Rafael & Betker, 2012).

CHN Roles: Primary Prevention

Health education is one of the key primary and tertiary prevention strategies used by CHNs (CPHA, 2010). Education around drug use involves safety, hygiene, and harm reduction strategies (Lightfoot et al., 2009; Sharp, 2018). For example, harms associated with injection drug use (e.g., blood-borne infections, skin infections and drug poisonings) can be minimized through education (Lightfoot et al., 2009). Moreover, they provide education around specific drugs such as opioids to support safe use (Jones & Arms, 2018). Education is also provided in collaboration with peer outreach workers (Limbu, 2008). CHNs also have a role in providing education and training to other professionals, such a law enforcement, first responders, teachers as well as other community service groups or health care providers, including college or university students (Gold, 2009; Norwood et al., 2015; Villegas-Pantoja & Mendez-Ruiz, 2016).

Harm reduction interventions are an important part of the CHN role to prevent drug-related harms. CHNs distribute harm reduction supplies to PWUD (CNA, 2017b; Day et al., 2011). Supplies include sterile injection equipment, condoms (Gold, 2009), water, alcohol

swabs, tourniquets, filters, and dressings (Lightfoot et al., 2009). CHNs working in supervised injection facilities also have a role in supervising PWUD to minimise potential harms such as drug poisonings (Gagnon et al., 2019; Lightfoot et al., 2009; Sharp 2009). For example, they may have to administer oxygen or life-saving medications like naloxone during opioid poisonings (Gagnon et al., 2019).

Ensuring access to naloxone is another important harm reduction strategy that can prevent opioid poisonings (Jones & Arms, 2018). CHNs have a role in educating and training community members on how to use and distribute naloxone (Norwood et al., 2015). CHNs also have a role in educating the community about harm reduction (Kulikowski & Linder, 2018; Limbu, 2008; Self & Peters, 2005). Data collection and research showing the effectiveness of harm reduction is of utmost important (Kulikowski & Linder, 2018). They have a role in supporting community-based organizations in their communities (CPHA, 2010). For example, Project Safe Audience is a harm reduction project for PWUD at raves implemented by two nursing students (Koch & Keilty, 2018). According to Koch & Keilty (2018), they provide educational material, harm reduction supplies, psychedelic crisis intervention and substance testing at raves and festivals. It is also important to note that harm reduction is not just an intervention, it is also an approach and a philosophy that involves meeting people 'where they are at' (Sue, 2021; Lightfoot et al., 2009; PHAC, 2020; RNAO, 2015). That is, CHNs use a non-judgemental, client-centred approach to build relationships and reduce the risk of harms to PWUD (Lightfoot et al., 2009; Self & Peters, 2005; Sharp, 2007). It is important to gain trust with PWUD, who are often marginalized or discriminated (Self & Peters, 2005). CHNs also have a role in advocating for harm reduction practice (CNA, 2017b; Kulikowski & Linder, 2018).

Harm reduction is intended to prevent and reduce harms which in line with values listed in the Code of Ethics (CNA, 2017a; Pauly, 2008a).

Community participation and engagement is an important and evolving role of CHNs (CPHA, 2010; Kulbok, 2012). This approach involves CHNs working as partners with community members to address health issues and conditions within their communities such as problematic drug use (Kulbok, 2012). According to Kulbock (2012), CHNs can also team up with educators and researchers to develop and implement evidence-based interventions within their communities. A study by Nyamathi et al., (2012) showed that two nurse-led prevention programs were effective in reducing substance use (i.e., alcohol, cannabis, cocaine, methamphetamine, and hallucinogens) in homeless youth. These programs enabled the development of relationships and social networks among nurses and homeless youth (Nyamathi et al., 2012). Another study by Campbell-Heider et al., (2003) involved the development of a 10-week intervention called Teen Club for high risk teems in a community by a CHN. Evaluation of the Teen Club showed that it helped reduce risk behaviour, such as drug use (Campbell-Heider et al., 2003). These types of interventions provide space for connectedness and a sense of belonging among youth and show promising results for nurse-led initiatives involving community members to reduce drug-related harms.

CHN Roles: Secondary Prevention

CHNs are often the first to recognize problematic drug use and sometimes the first or only point of care for PWUD (Jones & Arms, 2018; Limbu, 2008; Nikowane & Saxena, 2004; Pauly, 2008b). They are well positioned to detect and follow up on problematic drug use or drug-related harms (Limbu, 2008; Nikowane & Saxena, 2004; Rassool & Villar-Luis, 2004). In other words, epidemiology and surveillance is an important role of CHNs (CPHA, 2010). Screening

involves detecting problematic drug use and other complications such as blood-borne infections (Gagnon et al., 2019; CNA, 2017b). Through early detection, CHNs can reduce their prevalence (Nkowane & Saxena, 2009). CHNs also provide testing for STBBIs and pregnancy (Day et al., 2011; Gagnon et al., 2019; Self & Peters, 2005) and collaborate with PHNs to locate sexual contacts (Self & Peters, 2005). They may also provide outreach services to hard to reach populations, such as PWUD and people experiencing homelessness (CPHA, 2010; Day et al., 2011; Gold, 2009; Self & Peters, 2005). Screening, brief intervention and referral to treatment (SBIRT) is an approach that is also implemented by nurses, including CHNs (Newhouse, 2019; Rassool & Villar-Luis, 2004). CHNs working with PWUD often perform health assessments to detect and address health concerns (Lightfoot et al., 2009). They work in partnership with other community programs and make referrals when needed (Day et al., 2011; Lightfoot et al., 2009). In other words, CHNs are a vital link to other health care and social services.

CHN Roles: Tertiary Prevention

Upon detecting drug-related harms (e.g., blood-borne infections or substance use disorders), or other medical issues, CHNs have a role in addressing and treating them (Gagnon et al., 2019). Furthermore, CHNs can refer PWUD to addiction treatment or peer support groups, if desired by the client (Jones & Arms, 2018; Lightfoot et al., 2009; Sharp, 2018). For example, an individual with an opioid use disorder may want to begin opioid agonist therapy with medications like buprenorphine, methadone or naltrexone (Jones & Arms, 2018). CHNs also have a role in providing non-pharmacological interventions such as counseling and brief intervention (Gagnon et al., 2019; Jones & Arms, 2018). Lastly, CHNs ensure culturally safe and trauma-informed approaches are used when caring for PWUD (Kulikowski & Linder, 2018; Lightfoot et al., 2009).

Barriers to CHNs Addressing Drug-Related Harms

Organizational and governmental policies that do not support harm reduction can act as a barrier for nurses providing services to PWUD (Bardwell et al., 2017; CNA, 2017b; Gagnon & Hazlehurst, 2020). Organizational policies also influence the quality of care provided by health professionals. Cohen (2006) explored the perspectives of public health nurses, finding a number of barriers at the individual, organizational and extra-organization level to providing population-focused health promotion. Public health nurses felt more comfortable and competent providing individual and family level care over population level care. At the organizational level, acute and long-term care were prioritized over population-focused health promotion. In addition, a number of provincially mandated programs gave them less time to focus on population-focused health promotion. They said politicians and the public favored acute care issues over population-focused strategies. These findings are significant since population-focused strategies are needed to address the inequitable impact of drug-related harms among structurally disadvantaged populations.

Studies have also shown that nurses and other health professionals can have negative attitudes while caring for PWUD (CNA, 2017b; Rassool & Villar-Luis, 2004; Schuler & Horowitz, 2020; Salmond & Allread, 2019; Villar-Luis & Rassool, 2004). These negative attitudes occur as a result of societal norms and organizational policies (CNA, 2017b). In some cases, PWUD are labeled as drug seekers (Pauly, Goldstone, McCall, Gold & Payne, 2017). These views pose a significant barrier to the provision of quality nursing care and further marginalize PWUD (Pauly et al., 2007). Villar-Luis & Rassool (2004) claim that a lack of knowledge is also to blame, and the provision of education and training could shift nurses' attitudes. Moreover, there is sometimes lack of agreement on nursing curriculum when it comes

to drug use (Villegas-Pantoja & Mendez-Ruiz, 2016). Pauly (2008b) also suggests enhancing nursing students' knowledge with curriculum on social conditions and harm reduction. However, other scholars argue that education is not enough and that there is a need for more supportive environments (Ford et al., 2009; Schuler & Horowitz).

According to Lightfoot et al., (2009), ethical concerns also pose a barrier to providing harm reduction services. They claim that politicians and the public do not always support these practices. In addition, there is tension between law enforcement approaches and public health approaches (Lightfoot et al., 2009). Another obstacle to the continuous provision of care by CHNs working with PWUD is burnout (Limbu, 2008). Limbu states that CHNs, especially those working in outreach, may experiences stress and exhaustion. Notably, providing care to people experiencing social inequalities increases the risk of burnout, stress, moral distress, trauma, and vicarious trauma (McMenemy et al., 2021). Heightened stress related to increased drug-related harms during the COVID-19 pandemic has made CHNs' jobs even more stressful (McMenemy et al., 2021).

Facilitators to CHNs Addressing Drug-Related Harms

A clear set of competencies for nurses can assist them in performing their role. For example, the Code of Ethics for Registered Nurses outlines key ethical responsibilities and ethical endeavours to address health inequities (CNA, 2017; Falk-Rafael & Betker, 2012). The CHNC and CPHA have regularly updated competencies, roles, and activities for CHNs to follow (CHNC, 2019; CPHA, 2010). These guidelines assist in shaping the roles of CHNs along with values that underpin nursing practice such as respect, autonomy/self-determination, honesty, fairness/justice, and social justice (Falk-Rafael & Betker, 2012). Equity-Oriented Care is another tool that aims to help health care providers, such as CHNs, address health inequities within the

organizational context (EQUIP Health Care, 2017). Although the framework is not specifically focused on the role of CHNs, it is relevant to the context for CHN practice when caring for PWUD. Key dimensions of the EQUIP framework include trauma- and violence-informed care, culturally safe care, and harm reduction. In addition, strategies such as committing to equity, attending to power differentials, countering racism and discrimination and enhancing access to social determinants of health are included to enhance equity-oriented services within organizations. Most importantly, facilitators include policy changes that enable CHNs to provide harm reduction services. For example, Vancouver's Insite was established after the federal government made an exemption for the facility under section 56 of the *Controlled Drugs and Substances Act* (Lightfoot et al., 2009). Lastly, Nash et al., (2017) claim that education and training around drug use can increase nurses' self-efficacy in caring for PWUD. Having courses and community-based practicums related to drug use can increase confidence of nursing students in caring for PWUD and change their attitudes toward PWUD (Lanzillotta-Rangeley et al., 2020; Nash et al., 2017; Schuler & Horowitz, 2020). In other words, education and training for CHNs or future CHNs can assist them in performing their roles.

Summary of Literature Review

Drug-related harms pose significant challenges to Canadian provinces and territories. CHNs are well-positioned to address some of these challenges. It is important to note that much of the literature focuses on drug use prevention, although, it has been clearly articulated that most drug use is not considered problematic. Reason for this focus is probably due to the dominant biomedical model in healthcare which focuses on treating and fixing rather than focusing on human rights and reducing harms (Lago et al., 2017; Pauly, 2008b). Nonetheless, drug-related harms do affect a small percentage of people and there is evidence of an inequitable

impact of these harms among structurally disadvantaged populations in Canada and Manitoba. These harms are highly influenced by the social context around drug use and more attention toward primordial prevention strategies and upstream thinking will be required to address these drug-related inequities. This often involves addressing the basic needs of people. That being said, drug-related harms are not an issue of the drug itself, but our response to it. As mentioned by CCPAM (2019), the "drug problem" is viewed as a symptom of deeper issues rooted in colonialism and failure to address inequities in our communities. Importantly, how we understand or perceive a problem will shape our response to it. There is a paucity of evidence in the literature regarding CHNs' perspectives about drug use and drug-related harms, especially in the Canadian and Manitoba context. Research is needed to better understand CHNs' perspectives around these issues, their roles in addressing them as well as barriers and facilitators in performing these roles, particularly amid a global pandemic.

Chapter Three: Methods and Procedures

Research Design

Qualitative inquiry is useful when little is known about a research topic and to describe or explore a phenomenon from the emic perspective (Morse & Field, 1995). As determined in the literature review, little is known about CHNs' roles in addressing drug-related harms. This study explored CHNs' attitudes and beliefs about drug use, their current roles and potential roles in addressing this issue as well as perceived barriers and facilitators. Thorne et al.'s (2015) interpretive description design was used to explore CHNs' perspectives on this topic.

Most traditional qualitative methodologies used in health (i.e., grounded theory, phenomenology and ethnography) are derived from the disciplines of social sciences, anthropology and psychology (Teodoro et al., 2018; Thorne et al., 1997; Thorne et al., 2004). These approaches have often fallen short on developing knowledge that supports nursing practice (Teodoro et al., 2018; Thorne et al., 1997). Teodoro et al., (2018) attest that "the origins and characteristics of these areas of knowledge are solidly directed and grounded for the understanding of problems of a more theoretical rather than practical problems" (p.2). Complex relationships exist between these methodologies, their standards and their objectives and methodological variation was discouraged and judged to be sloppy (Thorne et al., 1997). Thus, the interpretive description method offers an approach capable of addressing real-world clinical problems in the health care setting, therefore meeting the needs of the nursing discipline (Teodoro et al., 2018; Thorne et al., 2015). In other words, the interpretive description design aligns with nursing's ways of thinking (Thorne et al., 2015). According to Thorne et al., (2004), it is an inductive approach acknowledging human experiences as being complex, contextual, and

constructed realities that can be shared. In addition, the researcher and participants interact and influence one another (Thorne et al., 2004).

Epistemology and Guiding Frameworks

Typically, a theoretical framework is used to guide a qualitative research study (Thorne et al., 2015). Instead, the interpretive description design draws on nursing's disciplinary epistemology to provide direction and guidance to the research (Thorne et al., 2015). Thorne et al. (2015) cautions that a nursing research question is "never context-free, but instead arises on the basis of critical reflection, informed by a conscious awareness of the limitations of current knowledge for the practice of the profession" (p.455). Therefore, what is known about the research topic from the literature review is used as a solid basis to orient the study (Thorne et al., 2004).

Setting

This research study was conducted in a large urban region of Manitoba (Winnipeg). The community health setting was selected as CHNs are often the first point of contact for PWUD. CHNs were recruited from the following organizations: Winnipeg Regional Health Authority Health Sexuality and Harm Reduction Team, Mount Carmel Clinic, Nine Circles, Klinic, N'orWest, AFM, Main Street Project, Northern Medical Unit, Aboriginal Health & Wellness Centre, Health Outreach and Community Support, Housing Support and Service Integration, Women's Health Clinic, and Access Centres. CHNs working at these locations provide community and public health and primary care services to PWUD.

Sample Size and Recruitment

When using interpretive description, the sample size remains relatively small with approximately between three to thirty participants (Teodoro et al., 2018). Infinite individual

variations are possible making it impossible to reach saturation (Thorne et al., 2015). Thorne et al. (2015) attest that nurses are morally obliged to discover the individual needs of each case; therefore, saturation is not a concept that aligns with nursing's "ways of thinking". Instead, the sample size is based upon the idea that a proposed number of cases will generate some probable commonalities along with some inevitable variations. Based on knowledge of the CHN workforce and study settings, it was anticipated that 10 to 15 CHNs would participate. Thirteen CHNs were successfully recruited.

There is no single way or rigid process involving the recruitment method when using interpretive description (Teodoro et al., 2018). Sampling and data collection are largely informed by what is already known about the research topic (Thorne et al., 2004). Intentional or purposeful sampling involves identifying participants who can contribute rich and relevant data to the study based on their lived experience (Teodoro et al, 2018; Thorne et al., 1997). In this case, an effort was made to purposefully recruit CHNs from different geographic areas of the city and from different types of service settings (as listed above). CHNs with at least one year of experience working part-time or full-time in one of the above-mentioned settings were invited to participate in this study.

After approval was received from the Education-Nursing Research Ethics Board at the University of Manitoba, a letter of permission (Appendix A) and invitation to participate (Appendix B) in the proposed study was sent to the directors of all community health agencies where CHNs provide care to PWUD. These individuals were asked to circulate an invitation letter to their staff. In addition, a notice advertising the study was circulated via the email list of Community Health Nurses of Manitoba and interested individuals were asked to contact the researcher (Appendix C).

Data Collection

In qualitative research, the main method of data collection is interviewing (Morse & Field, 1995). When using interpretive description, data can be collected using various approaches (Teodoro et al., 2018). In this study, data was collected using individual semi-structured interviews. Virtual interviews were conducted using Zoom video-conferencing technology (Zoom Video Communications Inc., 2022). In-person interviews were not possible due to provincial public health restrictions implemented during the COVID-19 pandemic.

Interested participants were contacted to schedule Zoom interviews at a time of their convenience. Informed consent was obtained from all study participants before interviews (Appendix D). Interviews were between 25 to 60 minutes in duration. They began with several demographic questions: [age, gender, ethnicity, level of education, years of experience, setting of practice (public health or primary care), geographical area of services and questions around whether they provide harm reduction services and if they have training in trauma-informed care, cultural safety and harm reduction]. Subsequently, open-ended questions were used to evoke CHNs' perspectives on drugs and their roles and visions in addressing drug-related harms (Appendix E). The interviews were audio-recorded using a hand-held digital device and professionally transcribed verbatim for data analysis. Field notes were taken during interviews as they were helpful for contextualizing data (Teodoro et al., 2018; Thorne et al., 1997). They can also assist in demonstrating the analytic reasoning and interpretive process to ensure research integrity (Thorne et al., 1997).

Data Analysis

When using interpretive description, thematic data analysis is an iterative process requiring exceptional intellectual ability (Thorne et al., 2004). To avoid narrowing down themes too soon, coding should not be meticulously applied early in the process (Teodoro et al., 2018; Thorne et al., 2004). Thorne et al. (2004) caution that "[s]taying overlong in the microscopic view of the trees has a tendency to blur one's perspective on the forest" (p. 7). All transcribed data must be read and reread several times before coding (Teodoro et al., 2018). Creswell (1998) suggests reviewing all information (i.e., transcriptions, field notes) to get a sense of the overall data, while also writing down memos and reflective notes. Other strategies include comparing and contrasting data by displaying ideas in graphs or charts and working with words by creating concepts and metaphors (Creswell, 1998). One must be completely immersed in the data which requires patience and endurance (Creswell, 1998; Teodoro et al., 2018; Thorne et al., 1997). Thorne et al., (2015) warn that simply naming themes and categories is not enough. The researcher will start to recognize patterns within the data that will serve as insights for practice (Thorne et al., 2015). This is where the researcher begins to interpret and make sense of the data based on insights and intuition (Creswell, 1998). Rather than generating new truths or facts, the end result will consist of constructed truths or insights that are presented in a meaningful and useful way for the nursing discipline (Thorne et al., 2004; Thorne et al., 2015).

It is also essential to explicitly make known that the researcher is responsible for the interpretation of data and its final conceptualization (Thorne et al., 2004). Moreover, external support and guidance will be provided throughout the process. Thorne et al., (2004) state that it is important for new researchers to avoid clinging to assumptions and prevent premature closure of ideas. In this case, the researcher and her advisor independently reviewed and completed

initial coding of the first two interview transcripts. The researcher then completed the analysis, consulting with her advisor as coding progressed.

To ensure consistency and structure in data analysis, the framework method developed by Jane Ritchie and Liz Spencer was followed as it is commonly used for thematic analysis of semi-structured interview transcripts. It is a flexible tool that is not aligned with any epistemological, philosophical, or theoretical approach (Gale et al., 2013). The stages of the method as described by Gale were applied as followed:

Stage 1: Transcription

Verbatim transcription was completed by Transcript Heroes Transcription Services. An oath of confidentiality (Appendix F) was signed by transcribers.

Stage 2: Familiarisation with the Interview

This stage involved re-listening to audio-recordings while making notes of thoughts and impressions. This was completed by the researcher.

Stage 3: Coding

In this stage, transcripts were read line by line. Codes (i.e., labels) were attached to substantive things, values, beliefs, and emotions. The aim of coding is to classify data so it can be compared with other sets of data. At the beginning, the researcher and her advisor coded the first two transcripts independently.

Stage 4: Developing a Working Analytical Framework

This stage began after coding was completed for the first two transcripts. After coding the first two transcripts independently, the research team (in this case, the researcher and her advisor) met to compare and agree upon a set of codes that were used to develop an analytical

framework. This framework was used to analyze subsequent transcripts. The initial analytical framework was developed and refined by the researcher as analysis progressed.

Stage 5: Applying the Analytical Framework

The initial analytical framework was applied to subsequent transcripts to identify codes and categories within them. At this stage, codes were assigned letters and numbers for easy identification. This was completed in a Word document. Colors were also used at this stage to better distinguish codes.

Stage 6: Charting Data into the Framework Matrix

This stage involved charting data into a matrix which provided a summary of data from each transcript. This was also completed in Word. Again, colors were used to distinguish evolving codes and categories.

Stage 7: Interpreting the Data

It was useful to keep notes of thoughts and impressions throughout data collection and analysis. Ideas, concepts, or potential themes were tracked using analytic memos in each transcript and then further discussed with the research team. Characteristics and differences between data were identified and connections were made categories.

Trustworthiness

According to Guba and Lincoln, trustworthiness includes the four following criteria: credibility, transferability, dependability, and confirmability (Guba, 1981). Each is discussed as cited in Guba (1981) further below.

Credibility

Credibility refers to the truth value of the findings. Credibility was ensured by peer debriefing. Peer debriefing involves meeting with faculty colleagues or committee members to

discuss thoughts and insights. Several debriefings were completed with the researcher's academic advisor and committee members.

Transferability

This concept refers to the transferability of findings from one context to another. Transferability is dependent on the degree of similarities between two contexts. This study took place in a large urban region of Manitoba (Winnipeg). Thick descriptive data was generated and displayed in the form of exemplar quotes. This way the reader has information to determine whether the findings are applicable to other times, settings, or people.

Dependability

Dependability refers to the assurance that findings are consistent. The Framework Method was used to ensure consistency in data collection and analysis. The Framework Method served as an audit trail that will be examined by the researcher's committee.

Confirmability

Confirmability involves ensuring that findings are objective. This is ensured by adhering to the chosen methodology and disclosing any biases or predispositions of the researcher. The audit trail and journal will aid in displaying some of these biases and predispositions discussed further below.

When using interpretive description, rigour lies in the integrity of the interpretive process (Thorne et al., 2004). Moreover, biases cannot be eliminated. It is therefore important to explicitly disclose possible biases that could influence the study (Guba, 1981; Thorne et al., 1997). Foremost, it should be acknowledged that external guidance is required for a master's thesis. Beginner researchers require a considerable amount of guidance and support (Thorne et al., 2004). Secondly, there may be an inherent bias as nursing professionals to achieve good and

equal health for all (Thorne et al, 1997). For this reason, the researcher must practice reflexivity which involves keeping track of introspections related to the potential impact of one's view of the world on data analysis and interpretation (Guba, 1981). Introspections were tracked by the researcher using a journal and discussed during debriefings.

Ethical Considerations

Ethics approval was obtained from the University of Manitoba Education and Nursing Research Ethics Board and from the Winnipeg Regional Health Authority Research Access Committee. Few risks were anticipated for this proposed research study. All information obtained during interviews has remained confidential. Anonymity was maintained by changing names of participants and removing any distinguishing details which may reveal a participant's identity, work site, or identity of people spoken about during interviews. In addition, only aggregate demographic information was reported.

Chapter Four: Findings

Introduction

In this qualitative study, the perspectives of CHNs on drugs and drug use, the "drug problem" and their roles and visions in addressing drug-related harms were explored. Demographic information is presented followed by themes: healthcare and social systems as a punitive, colonial system of harms; tensions between individual level and system level care; perceptions and tensions in the role of CHNs; and evolution of CHNs' perspectives with time and experience. Please note that names of participants are pseudonyms.

Demographics

Thirteen participants were interviewed individually via Zoom technology (Zoom Video Communications Inc, 2022). Zoom was used rather than in-person interviews due to COVID-19 pandemic public health restrictions. Interviews were conducted between March 3 and June 7, 2021 and were on average approximately 42 minutes in duration (range 25 to 60 minutes). Participants were between 25 and 55 years of age, with six participants under 35 years of age and seven over 35 years of age. Eight participants identified as female and five identified as male. Most participants were white (n=8). Two (2) participants identified as Métis and three (3) participants identified as other ethnicities. The majority of participants (n=9) indicated that their highest level of education was a baccalaureate degree in nursing and three (3) had earned a master's degree; one (1) participant was diploma-prepared. Three participants indicated that they were registered psychiatric nurses. All participants worked in a community health setting, with three (3) working in public health, three (3) working in primary care and the rest in other community health contexts. Participants had a range of years of experience working in community health; four (4) participants had fewer than 5 years of experience, four (4) had 6-10 years of experience, four (4) had 11-15 years of experience and one (1) participant had 16-20

years of experience. Participants worked in several geographical areas across Winnipeg, with the majority (n=9) working in the inner city area. All participants said they provide harm reduction services in their workplace and the majority (n=10) said they received trauma-informed care, cultural safety, and harm reduction education at their workplace.

Healthcare and Social Systems as a Punitive, Colonial System of Harms

Participants described how systems in place in the broader society, including the healthcare system, the justice system, and other social service systems are punishing. Participants emphasized that existing systems do not inherently foster healing and are ineffective in helping people and in some cases, these systems even create more harm. In their narratives, participants described systems that punish PWUD. When exploring their perspectives about drug use in Winnipeg, participants brought forward a number of concerns within the healthcare system and broader society such as drug use stigma, individualism (victim-blaming), criminalization, colonialism and the dominance of Western medicine in healthcare. Each of these concerns are explored further as sub themes below.

Drug Use Stigma in Healthcare and the Public.

More than half of participants (n=7) identified drug use stigma as a major concern. Stigma around drugs and drug use has a negative impact on PWUD and the services being provided to them. Mia explains:

> I would say the key issue around drugs probably is stigma. It sort of prevents our clients or various people to get help…any type of help, whether it be treatment, harm-reduction, there's a lot of shame associated with that.

Tim also shared his perspective:

> So I think the huge problem is related to stigma, not fully understanding what leads people to be using things like drugs and those substances …. That's a huge thing that I see whether that's … government … politics, even our own healthcare, family members, things like that. All these things have an impact on how people perceive substance use and then ultimately it just kind of affects if people actually are even accessing care or not.

He further shared his experience with stigma while working in the addictions field:

> And I heard it, even when I was in the hospital … people being like, "oh why would you want to work at a methadone clinic? You're just giving people drugs." And it's like you don't really actually fully understand what … purpose it's serving.

Hank shared that some clients do not receive treatment of their withdrawal symptoms while in hospital, which he suggested was one of the consequences of drug use stigma within the healthcare system:

> I think that there's that lack of support for someone … who's coming off alcohol for example. And they're not having the withdrawal needs met when they're admitted to the hospital. And then they end up leaving because they need to drink because they don't want to go through the withdrawals.

Alice shared her thoughts regarding stereotypes:

> So you only hear about the stereotype that is the intravenous substance user that uses meth. … that's the stereotype, that's just what people think of. And they're like 'Oh my God you use it once and your life is ruined.' That's a lie. That's just not how … the addiction process works, it's not that simple.

Participants described how these stereotypes were harmful but continued to be present in the healthcare system, even among nurses. Hank shared further thoughts on this topic:

> [T]here is definitely a discrepancy and way more stigma with the hospital-based setting. And I'm going just anecdotally from what clients have told me and things that have been said to them. And just even with some of the conversations that I've had when I've been getting clients who come directly from hospital. There's definitely not a very friendly and a very judgemental tone with some of the nursing staff.

Kitty articulated the following regarding attitudes in the emergency department:

> And the health care system… in the hospitals the emergency department is not known for being warm and fuzzy and kind. The staff there are in a bit of… a zoo and they're just trying to cope with the issue in front of them. So they don't have the time to be sensitive and use the right language when dealing with a person who's overdosed or is dealing with meth-induced psychosis or – they're just not equipped.

Other nurses also brought up the need to address drug use stigma. De-stigmatization of drug use was an important vision shared by several participants (n=5), as well as educating the public about drugs, addictions and mental health so they have greater understanding and empathy for PWUD. Alice shared her thoughts regarding the need for more training in healthcare:

> [O]ur healthcare system really needs far more training regarding social determinants of health, cultural safety, trauma-informed care and harm reduction. We need to make space for voices to be heard that have been historically oppressed, we need to address stigma and stereotypes. We have to stop blaming the substances and the people who use the substances, because it perpetuates that stigma and stereotypes.

Hank also shared his vision regarding de-stigmatization:

> …my vision is to get rid of the stigma around [drug use]… that would be in an absolutely perfect world where people are treating people like people … and not differently, because

> they have an addiction. …Just because someone has an addiction doesn't mean they're not a person, it doesn't mean that they don't need to be treated with respect.

Essentially, participants explained how drug use stigma within the healthcare system and broader society leads to discrimination and judgment of PWUD, resulting in them facing additional barriers when seeking care, thus contributing to negative health outcomes. They suggested that PWUD are mistreated, disrespected, and even dehumanized at the hands of health care providers who don't fully understand the processes of addiction, lean into stereotypes or lack the capacity to give them adequate care. Participants also described how the struggles of PWUD were often viewed as a fault of their own or a moral failure, stemming from an individualistic perspective of drug use.

Individualism in North American Society.

One participant described how PWUD are often blamed for their complex health issues with little focus on the structures and conditions that have put them in these positions or at a disadvantage in the first place. A few participants (n=3) expressed concern with this individualistic and punitive approach to working with PWUD. Kitty explains,

> … a lot of people in our North American society, when someone's having a problem, we typically tend to point a finger and say, 'you have a problem, you need to change your behaviour'.

Here, Kitty is describing the individualistic worldview that dominates many structures in North America. In such a framework, the individual person is held responsible for their actions and choices without acknowledgment of underlying systemic social or environmental issues they may face. Participants described how this individualistic perspective places blame on individuals and promotes behavioural change models that fail to acknowledge underlying issues faced by

PWUD. Alice also shared her thoughts on the need to change our way of thinking by asking system-level questions:

> …what are the root causes? Like, we're so capitalistic and we need to be productive, and …[the] *I've got mine, screw you* type – … you've got to get rid of that thinking.

Participants described how a victim-blaming approach had a negative impact on PWUD as they are often told to simply change their behaviour. Participants also indicated that the way nurses perceive the "drug problem" shaped their response to it. Kitty shared:

> I think it's more of a societal issue than it is an individual issue. And that is the issue, because we view it as an individual issue and not a societal issue.

Criminalizing People Who Use Drugs.

Participants described criminalization as an approach that further stigmatizes and punishes PWUD. It was identified as one of the key issues contributing to the "drug problem". Participants explained how decriminalization would reduce the harms inflicted by the criminal justice system on PWUD. Michele stated:

> The fact that drug use is strongly connected to the criminal justice system, I think that … it makes the whole problem worse because you have individuals that are already struggling and then … now they're struggling and they're a criminal, or they have a conviction. So it just creates more barriers and more shame, more guilt, more regret when really there should be more compassion, more support.

Other participants also agreed that criminalization is not helpful. Bain shared his perspective on the matter:

> Policing, arresting people, imprisoning: it does not work. And people will use because they're in pain. So, there should be some different approach that helps people.

One participant also explained how criminalization contributes to the continuing availability of an unsafe drug supply, increasing the risk of drug poisonings for PWUD.

> The people who are creating illegal opiates in these super labs across … North America…Asia, wherever it's coming from, they've shifted to these more potent concentrated toxic forms of opiates such as fentanyl, sufentanil, [and] carfentanil. So… they're making fentanyl, sufentanil, [and] carfentanil because you get more doses and it's easier to ship. So now it's so toxic people are accidentally overdosing and dying through tiny amounts that are smoked or injected [Alice].

More than half of participants (n=7) shared their vision and support for the introduction of a safe supply and the decriminalization of drugs for personal use. For instance, Kitty described how Portugal decriminalized drug use, with promising results:

> You also have to have the police onboard. They have to agree to not arrest people for illicit drug use. The feds also should push that we should just decriminalize all street drug use. That's what they need to do. Portugal's done it and it seems to be going well. And Amsterdam, also, it's not illegal to use any street drugs. It's illegal to traffic it. But it's not illegal to just be caught using for personal use. So that's what Canada needs to do.

Bain also spoke about this approach:

> And I, frankly, believe in legalizing limited drugs, so people don't have to use – search their drugs on – in a criminal way, if it's affecting them seriously. A lot of people are dying. Decriminalizing the drug use is … one of the steps that I think the government could take, to decrease the harm and also encourage people to kind of live their life in a way that's productive.

Colonialism in Healthcare.

Some participants (n=6) described colonialism, an ongoing system of power in Canada that continues to affect Indigenous peoples, as contributing to a healthcare system that is hostile to PWUD. They described how this system of power persists within the healthcare system in Manitoba. As Lucy stated:

> […] in Manitoba, we have a lot of Indigenous people, and why are so many white people still in power and in control and making decisions for a lot of other people especially like as far as the health region goes as well? … I don't think we do enough … [The] people that work directly with patients … I don't think we have enough feedback … from people that we work [with] … if what we're doing is doing good for them or … doing harm for them …. I think that plays a big impact.

Participants described ways in which the healthcare system, which is controlled and led by settlers, continues to be oppressive to Indigenous peoples and creates the conditions for poor health. For instance, Dina expressed a deep concern about the hardships faced by Indigenous peoples:

> … I think it's really a government systemic issue. I think having 140 communities in Canada that can't turn on their faucet to drink water… I think there's … a lot of bigger issues here that I don't know that we can necessarily piecemeal and nitpick one specific one. But I think it's important to recognize that we've created a place where the things that are occurring are occurring there because we created it.

For his part, Bain shared how ongoing inter- and multi-generational trauma has had severe consequences for many Indigenous peoples:

> So, the current[system] – I don't think it is working, seriously and it's affecting significantly the lower socioeconomic part of the population. A lot of it has to do with historical, colonial problems that people do have in their life, and trauma that they have experienced. And it goes through from generation to generation. You can clearly see three generations in the household using illicit drugs and every single one of them incurring serious harms.

Participants described how a system based on colonialism has led to ongoing mistrust of the system for Indigenous peoples, and how accessing services can be re-traumatizing for those who have experienced trauma within the system in the past. Kitty described the term "decolonization" as "a buzzword that we're all using" but that she didn't think the term was readily or fully understood by "a lot of us privileged white people." Kitty shared further:

> But to a person who has suffered childhood trauma and … we know that the Indigenous population … over-represent a lot of those health issues… I don't know as a privileged white lady that I can fully speak to how to fix that piece. I know a lot of clients come in and they're very, very sad about what has happened to them because they are either Indian day school survivors or residential school survivors, or they're the product of a residential school survivor, and you just see that perpetuating pain and it just looks like it's not an easy fix.

When asked about their visions, five (n=5) participants said that colonialism and its effects need to be addressed. Participants described ways of addressing racism towards Indigenous peoples and educating the public about Canada's history. Bain stressed the need for grassroots approaches that comes from within the communities affected:

> And the approach – I think there should be …a more grassroots based approach, to really encourage that the solution should come from within and then the help should be provided by the government, or even every Canadian, every individual, every member of the society should help at this moment. Like I said, it's an incumbent call to the society, to the Canadian society and the government, to help these specific group of people, who are really feeling the pain and getting the harms… of this drug use, disproportionately.

Alice also stressed the need for culturally appropriate services:

> …We also need…culturally-informed addiction places. Like places that if you've got a whole bunch of people who identify as Indigenous and they need help they should be able to go to a place that has like culture and ceremony to help them.

Participants described how awareness of these conditions and a commitment to reconciliation from all of society was needed. However, several participants acknowledge that this was much easier said than done, especially in a system that continues to be dominated by Western European and settler colonial ways of thinking.

Dominance of Western Medicine in Healthcare.

Perspectives and approaches to addressing "addictions" or problematic drug use within healthcare were described with some variation. One participant described the healthcare system as being very "white" and "paternalistic", deterring people from accessing its services. Two participants described ways in which the dominant Western medicine focus in our healthcare system created structural barriers to addressing drug-related harms. Alice shared:

> … another inhibitive factor is the history of our Western-European healthcare system, it's so paternalistic. It's been damaging to people in the past. People that I try to engage with

> don't want to engage with the healthcare system because trust has been so badly damaged.

In addition, she described how a strict biomedical orientation hindered patient care. For example, Alice stated:

> …but I find that a lot of the places are so medicine focused. They're just like – OK you want to get off opiates, here's … [buprenorphine], or here's [Suboxone], and like good luck. It's … not holistic enough.

Despite opioid agonist therapy being an important harm reduction measure, this participant still found that current healthcare services were not holistic enough. She shared further:

> … it's so addictions-focused and it's very much 'just say no to drugs'. 'Just say no'. Instead of … meeting people where they're at, being harm-reduction focused, saying 'What does your substance mean to you?'

Another participant also described how he believed an abstinence focus, rooted in Western medicine, led to poor outcomes. Hank shared:

> But the biggest piece is that everyone has… that expectation … that abstinence is the answer. And I think when you are dealing with the individual…you have to …meet them where they're at. And look at what that recovery piece is going to be for them.

Some participants explained that while a biomedical view tends to focus on curative care and drug abstinence, a chronic disease and harm reduction model is of greater benefit for patients. One participant indicated that this perspective represented a shift in her thinking:

> So I would say now … my perspectives would be… viewing addiction as … a chronic illness similar to … diabetes, for example [Mia].

Participants felt that although viewing drug use as a behaviour that needs to be changed (n=3) (i.e., "stop using drugs") was overly simplistic, this view continues to dominate the healthcare system. Hank shared the importance of the need for health care providers to view problematic drug use as a medical illness rather than a choice:

> I think there's a lot of things that are looked at as, 'Well, it's their choice. They made the choice to start using. They made the choice to have that drink. They made the choice to have… shot up with that substance.' And I think until we actually look at changing the lens in which practitioners look at substance use and look at it more from a medical illness, like from an illness versus a choice that someone makes. I think that's … probably one of the biggest things that has shifted with my views on drug use.

This demonstrates that some participants still favor the disease model of "addiction" or problematic drug use. A harm reduction perspective was also prominent among participants. Rather than pushing people towards abstinence-based services, most participants favoured harm reduction as a key approach, meeting people where they're at and looking at reducing harms. For example:

> …We also need … harm reduction principles; we need to … acknowledge that some people have so much trauma, they have complicated lives, they're not ready … they don't want addictions treatment yet. And so instead of … 'just say no to drugs, just stop using drugs,' … that's just not realistic for some people. That's not what their lives dictate. …It's just too simplistic [Alice]
>
> We have to be not telling them that they have to just stop doing what they're doing… we have to kind of accept people for where they are and where they're at and what they want to tell us. [Lucy]

> I feel there's a lack of sort of the complex understanding of addiction, and that … some [people] can't stop, some aren't ready to stop. So we have to sort of again meet the client where they're at and respect what's going on with the client, and sort of help them as best we can. [Mia]

Overall, participants expressed the need for an improved understanding of drug-related harms, and problematic drug use, among health care providers along with improved efforts to consider and address these harms.

Tensions Between Individual Level and System Level Care

Participants described several factors contributing to their patients' drug use, including trauma, pain, colonialism, lost culture, mental health problems, socioeconomic status, poverty, and homelessness. They discussed the need to address these "root causes" or societal issues at hand. Participants described the urgent need for the healthcare system to shift beyond the perspective that drug use and its harms are an individual issue and rather, that it should be viewed using a system level lens, which can give rise to upstream solutions. This section is divided into the following sub themes: the "drug problem" is a symptom of a larger problem, complex web of causation, upstream mitigation of trauma at system level, harm reduction as an important downstream measure.

The "Drug Problem" is a Symptom of a Larger Problem.

The majority of participants shared the view that drug use is not issue of individual failings. Rather, they identified a number of social issues or circumstances contributing to drug use and drug-related harms. Ian stated:

> …there's people that are kind of in it more circumstantially, like the clients that I often see often are using cheap drugs, so like meth and alcohol and are using it for a lot of

> different reasons. So that could be like survival, super multifactorial, but essentially they have low socioeconomic status. They don't have a lot of money, live in poverty, have no education, have no familial support and this is all they know. And potentially this has been a generational thing for them where their parents were the same as well.
>
> Pretty much all the people that I've seen that are abusing it's because they've had things happen in their life, and this is the way that they learn to deal with it. So really like a root cause, it's kind of deeper than just the use, it's like why they're using it, and having to kind of dive deep into the reasons why and such.

Michele also shared:

> … it's never been a simple issue, right? With drug-related harms…it's never a simple situation. An individual that's struggling with problematic drug use is not just struggling with problematic drug use. There might be… previous trauma or family dynamics or … the finance piece. There's so many other factors to it that to think that one person or one specialty could address all of those factors. It's just not realistic.

Hank shared similar thoughts:

> The root cause of the majority of the clients that I've seen who have some substance use issues has been some kind of trauma that they've gone through. And I mean, trauma in and of itself, what could be traumatic to me wouldn't be to you. So, it's such an individual thing for each and every person.

Notably, one participant, Alice, expressed that drug use itself is not a problem, it is the relationship that one has with the drug that matters and the social determinants of health that keep the person trapped:

> … the problem or key issues are not the drugs themselves; I believe this is so simplistic and an old-school way of thinking. The problems are the social determinants of health and the accompanying environment. So people that have social determinants of health working in their favour experience much less harm than someone who has most of the social determinants of health working against them.

Participants (n=4) described these factors as being beyond the control of the individuals experiencing them or that society has placed these individuals in these positions. Therefore, they believed, certain groups of people in society were disproportionately experiencing drug-related harms. Ian shared:

> …[W]hen I worked downtown you would see a lot more extreme poverty, much more…debilitating drug use where people really aren't thriving at all and functioning [poorly] in society, it's kind of become over-compassing, right? But then when you go [to] the suburbs you see …people are still … able to work, have families, …it doesn't take over their entire life there like that. You know, they're still able to function to a certain degree.

Other participants also described how not all drug use is problematic, i.e., many people use drugs non-problematically. Joe indicated that drug use itself was not as harmful as structural influences around drug use:

> I think that systemically there's more issues with drug use as far as the way that we criminalize drug use, the way that we stigmatize drug users, the way that we fail to look at other factors that go into people's health when they're using drug, and that we're not looking at drug use as something that is individualized and we should be asking patients

> themselves how it's affecting them and if it is problematic. We automatically assume it's problematic and I think that assumption … [is] harmful.

Other participants also described the interplay of social factors that keep individuals trapped in problematic drug use patterns:

> I think that we put a lot of judgment socially on people that are experiencing other issues in their life that maybe we as a society have caused or made it very hard to get out of their current situation. [Lucy].
>
> …people do have a lot of pain that they encounter in life because of many other reasons beyond their control. And once you go that route of using drugs, then that becomes many times problematic and then that ruins peoples' lives. And you can really see people going down the spiral right after they start. [Bain].

Alice went on to explain the role of systemic forces in drug use:

> …the big root causes of colonialism, or capitalism, or trauma, … and culture – … so the substance use [is] usually a symptom of a larger problem; it's rarely the root issue. So there was/is no meth crisis, it is a housing crisis, it is a legacy of colonialism crisis, it's a mental health crisis. It is not just a meth crisis.

One participant described in detail the role of various forms of system-originating trauma on drug use:

> … many people who are problematic substance users, and problematic by their own terms, have a significant history of … unresolved trauma. So trauma as in… sexual abuse, physical abuse, intergenerational, survivors of trauma, trauma of being incarcerated or criminalized, trauma of being homeless, trauma within the system, of being disrespected, stigmatized, and felt to be lesser than [Joe].

Complex Web of Causation.

Participants went further to describe that social and health systems are contributing to worsening social problems. Some examples include the housing crisis, poverty, and ineffective chronic pain management in healthcare. Below, participants described the worsening housing crisis (n=9) and poverty (n=4) and how upstream solutions to address these issues were lacking within the broader system.

> … the government needs to invest in housing. I'm tired of the government telling me that they don't have money for housing and yet they spend money on repeated visits to the emergency room. They spend money on shelters, they spend money on all these things, when they don't realize that if they made the initial investment in housing half of those costs would disappear in the long run. [Joe]

Joe shared further:

> … I really do think this all starts with housing. Like, Housing First initiatives. I don't expect that anybody could do anything while they're precariously housed or homeless. I think …it's a gross misstep to think otherwise. If we don't have access to… regular sleep and safety and stability, then I'm not sure how you could think that… you're going to tackle some sort of major life-changing addiction.

Michael also shared similar thoughts:

> I think other factors aside from substance use and mental illness…play a role, so of course like depending on … severity of symptoms of mental illness plays a role, homelessness definitely plays a significant role. … having the lack of … proper housing and… stability, meeting … basic needs definitely gets in the way.

A related issue discussed by participants is the healthcare system's failure to effectively treat chronic pain. Two participants identified mis-prescribing as a key issue. For example, Kitty shared:

> …There's lots of mis-prescribing on the part of the physician, even though it's a prescription drug they're giving them too much of that prescription and then that's like inventing the addiction, and then when say for example we inherit clients who are on whacky, whacky doses of pain killers for chronic pain, sometimes its fibromyalgia, right? Any of those things, or chronic pain post-surgery ….

Tim also shared his experience with clients who have been prescribed analgesics:

> And for a lot of people they don't fully understand that … … non prescriptive drug use, sometimes that stems from prescriptions. These are people that come in and they're like 'Well I've been prescribed this for pain, but it's not working for pain anymore.'

He explained further that some people then turn towards street drugs to manage their pain symptoms. Claire shared her experience with clients as well: "[W]e have some clients who come in with this expectation that a prescription for narcotics will be filled but our providers are pretty strict on guidelines." She explained further:

> And so as a nurse … being that middle person between the client and the provider, it's definitely difficult when they're trying to challenge you and trying to push for a refill. They'll try to navigate every other provider, you know.

In other words, clients will seek out other providers to fill their prescriptions for the medications they need.

Upstream Mitigation of Trauma at System Levels.

The majority of participants (n=11) shared that upstream measures are needed to mitigate trauma as a way to strike at the root causes of problematic drug use. Kitty shared:

> A lot of the harms start … with childhood trauma. There's the very odd duck who comes from a very privileged home who falls into the addiction cycle. Most folks that I meet and talk to have had childhood trauma. And this is a coping mechanism. And if we don't look at the upstream solutions it's just going to turn into a big factory. You know, where you're born to a parent with addiction issues, you're taken away and you're put into the system and more trauma ensues and then you move them from there into maybe jail, or into the EIA system. But it's all this disgusting little human factory of addiction making. And I often wonder if I would probably turn to the same mechanisms if I had the same story and experiences.

This "addiction cycle" was described as a consequence of the predominance of downstream services within the system which fail to address any of the circumstances that led people into the cycle in the first place. Joe shared his perspective:

> I think criminalizing drug use, pulling people in for breaches for using drugs, doesn't recognize the fact that these are addictions and that there's a lot of trauma that goes behind that. And without focusing on those issues, change will not occur. It's a waste of resources and it continues to re-traumatize the folks that are being pulled into those cycles, versus offering them support and real ways of addressing what's going on and why they're using.

Bain also shared his thoughts regarding this cycle:

> Just putting – detox is one part and opening up places where people can go in to help detox, that's good. But it's a cycle. Many do succeed and kind of change their life. But people from lower socioeconomic situations, what put them into harm using illicit drugs in the first place, if it is not taken away, then they are back to it.
>
> … sometimes we struggle to get a spot for someone who wants to detox and after detox, there should be a follow up of searching for employment, good housing, so that people are not forced to go back to where they came from. So, … it doesn't circle again.

He stressed the need for a greater emphasis on system-level and upstream approaches:

> So, there should be some different approach that helps people. …Addressing mental health issues, their socioeconomical issues, their generational [and] multigenerational traumas. And all kinds of approaches to address these needs would help… that's the vision I have.

Ian also spoke about the need to address underlying causes at the system level:

> I guess it would be like some more programming and longer detox places that people can go so that they can get clean. And then after that, you can start digging into what the causes are and addressing the traumas. … I think we kind of know a lot of times what the traumas are, but there's certain things that maybe the government or the system could do that could be trying to prevent those things from happening in the first place. [Ian]

Michelle also spoke about the need to address these issues using an upstream system approach, prior to these social issues becoming crises:

> …within the health care system we're well aware that … a lot of health care funding goes toward hospitals and acute care and the facility based care, and I recognize why that's important. But there's a lot of work that we do that prevents people from going to

> hospital. We can do a lot of that work in the community and prevent those crises from happening if we just had the capacity to do it.
>
> It never feels like there's enough resources to be able to do the jobs that we do. And … that's just my program, but I know that there are many community programs that feel the same way. That they would be able to have a much greater impact if we just had more capacity to address mental health, addictions, poverty, … the big societal issues. …[I]f we could tackle them prior to crisis then we can actually take the strain off the facilities and the health care system.

Tim also shared the need for proactive system-level prevention:

> And even when you look at things like preventative care and you look at … three levels of … primary and secondary and [tertiary] … from what I've see in practice, unfortunately sometimes we're very reactive and not proactive…

Participants articulated both the need for, and lack of, upstream solutions within the system, especially in healthcare. The healthcare system was described as providing mainly downstream services which focus on treating presenting issues, often ignoring root causes of health-related issues. For example, Kitty shared:

> … you need more than governments just throwing money into the systems. They are actually doing more harm than good. You need a really forward-thinking progressive government to get elected and you need a change of heart of the voters too to actually want to make a big change for their fellow… fallen brother and sister ….

Participants (n=11) shared visions regarding the need to address root causes like trauma, mental health issues, homelessness, and poverty. They described potential solutions, include universal basic income (n=1) and the need to change systems such as EIA and CFS (n=1). Having more

sustainable employment opportunities and affordable housing are also visions held by some participants.

> …how do you address the root problems? … you would need a societal shift to … first of all destigmatize substance use. Or [you] would need a societal shift to get rid of racism towards … Indigenous [people], like straight up. You would need to address this. …[You would need to] decriminalize substance use so it's a healthcare issue instead of a … criminal justice issue. You need to … teach … in schools… our actual history of Canada …the ugly parts too. You need to address … trauma, you would need … community supports funded by … consistent government funding that could actually give money to non-profit organizations and community-based organizations, so they can help … communities and families [Alice].
>
> I am a supporter of … the universal basic income idea. I think that we are well-positioned as a society to be able to pursue that in a more meaningful and kind of broader society way. Moving away from the social assistance system and just creating this universal basic income that will decrease some of the stigma that folks face when they are on social assistance [Michele].
>
> …we need to be looking at more upstream ways to help keep children in the arms of their parents. We need to … revamp so many systems, I mean even EIA is … like a hardnosed insurance company and I think that that could be reworked too. I think that a lot of folks struggling with addiction, that doesn't count as a disability. So that doesn't get you a little bit of extra funding that is totally essential for people to get housed in safe, clean places. I think we could do a better job of addressing homelessness. Not every person who's

> homeless is addicted and not every addicted person is homeless. But I think that there's definitely some overlap with some and that needs to be addressed [Kitty].
>
> I would love to see the [Child and Family Services] system get completely rebranded as the family system and work really hard on trying to keep families together rather than just quickly whisking kids out of people's care. [Kitty].

Harm Reduction as an Important Downstream Measure.

Harm reduction is a key measure to addressing drug-related harms shared by participants. A few participants (n=3) found that harm reduction services are lacking throughout the healthcare system.

> … it's all incredibly addictions focused [and] harm reduction is not even mentioned. And … the addiction programs don't even work super often. Addiction services are good and we need that but it's like one pillar, it's not the end all be all.".

Although a few participants were concerned about the need for more harm reduction services, some (n=4) indicated that there is some good harm reduction work happening in the province and it appears that the approach is gaining traction within the healthcare system. For example, participants described the impact of naloxone becoming unscheduled, a significant policy change that participants described as increasing access to the lifesaving drug. Joe shared: "I love that naloxone has been de-scheduled, … that's a step in the right direction". Michael also shared:

> So what I've seen [is] there has been movement towards more harm reduction approaches and including like wanting to promote, and also make available, harm reduction kits. So I think there has been movement towards addressing drug related harms.

Some participants (n=4) also noted positive efforts by community-based non-profit organizations committed to harm reduction for PWUD. Alice shared:

> There's a lot of goodwill in community-based organizations, the non-profit organizations, the people who … do so much work with shoestring budgets and they just live and breathe the stuff.

While harm reduction measures were seen as critical, some participants also indicated that as standalone measures, harm reduction interventions were inadequate to fully address problematic drug use. For example, Lucy shared:

> …we have a naloxone program right? That's great, but what is that really doing to help people with the other parts of their lives?

Moreover, the lack of consensus around what harm reduction entails was expressed by two participants:

> Well I think harm reduction to a lot of people means I give you clean needles and then that's it. I don't think that anybody considers safe housing… as a method of harm reduction or income as a method of harm reduction. I think people…have a narrow scope of what it actually means to provide harm reduction for clients [Dina]

> And I just think that there's not the consistent message and it's not consistent across all scopes of practice as to what harm reduction is…And… I think there's a lot of people who are doing harm-reduction stuff that don't realize that what they're doing is harm reduction [Hank]

In other words, harm reduction was often viewed narrowly as technical interventions, such as safe supply and naloxone distribution. Although, when defined and understood

differently, harm reduction was applied more broadly to address drug-related harms and its inequitable impacts.

Perceptions and Tensions in the Role of CHNs

Participants described their experiences with drugs which shaped their perceptions. They also described working in a variety of settings alongside different healthcare professionals. They described roles which vary depending on where they work in the system and the services being provided by their organization. Some of these roles are individual level roles while a small number are system focused. Participants identified organizational facilitators and barriers that impacted their roles as well as the impact of COVID-19 on their roles. They also expressed concerns regarding the poor response to the "drug problem" and the limitations of their roles in addressing it. The following sub themes are reviewed in this section: personal experiences with drugs, perceptions of CHNs' roles in caring for individuals, perceptions of CHNs' roles in addressing systems, organizational facilitators, organizational barriers, impact of the COVID-19 pandemic on CHNs' roles and moral distress and frustrations experienced by CHNs are reviewed.

Personal Experiences with Drugs.

The majority of participants did not express having personal experiences with using drugs themselves. Those who did disclose personal drug use (n=4) only described using certain drugs such as cannabis, psychedelics, and MDMA (Ecstasy). Joe shared his experience with drugs:

> …[G]rowing up [I] experimented with drugs in many different ways. Nothing – no IV drug use or anything but small drugs, consumed mushrooms, experimented…with hash, marijuana, alcohol, MDMA, things like that. Had those things growing up. Some of them positive; some of them were negative.

Others were exposed to drugs through family, friends, people within their community or through work-related experiences. Ian described his experience as follows:

> I didn't really have much of an experience with drugs myself. I had lots of friends around me that had done a little bit, but nothing really super serious. Again, it was mostly like it'd been like marijuana or mushrooms, those were kind of the things that people around me would use. You know, you kind of heard of some people doing some other drugs such as cocaine and things like that, and then that struck me as like, "Oh my goodness, that's serious stuff," right, when you're younger.

For a few participants (n=3), personal experiences with drugs and/or people who use drugs had a significant influence on their views and fostered empathy. For example, Lucy stated:

> I was seeing [substance use] as kind of an escape from my life or to like numb my experience as a person And I think now that … I've been able to really … be who I am, I think that I have a lot more empathy just generally and … I've worked in a lot of different places and … really trying to see people for who they are and what their experiences that got them there, that really has shaped kind of my view.

Michele also shared her experience:

> I haven't had any crisis with any of the use that I've experienced. But I have had close contact with family members, with friends, with even spouses that have struggled with addiction, pretty much throughout my adult life. … I was able to connect with some AFM programs for friends and family that have definitely expanded my current views [and] my understanding. Not just … my understanding as a family member, but an understanding of what someone could be going through. And be kind of the underlying

> reasons or the underlying factors that contribute to problematic alcohol and drug use. And it helped me really understand the inaccurate stigmas that I had previously held.

Perceptions of CHNs' Roles in Caring for Individuals.

Individual level roles are roles that focus on the individual which include a number of primary, secondary and tertiary prevention strategies. The majority of participants (n=11) identify harm reduction as one of their roles in addressing drug-related harms. Participants describe a range of harm reduction interventions including distributing harm reduction supplies, distributing naloxone and training people on how to use naloxone, facilitating drug testing and urine drug screens to determine what drugs are in peoples' drugs and staying up to date on drug trends to better inform PWUD about the current drug supply. Tim shared his role in staying current with drug trends:

> We're forever trying to keep our substance use [knowledge] evolving with like, …there was down or heroin which was never really actual heroin. And then there's … pink fentanyl and purple fentanyl and all these different things … And so for us it's trying to … stay on top of what these substances are and providing that education.

More than half of participants (n=7) also shared that one of their roles involves linking clients to services and establishing a therapeutic alliance with clients. Participants describe making referrals, acting as a liaison between sites, maintaining knowledge of community services, making connections with other organizations, and collaborating with other health care workers. Some participants (n=4) shared the importance of connecting with their clients. Kitty described how she establishes a therapeutic alliance and minimizes barriers to care:

> [W]e just try to be as flexible as we can with folks, especially the ones that don't have phones. They can't book appointments. So we just tell them during our business hours

> ‘Someone's going to see you. You might have to wait a little bit, but we'll fit you in.’ So we're really good at fitting in folks who struggle with life, not even necessarily drug addiction.

Several participants (n=5) shared ways in which they established a therapeutic alliance, such as using a non-judgmental approach when caring for PWUD. Participants described a non-judgmental approach as being honest, being kind, creating a safe space for people, using appropriate language, meeting people where they are at, and providing client-centred services. Kitty explained that as a CHN she needs to “lead with kindness, I think is the most important thing that we do. And trust has to be built. That's what a lot of the clients told us too”. Ian also shared his role building a therapeutic alliance through reducing drug use stigma:

> I … try to kind of de-stigmatise it. That would be kind of our role. Like if we have clients that [use drugs], to not make them feel bad, [and] to try to offer them support. And I know that a lot of them have anxiety in navigating the healthcare system because they do feel judged, and a lot of people are judgmental, so it’s kind of just trying to educate and trying to support and try to get people to help that they want and trying to reassure them.

Participants describe how one of their primary roles involves educating people about drugs and their harms. For example, Alice explained how she provided “education about substances and … vein care or alternate methods of consumption.” Almost half (n=5) of participants identified education as part of their roles in addressing drug-related harms. Some described providing information to clients about community resources. Michele explained:

> …no two clients are the same, no two situations are the same. It's my responsibility, really, to be aware of the system, the supports that are available out there, and the best ways to navigate those supports for people.

Some participants also described their role in providing education to other health care workers to prevent drug-related harms. Alice shared:

> …I train clients, I train community members, I train some professionals in Narcan. That's the antidote to opiates – all opiates. And so I give that out to people doing the training with them, show them how it works and everything like that, so they can save their friends' lives when they've accidentally overdosed.

Participants described a range of nursing services they routinely provided for PWUD: screening for STBBIs, assessing health assessments and making referrals. Claire explained:

> …[F]or STBBIs we do offer them … routine bloodwork, harm reduction supplies, talking about the risk for…HIV. …. So talking about that and Hep C and then also going over diagnoses if they are positive and referring them to the appropriate services… and following up as needed.

Participants also identified other nursing activities: education, wound care and physical care, treatment with medications (e.g., opioid replacement therapy), psychological approaches (e.g., motivational interviewing and crisis support), trauma-informed care, recovery-oriented approaches, and referrals to detox and addictions treatment services. Tim shared:

> I think one of the biggest ways that we address that is through education so we're getting a lot of people that come in that might not fully understand. [I]t's kind of going back to … my perspective of drug use and actually understanding that for a lot of people the reason why they're using substances, from what I see is…they're coping with different levels of trauma and pain and things that they've gone through.

Some participants (n=3) described psychological approaches such as crisis intervention and motivational interviewing. For instance, Bain mentioned: "…I do initiate conversations, in

regards to motivational interviews to encourage people to initiate change and have the urge or the need of change from within. That's the first step for everyone to change". A few participants (n=3), such as Michael, also spoke about using a recovery-oriented approach when caring for their clients:

> And a lot of addiction recovery counselling as well. …[W]e very much take a recovery and patient-centred approach, and we work on a variety of different goals aside from substance use, but ultimately which will help them move towards their recovery goals if that's what they want.

In terms of physical care, some participants (n=4) said they provide wound care and other physical care to clients experiencing drug-related harms. Dina explained:

> For direct harms or indirect harms… if they have any type of site infections, we'll see them and treat them for that. As well on the flipside we complete medical clearance forms for people to attend detox sites or also for just like application forms for any treatment facility essentially, we complete those there.

Almost half of participants (n=6) said they make referrals for clients interested in attending detox or treatment services. Some participants (n=6) also said they provide treatment with the use of medications, such as Methadone or Suboxone. Hank spoke about his role in providing treatment:

> Well, a lot of my work right now is specifically with clients who are using substances. So, and from a withdrawal standpoint it's utilizing different medications in order to prevent like psychosis to, it's using medications to treat withdrawal symptoms like your shakes, your tremors, your hot and cold sweats. It is looking at treating any skin infections that may have arised from IV drug use with antibiotics.

Perceptions of CHNs' Roles in Addressing Systems.

System level roles are roles that focus on addressing issues within the system. A couple of participants (n=2) spoke about providing culturally appropriate services. One participant spoke about the importance of addressing racism within the system. For example, Alice stated:

> …[O]ther ways that I address drug-related harms [is that] I address stigma and racism. So if I ever see it or hear it, or just you know educate myself. Because there's also … subtle like microaggressions and … systemic issues that are just built into the fabric of our systems here.

Some participants (n=2) identified advocacy as one of their roles in addressing drug-related harms. One participant said she also participates in research. Two participants mentioned participating on committees and boards. For example, Michele shares:

> I've been able to position myself on various boards to make sure that my voice can be a little bit louder, a little bit more powerful. And I'm also not afraid to contact… political representatives for the clients that I serve to let them know that this is an issue that is affecting their constituents and that they should be aware of it.

Organizational Facilitators of CHNs' Roles.

Many participants (n=7) described the location of their healthcare service a key factor in facilitating their roles in addressing drug-related harms. This was especially noted by those working in central locations that are easily accessible to their clients. Many clients have limited access to transportation, so having a centrally located clinic within walking distance for a number of clients was deemed beneficial for care. In a similar vein, Ian explained how private spaces for meeting with clients enables his ability to foster therapeutic alliances:

> [F]or us it's people coming in and being able to have conversations with them where they can open up, and if they're having concerns or if they're having needs that they can express that to us in a private setting… Because it's … a clinic, so you can go in a room and they can kind of just say whatever's on their mind.

Other participants also spoke positively about the community-based setting, especially when comparing it to the hospital-based setting. Claire shared: "So I think there's definitely opportunities for both nurses in each setting. But I think there are more advantages in a community-based setting because of the relationship building, the trust and knowledge of resources". Joe also shared a similar perspective and speaks about the context of care:

> I think in the community setting we have a lot more flexibility to take our time with people, to focus on what their goals are rather than the emergent needs of the emergency at hand, which helps build trust. And, again, if you're in the community it's often on people's own terms because they want to seek out care and not necessarily because they have to. So I think that that sets the context a lot differently for the way that that interaction goes with the client.

Kitty also shared her experience:

> So I've had hospital experience in the past. You don't get to get into the crux of someone's history and their life story in the hospital. You're just treating the failed organ or system and once they recoup they're out. And in an eight-hour shift you can't really connect with people. So once I moved into the community setting, that's when I was able to form relationships with people.

Almost half of participants (n=6) also described how working with experts in their field is a facilitator as they are able to consult and learn from these individuals in clinical practice. For example, Michael discussed working with a psychiatrist:

> I would say luckily, we have the opportunity to have a psychiatrist who works with us full-time who has specialisation in addiction medicine. So just having expertise around really helps, especially as our team environment, and our culture and being aware.

A number of participants (n=5) shared that a supportive workplace facilitated their roles. This includes having a supportive team and supportive managers where everyone is on the same page regarding services being delivered and approaches being used. Participants shared that working in an environment where harm reduction work is supported is a big facilitator. Kitty shared:

> …[J]ust having the safe[environment] – or like the harm reduction supplies onsite, easy to grab, that piece is great. And all of my coworkers are on board for handing those supplies out. So that's great. It's not like I'm a one-person show. Everybody where I work is on board with handing those supplies out….

Some participants (n=3) shared that working alongside people with lived experience of drug use is very beneficial and helps to inform services for PWUD. Joe shares: "[A]ll of our work is being peer-informed. They're involved directly in the interventions that we're implementing… and collecting feedback from the broader community about what we're doing and if it's working". Two (2) participants described the enabling role of community partnerships. For those distributing harm reduction supplies, informal distribution networks are created through partnerships with non-profit community organizations. Bain shared:

> … we have a lot of places around the city, and we have lots of partners. Even … at night – if people use, there are some places that they can go to and get clean needles. And … I think that's helpful. Probably the outbreak of syphilis – we would probably have an HIV outbreak as well, if there was not enough needle supply to the people who are using. … I think the partnership with different organizations and … getting that help of distributing the harm reduction supplies, was a good one.

Community partners are also not restricted in what they can do in the community. Joe shared:

> Working with other community partners that are not necessarily tied to the region, that are more independent places, allows us to, again, be more creative with working collaboratively to say, 'Let's try this,' and we're not tied up by the bureaucracy, having to throw it up the chain and wait for a response to come back from somebody who has no idea what we're doing.

In addition, partnerships between community organizations led to training opportunities for a couple participants (n=2). Network meetings is another facilitator expressed by one participant that leads to improved understanding of current services in the community. Michele shared:

> I very, very much value network meetings. [I]n our community we've got three or four different network meetings that we're a part of and then we have community – they're not called community navigators but that's basically what they do. They're folks within our communities that their job is to make sure that everyone knows what everyone else is doing.

A few participants (n=3) explained their use of a recovery-oriented approach which involves working on clients' goals which goes beyond just addressing immediate health concerns. For example, they work with clients to meet personal goals such as finding gainful employment which

is an important part of their recovery. Furthermore, a small number of participants (n=2) described the benefit of CODI (co-occurring disorders) services. Michael explained:

> I would say, maybe two-thirds of the individuals that we work with will have a history of co-occurring use of substance use along with their severe mental illness. So I think we always take a co-occurring disorder, a CODI approach in our work. … I think that always just goes hand-in-hand with using a recovery-oriented approach and working on what their goals are.

Organizational Barriers of CHNs' Roles.

In terms of organizational barriers, many participants (n=8) complained that services within the healthcare system were uncoordinated and fragmented. A couple participants shared that having multiple players involved within the private and public sectors has become a major barrier to client care. Dina shared her perspective: "I think it's a mixed bag and I think it's inconsistent and I think there's no communication across any sector". She further explained:

> Everybody kind of makes assumptions on what happens and that communication within these entities is seamless and it's not. So there's a lot of … cooks in the kitchen and none of them are talking.

Another participant, Bain, also shared: "Things are not linked together. …[T]here's disconnect between one service provider and the other; [it] needs some grassroot level movement, galvanize and this needs to change". Likewise, Hank shared:

> And when you collectively look at everything, it's actually quite interesting the number of agencies that are connected in and there's some overlap and some similarity. And sometimes I think that you could probably accomplish more if all of the players were at the same table at times. Instead of each individual organization doing their own thing and

> figuring, “OK, this isn’t working.” Whereas someone may have already figured out, “OK, this approach doesn’t work.” And it’s just that shared learning, that piece that I think could be tightened up within the different health agencies and like community centers, the harm-reduction network.

Other participants (n=3) also described the lack of a standardized approach when caring for PWUD and that poor communication between sites leads to disconnection and poor continuity of care. Claire shared:

> The barriers, I think right now, although we have the education piece, I think it’s just now implementing it in our clinic a bit stronger. Having guidelines that everyone’s using. It’s not standardized in our clinic just yet… I definitely feel like there’s room for the City to amalgamate all of our different services in one electronic records to provide like better care. It’s chaos.

Further communication barriers were identified. Michele explained:

> So communication just with the WRHA is sometimes very fragmented in the community. For example, like, WRHA home care nursing, they don't … chart electronically at all. Everything is paper-based. So if I want to find out what a nurse is doing for a client of mine, I have to figure out who that nurse is and how to get a hold of them. And that becomes very complicated.

The consensus appears to be that the multiplicity of sectors and players involved makes things more complicated for participants working within the system, especially given its lack of resources as described by participants. To improve the healthcare system’s efficiency, some participants (n=5) stated that services should be better coordinated and big players should be better connected and working together. Claire shared: “There’s not enough beds to support these

people and the wait times can be quite long. Even for just counselling services in addictions, it's just because it's just so high..." Other participants also indicated:

> …if you want to get somebody in an inpatient treatment, the wait time is very long. So it's nothing that can happen right away, like it should be. If you're in medical distress you can go to the hospital and you can get admitted right away. But if you're having a mental health crisis or addictions, unless you're overdosing [Ian]
>
> With limited response to addictions and treatment centres, long wait times, that by the time people are actually ready for bed or ready for change, they can't get a bed for weeks or sometimes months thereafter and, by that time, their opportunity is missed [Joe].
>
> … I've got folks that want to quit, and the system is not ready for them when they're ready. And then by the time the system is ready they've relapsed or they've become incarcerated or they've changed their mind and they're just not interested anymore. So I think that timely access to care and supports is – still remains a huge gap [Michele].

And Ian also identified that long-term support for mental health is limited:

> …I think it comes down to having this kind of a long-term follow-up for these people, like with a mental health system that follows people long-term. Because often, like in the public system, you get a short spurt on mental health and it kind of gets you over whatever hump, and then that's it, and then you're done".

The majority of CHNs (n=11) expressed that there should be an increase in the availability of health and social services such as harm reduction services, long term treatment services and trauma and mental health services. Joe pointed out the need for trauma resources in Winnipeg:

> But I think ultimately we cannot address the root cause of substance use, that people, when they are running, when they are running away, when they are self-soothing, when it

> comes to the point where it's not just recreationally fun anymore or they're not experiencing pleasure from it and there's harms that they identify that they are not wanting or willing to sustain but cannot help themselves, I think we need to work to reconcile why this is. And at the root of that, at least from my experience, and from my research, much of that has to do with trauma, and we don't have – we have very limited trauma resources in Winnipeg.

Participants (n=5) also noted a number of organizational barriers related to working in a hierarchical healthcare system in which rules and policies must be followed. They found that when caring for PWUD, organizational rigidity poses a barrier as it leads to role constraint and limits their ability to perform innovative or outside the box activities. Lucy shared: "I feel like there's so many like rules and policies. When you work for a health region then it feels really hard to have any kind of freedom to do anything kind of outside of the box". Another participant, Michele, also shared her thoughts on the matter:

> … I know I'm under the WRHA umbrella so there are certain things that I am just not able to do. …[S]ometimes … I need to reach out to some of these smaller organization and go, "Listen, I know this is what this person needs, but … it's not in our scope. So is there anything you can do?"

Likewise, Kitty noted: "[In] the community setting the barriers are management and their insane fear of liability issues. They will never agree – or it'll take them an insane amount of time to agree". Alice also notes that the healthcare system is very slow to change:

> The health system also is so large and bureaucratic, it's slow to adapt to the clients' changing needs. The system is sustainable; it's going to be there year after year after year, but it's very slow to change. And so you have to have … meeting after meeting, and

> you have to have conversation after conversation, because they want to do it well. They want to do it right, you're working with taxpayers' money. It's a big bureaucratic institution so it's pretty slow. Whereas drug trends change fast, super fast.

Tim noted that securing funding is also dependent on quantitative statistics which does not adequately portray services that are being delivered:

> …unfortunately they look at quantitative data more than qualitative so they just want to know like how many people you're seeing, but they don't understand that like I can be with a person in our walk-in clinic and they can take hours.

Some participants shared that being nurse-centric or always wanting "to fix" is a barrier to providing care to PWUD. Lucy remarked:

> And it's hard because I also feel like in nursing we're always trying to do stuff for people and so you want to … have something to offer, be doing something for someone. So it's also hard … not be doing that all the time.

Michele also made a comment which relates to this fixing instinct:

> "So I've had to kind of, you know, my instinct is, let's just jump in and do everything because that's just … what nurses do".

Another significant organizational barrier described by two participants (n=2) was that the health care system itself is lacking adequate representation of BIPOC, leading in some cases to culturally inappropriate care. Lucy shared:

> …A lot of it to me is just trying to keep things open and because we are the healthcare system. … I am white and when I call people they're like "Oh your worker's calling" and it's like OK obviously I have a very stereotypical voice and that's … not going to be great for everybody".

Lastly, some participants (n=5) stressed the importance of education and training for healthcare professionals. At this time, participants feel that there is a significant lack of understanding caring for PWUD. Hank shared: "…[W]ithin the healthcare community, I think there's a significant lack of understanding around addictions and how to support people who suffer with addictions". In addition, nursing students entering the field are not always adequately educated and trained to care for PWUD.

> I think in nursing school it's important to really go over the principles of harm reduction and why it's important and having more in-depth education regarding substance use and trauma-informed care rather than glossing over that and briefly touching on that. I think it does need to be more intensive. There obviously is this major crisis, it's not going away, and it affects all areas of nursing. So I think that's where – nursing education is sort of doing a poor job in that regard and they could step up [Joe].
>
> …having everyone trained in that field is essential in providing quality care. Especially when it comes to addictions because it's not like "OK, here's Suboxone." There's so many layers that need to be addressed [Claire].
>
> I think my vision would be doing more … community education towards just different nurses, doctors, community organizations, specifically probably around harm-reduction, voicing more of the de-stigmatization, and also having … more community support, and … help them with community availability [Mia].

In addition, Tim identified that support and training for primary care providers is lacking for opioid replacement therapy:

> …when people are put on medications like suboxone there's … only … a handful of providers that actually feel comfortable or that are trained in prescribing suboxone and we don't really have a lot of programs right now that are accepting patients.

Impact of the COVID-19 Pandemic on CHNs' Roles.

Participants were asked about the impact of the COVID-19 pandemic on their roles in addressing drug-related harms. According to them, the COVID-19 pandemic had a significant impact on health and social services. Participants (n=8) described that several of their roles were adapted during the COVID-19 pandemic to comply with public health orders such. This compliance led to a service reduction for many community health offices and other community resources thereby limiting their accessibility. Participants (n=4) indicated that, while many health and social services became accessible by phone or virtually, many PWUD did not have phones or access to the Internet, thus causing disruptions in care. Mia explained:

> COVID-19 has impacted our roles: we're not meeting as much in person, we're doing a lot on the phone, for example, because we see clients here. Some clients don't have access to a phone, so it's difficult … for communication. There is more crisis going so we're dealing a lot more with that. Many of the programs aren't running or available during this time, so it's causing more distress for the clients.

The number of beds for addictions treatment services also decreased and a negative COVID-19 swab was required prior to accessing them, a change that two participants (n=2) explained made treatment even less accessible. In addition, a few participants (n=3) identified that fear of COVID-19 prevented people from accessing services. Claire shared:

> [A] lot of people are scared to come to the clinic right now if they're feeling fine. And there's some people … who have members of their family or they have

> friends who have gone to a clinic or a hospital for like an overdose or for substance use and never left because they died. And so they just don't even want to come in….

Most participants (n=9) also said that they witnessed an increase in drug use and drug-related harms over the course of the COVID-19 pandemic for several reasons. Participants described how drug trends changed due to border closures and resultant supply interruptions. Many people changed their drug of choice to "down" (a street opioid generally thought to be a mix of heroin and fentanyl) due to the increased cost of methamphetamine. This resulted in more opioid poisonings and deaths along with increased naloxone distribution and Suboxone inductions. Alice explained:

> At the beginning of COVID there was hardly any crystal meth [and] it became very expensive. People switched over to crack much more, and down, because now down and fentanyl – or meth at the time were the same price. So now you've got a lot of people switching to down and they're overdosing. And it's also because it's so concentrated and potent. So now we're like giving out much more Narcan. We're doing much more Narcan training.

Some (n=3) also shared that they believed sexually transmitted and bloodborne infections (STBBIs) have probably increased and that testing for them has probably decreased due to the reduced access to health services during the pandemic. In addition to changing drug trends, participants (n=8) shared that the COVID-19 pandemic resulted in worsened mental health, job loss, broken relationships and crises which contributed to relapses and increased drug use of their clients. Tim explained:

> [H]uman beings are very social beings and what COVID has done is it's isolated a lot of people which then has led them to…. I mean people have lost their jobs, they've lost loved ones. There's been a lot of fear, anxiety around it and so then that has had a trickle effect of then people substance use either starting or it's been increasing. And then what happens is then as that increases starts leading to all those other drug-related harms. … people have struggled mentally, and often in crisis, and we've seen people having overdosed, and accessing emergency services more frequently [Michael].

Moral Distress and Frustrations Experienced by CHNs.

Participants expressed frustration with what they perceived as failures at the levels of both the health care system and government in addressing drug-related harms. Moral distress is generally recognized as individual distress arising from knowing the morally right thing to do but failing to perform that action due to various constraints (Campbell, Ulrich, & Grady, 2018). This is consistent with the distress described by some participants. Several participants pointed out that, while for PWUD, the healthcare and provincial government responses have been poor overall, the onset of COVID-19 garnered a prompt response at all levels. Lucy expressed that she did not think that the current conservative government cares about drug-related harms or the people experiencing them:

> I think that there's some people that are doing really good work, that are really selfless and kind of go above and beyond., but ... our government, I really don't think they care.

Participants noted that while other provinces have implemented a number of services such as safe supervised consumptions sites, the provincial government in Manitoba has refused to support some types of harm reduction initiatives. Joe shared his perspective on the matter:

> I think our response is poor. I think our response is critically behind the masses of new ways of dealing with addiction; …other provinces and other countries are far ahead of Winnipeg and Manitoba in dealing with substances in that regard.

Many participants (n=9) said that the lack of a supervised consumption site in Manitoba is problematic and contributing to the ongoing death toll from drug poisonings. Several participants (n=5) felt that government resistance was one of the biggest barriers to addressing drug-related harms. They recalled that the implementation of evidence-informed harm reduction measures has repeatedly been rejected by the provincial government while other provinces continue to be more progressive. Several participants commented:

> [T]the provincial government also doesn't allow for supervised consumption sites, so that is very inhibitive. If we had one of those and people could come and we could have these conversations, and we could make it an awesome space where people like would want to actually engage and build trust, and then you could have that one-stop shop. [Alice]
>
> The fact that we don't have … safe consumption sites, I think that would be huge for the government to support. I mean, it works and officially in other provinces so I don't see why we're not going there. [Claire]
>
> … the Conservative government has below zero interest in assisting with that despite the body count during the pandemic when the crystal meth supply went so low that the price of just a small amount was a hundred dollars. It was completely out of touch for what people who are typically addicted to crystal meth could afford, so they switched to using down, or a fentanyl-based product and that's when all the overdose deaths started in Winnipeg. [Kitty]

> I don’t really think there’s much response… We don’t have a safe supply centre. There’s a lot of focus on abstinence. The government isn’t doing too much on our end… and the [Addictions Foundation of Manitoba] didn’t get any funding [Mia].

In addition, Michele shared the following in regard to safe supply:

> I don't believe that our current leadership is at all open to exploring safe supply of drugs. … I'm speaking more provincial than federal. But that is … a non-starter. …we can't even get safe consumption sites, never mind a safe supply. And it goes against all of the best practices and research and evidence that we have out there. So it is very much stigma-based.

It is this ongoing resistance by the provincial government to implement evidence-driven interventions that has caused frustration among participants. In addition, participants expressed concern with the continued unmet needs of Manitobans. One participant expressed her feelings of distress with the lack of proper housing:

> Even if you get into housing here, a lot of the housing is really awful and then … what do you do and what’s the answer and how do you start? And then I just get overwhelmed; it’s like an existential crisis … but I’m safe in my house so … it shouldn’t be so stressful on me because that’s the thing: their life is stressful, my life is not stressful [Lucy].

Another participants shared how unmet basic needs of his clients impacted his role:

> Things like lack of affordable housing and Housing First initiatives are really important. And, again, that’s a barrier. I can do as much treatment and as much rapport-building and as much facilitating with getting people connected to services, but if they don’t have the basics like [in] Maslow’s Hierarchy of Needs, and… some food, I’m not going to be very

> successful with sustaining any of those interventions along with the client and working with them [Joe].

Participants articulated that something needed to be done but felt unable to create this change themselves:

> I don't think it's OK. People are feeling pain. People are suffering. And … Canada has resources to change this, … and we can get the means. I don't have a clear cut, 'We can do this and that,' but it could be done – [through] focus[ed] work on it – passionate approach from all angles and people – and the situation can change is what I see [Bain].
>
> …[Y]ou would need … so many things. Like how do you give someone meaning, purpose, belonging and hope? Like how do you? It's a wicked problem.
>
> …[T]here's just no easy answer here [Alice].

Participants articulated an urgent need to prioritize drug-related harms. They described how such a shift in priorities would necessitate a change in Manitoba's current government from conservative to one that is more progressive and forward thinking. At the healthcare level, many participants (n=9) expressed the view that the healthcare response was inadequate to address drug-related harms. Some felt that the demand for services was exceeding the system's capacity. Overall, participants described a lack of timely services for mental health and addictions treatment and not enough harm reductions services. Ian stated:

> … I personally think that the government/healthcare response [is] … pretty slow, and not quite far reaching enough. … it tends to be more of … a Band-Aid solution, quick fixes. But there's not really any … government supported long-term treatment that covers that whole kind of mental health part. [Ian]

> … although there's a lot of talk about mental health and addictions being thrown a lot of money, what they don't realize is that we're so far behind that that's just …a tiny drop in the bucket". [Joe]

A few participants (n=3) shared further that they are feeling the pressure as demands are exceeding the healthcare system's capacity to adequately respond to the needs of people seeking treatment. Bain states that he believes the healthcare system is "stretched beyond the limit right now". Michele had similar thoughts:

> We don't have enough supports when it comes to mental health and addictions. The community supports are… as great as they are, they are also at capacity, over capacity, particularly with the current pandemic.

Notably, the COVID-19 response has taken priority over everything else, but to participants it revealed the lack of government and health care system response to the "drug problem." One participant added that the COVID-19 pandemic response widened already existing gaps in services in our healthcare system. Michele stated:

> …those gaps have just widened into chasms. …I mean, these gaps existed before. The wait list for addiction treatment is not new. For supports for mental health, it's not new. But they've just become bigger.

Participants (n=4) said they felt that the rapid and comprehensive response the pandemic contrasted starkly to the lack of support for other societal issues, like homelessness and drug-related deaths. Hank expressed his frustration:

> I think that some of that has come to light, like even with COVID being on the forefront now. Because it seems like there is endless dollars that is going – thrown into COVID when the reality is, there's more people dying every day from an opioid overdose than

> there are COVID. So, and it just seems like the drug issue is just kind of being brushed under the rug because no one wants to deal with it because they're – no one has a solid plan but there's endless supply. So that from someone who's working in that field, that's probably one of the, I'll say the little frustrations. And I'm not downplaying the seriousness of COVID or anything.

Similarly, Lucy shares her thoughts regarding COVID-19 isolation housing: "…if we can use hotels to put people in to isolate for COVID, can we not use those spaces to house [homeless] people and help them? I don't know. It just feels so complicated". Joe stated:

> I think that there's a lot of money wasted within the system. I even think when you want to talk about COVID…and how this has affected things, the government has spent exorbitant amounts of money on having these isolation shelters, which are much needed. However, I've worked at some of the isolation shelters and they had a staff ratio of people being pulled from all over the system of probably 50 staff, to sometimes as little as three patients, because they staff them regardless of how many are in isolation in case – in case they need isolation. But that's a lot of money wasted that could be put towards actually sustainable housing where people get to isolate independently in their own suite.

Bain also expressed the need to focus on drug-related issues:

> How we are doing the COVID-19? Everyone is focusing, talking about it, we're getting regular updates and so forth. Because everyone – all of us are affected by it. But this drug use, mental health issues, all kinds of diseases related to drug use and the trauma, this issue was going on for generations and [is] still there and once the COVID is over, it will continue. I think it needs, on its own, a serious focus – a serious funding, a serious approach….

Participants who are passionate about addressing the "drug problem" are frustrated at their inability to create change and are calling for action. In addition, participants explained that CHNs would need to be provided with the tools and resources to be more effectual in their roles, rather than being limited by the present system.

Evolution of CHNs' Perspectives with Time and Experience

Participants described diverse experiences and environments that played a part in influencing their views over time regarding drugs and people who use them. They were asked about their perspectives before entering the realm of nursing and their thoughts on their nursing education and its impact on their views.

Perspectives on Drugs Before Nursing.

Participants described their perspectives on drugs and drug use prior to their nursing education. While some participants began their nursing education soon after high school, others started later in life. Many participants (n=9) expressed having limited knowledge of drug use before nursing school. They shared:

> …I … was very influenced by… colonial [views]…like being white … growing up in Winnipeg. … I would be a lot more judgy of [people who use drugs] because if that was how I was raised … like if people are Indigenous and on the streets of Winnipeg well obviously they have substance use issues and obviously it's their choice. That's what the mindset was that I think I totally grew up with and I think that has totally shifted as I've grown older and become more aware of things [Lucy].
>
> … I didn't really understand … the context of why people are using, I didn't really understand … somebody that comes through the door, this is somebody that's 30 years old that has experienced 30 years of trauma and pain, emotional pain and you know,

> physical abuse, sexual abuse, emotional abuse, things like that. And so I never really had that full understanding of that before coming to this field [Tim].

Participants described how family and upbringing, including the area where one was raised and religious beliefs influenced their views and attitudes. For example, Michael shared:

> …I would say my perspective on drugs before starting my nursing career. I think I took a very conservative perspective just having grown up in a conservative background. I was raised in a conservative environment, so I would say my opinion and my thoughts on drugs were very almost anti-drugs and … against people who were using illicit substances… definitely a lot of stigma attached towards substances…before I started my nursing career.

Other participants (n=3) shared that they were quite open-minded and non-judgmental regarding drug use prior to their nursing career. For some, it was a normal part of the culture growing up and not uncommon for the people around them to be experimenting with drugs. Joe shared:

> … I was quite young when I started my nursing career. So I think that I was quite open to drug use. Just from being a young adult and experimentation, recognizing that that was a normal part of the culture of my friends and I growing up.

However, certain drugs appeared to be more acceptable to some participants than others, such as cannabis and magic mushrooms. For example, Lucy shared:

> I feel like I drew a line at things that had to be chemically … created, whether that was like crack or like prescription drugs that were just being used in … a recreational way…. I guess [that] always was kind of a line in my mind. It was like if you're smoking pot or you're doing mushrooms or maybe even like acid like whatever, you're fine.

Similarly, Ian reflected on how he viewed drugs in the past:

> … growing up, … when you would think of the drugs, you wouldn't think of marijuana in there. That was not really like a drug, you know? It was kind of anything else other than that".

Many participants (n=8) described past assumptions they had when it came to drug use and PWUD. Some participants made reference to the individualistic willpower-based view on drugs discussed earlier. For example, Dina shared that she thought that "somebody could just choose to stop [and that] people started based on choice, not based on circumstance."

Similarly, Michele shared:

> I had some experience with addiction but not a very clear understanding of it with my dad and his smoking. And really kind of my family's poor understanding of what it actually takes to quit an addiction. So I witnessed the struggles that he went through trying to quit over and over and over again. But it didn't resonate for me as anything other than you know, he didn't really want to, or you know, he didn't have the willpower. And that was more messaging that I'd gotten from my family because of their poor understanding of addiction and addiction issues.

Ian shared another assumption relating to who is engaging in drug use:

> Prior to starting my nursing career, I guess my thought towards drugs was [that] it's more of a problem really only for … a certain group of people, but it wasn't widespread. …[w]hen you think of like the downtown core and that's kind of where drug problems were. … I grew up outside of the city in a small community, so it wasn't really evident in my daily life. So I kind of grew up thinking that it wasn't a problem that affected that many people and it's really only like a certain type of person.

Some participants (n=4) explained that the messaging they received in middle school or high school was often anti-drug, summarized by the phrase, “just say no”. This influenced their views along with similar mindsets represented in the media at the time. Mia stated:

> So in high school I guess there was just a consistent message: Drugs are bad. There was no further kind of development on harm reduction, or more information about that. There was no resource discussion. So I would say it was quite a limited understanding of drugs and the effects of drugs.

Nursing education is described further below.

Influence of Nursing Education on Perspectives.

Nursing education appeared to have little influence on participants’ current views regarding drug use. A few participants (n=3) explained that it is their experience in the field that shaped their views, rather than their nursing education. A couple of participants (n=2) explained that drug use was a topic discussed in little detail as part of their mental health course, while two others (n=2) described having a full course on addictions. Practicum experiences with PWUD were also limited. Claire shared her thoughts:

> But even with that you weren’t exposed to it as much too because even in your nursing school we would spend like our community rotation – or the program anyways, is only a term and being a community nurse, it does not even touch like the tip of the iceberg. It’s such a small aspect of it.

Participants who graduated from psychiatric nursing programs shared slightly different experiences when it came to their schooling. Tim explained:

> I’m a registered psychiatric nurse so I did my bachelors in psychiatric nursing. So you take one addictions course and you don’t have a lot of exposure to it unless you do it

> clinically in addictions and based off of our schooling we don't really have that as an option unless you choose that as your senior practicum. So even in school … they kind of touch on all the different substances, but you don't really get a full exposure experience with it. So it wasn't probably until actually I went into the field that I had a better understanding on substance use.

Participants indicated that rather than nursing school impacting their perspectives, their views were shaped by their work experience, work-related education, co-workers, books, statistics, research, conferences and lived experience with drug use or family members. Below are a few examples of such experiences:

> Not so much the education part. I don't recall there being much discussion about it, … in my schooling and stuff. It was more once I started working then you kind of got to see more of the actual effect and how widespread that it actually is [Ian].
>
> … I gained most of my experience just working in community health as opposed to [in] my education. So I think education-wise just for all healthcare providers there should be more standardisation for an awareness of … drugs [and the] crises that are going on, and … how we respond as healthcare providers, and working with individuals who use substances, and different ways we can engage in a therapeutic manner [Michael].
>
> And even to this day I'm still learning. It doesn't matter how many courses I take, it's like until you are out in these certain scenarios you don't really know. So at [healthcare organization], that's when I realized that it was multifactorial. So it was not just the addiction piece, there was trauma, abuse, there was housing issues [and] social issues. ..[A]ll of the different social determinants of health were at play and addiction was just a piece of that puzzle [Claire]

> I don't actually think nursing school had an influence on my views. I think I felt conflicted with a lot of views that nursing school had initially sort of talked about. Like, when we're talking to patients… quitting smoking is at the forefront of course is negative, but it was never a discussion about what does smoking do for you [Joe].

This suggests that the focus in his nursing school remained on changing the "unhealthy behaviour" in line with a Western-based biomedical perspective. Nonetheless, participants insinuated that the nursing profession is driven by values that include advocating for human rights and addressing injustices experienced by clients that are served. Two participants (n=2) mentioned that nurses have an obligation to address issues within society such as drug-related harms. They stated:

> I consider that as part of my responsibility as a nurse. And that has been, I think, from the word go… in nursing education, we're taught that it is part of our responsibility to advocate for our patients… in whatever capacity we're in [Michele].
>
> …I'm excited that more people, specifically within the discipline of nursing, are talking about these issues…as a profession and as a discipline, we have an obligation and we have a duty to be focusing more attention on this area and figuring out how do we work collaboratively to make a change [Joe].

When sharing their personal vision regarding their roles in addressing drug-related harms, a number of participants (n=6) mentioned advocacy. For example:

> I could also see myself being part of an advocacy group that addresses the provincial government to be more progressive, get with the times and have a more dignified humanitarian approach to substance use that incorporates harm reduction principals [Alice]

> [We must] advocate for our clients, so they can get clean supplies. And also … keep asking the government or legislators or policymakers, to come up with an overall plan to help this segment of our population, in addressing the drug harms issue seriously, as opposed to just some talking point, but in a fundamental way [Bain]

In other words, there is a strong drive among several of the interviewed participants to address societal issues at hand.

Chapter Five: Discussion

In this chapter, significant findings are discussed further in relation to the literature, followed by recommendations for practice, education, administration, and future research. It is important to note that drug use is a global phenomenon, influenced by various human practices and cultures. Drugs have been used by humans for centuries and will continue to be used. Importantly, most drug use is not considered problematic. The focus of this study was on addressing drug-related harms, rather than preventing drug use. Some of these harms are direct, such as drug poisonings and death, while others are indirect and often occurring as a result of society's response to the "drug problem". CHNs are well-positioned to address these harms in their practice. Given the rise in drug-related harms and its inequitable impacts in Manitoba, especially over the course of the COVID-19 pandemic, an improved response that does not cause further harm is crucial. Lastly, study limitations are reviewed and concluding remarks are made.

Participants described the "drug problem" in Winnipeg as a social problem rather than an individual issue. They spoke of drug-related harms in the context of social determinants of health and discussed the need to address "root causes" of drug-related harms. Similarly, other researchers have also described the "root causes" of drug-related harms as stemming from underlying issues and inequities (CPHA, 2014; CCPAM, 2019; Tootle et al., 2015; Pauly et al., 2015; Pauly, 2008a, 2008b). Participants identified a number of these issues and inequities. For example, poverty and homelessness were identified as key issues warranting upstream solutions, a notion also supported by Falk-Rafael & Betker (2012) & Pauly (2008a, 2008b). Mental health problems were also noted as significant contributors to problematic drug use with many participants concerned with the lack of services and resources for mental health. Pauly et al., 2015 and Krausz et al., (2021) have also made this connection previously. Simon et al. (2021)

also found comorbidities linked with opioid use disorder such as chronic pain and mental health issues.

Notably, trauma was described by the majority as a "root cause" of problematic drug use, including intergenerational trauma experienced by Indigenous peoples from the effects of colonialism. The role of trauma in problematic substance is well supported in the literature (CDPC, 2012; Chandler et al., 2018; Health Canada, 2018; Herron & Venner, 2022; PHAC, 2020; Renstrom, Ferri & Mandil, 2017; RNAO, 2017; Shier & Turpin, 2017). Krausz et al., (2021) and Shier & Turpin (2017) state that trauma and mental health issues often accompany problematic drug use and attention is needed to address both. While nurses' perceptions of the role of trauma on drug use has not been explored, the present study illuminates the connection between trauma and drug use and the lack of services to address trauma in Winnipeg. The impact of trauma is particularly disturbing in the case of Indigenous peoples, who suffer from problematic drug use and associated harms at a higher rate than non-Indigenous Canadians (CCPAM, 2019; ICAD & CAAN, 2019; Government of Canada, 2018; Health Canada, 2018; Nutton & Fast, 2015; Pride et al., 2021; Winters & Harris, 2019; WRHA, 2016). Indigenous peoples in Canada continue to experience health inequities due to legacies of colonialism, a fact well substantiated in the literature (Health Canada, 2018; ICAD & CAAN, 2019; Government of Canada, 2018; Hunt, 2015; WRHA, 2016; Winters & Harris, 2019). Importantly, equity-oriented approaches such as culturally-safe and trauma- and violence-informed approaches are strategies that are garnering attention in Canada (Pauly et al., 2015; Pride et al., 2021). For example, a recent study by Urbanoski et al. (2020) explored the views of PWUD, including Indigenous participants, regarding what culturally safe primary care looks like to them. Equity-oriented tools have also been developed for health care providers and organizations by EQUIP Health Care, a

research and implementation program based in Vancouver, BC (EQUIP Health Care, 2017). Indigenous approaches to harm reduction are also recommended as noted in a policy brief (2019) by the Interagency Coalition on AIDS and Development and the 15th annual State of the Inner City report (2019) by the Canadian Centre for Policy Alternatives Manitoba. In addition, studies have shown that treatment programs in First Nations communities are more effective when they are community driven and combined with traditional healing (Kanate et al., 2015; Mamakwa et al., 2017) For this reason, Indigenous-led services should be prioritized. That Indigenous Canadians are disproportionally affected by problematic drug use, and stemming back to colonialism and other traumas, is in itself a call to action.

Participants further described health inequities in a variety of ways, some suggesting that individuals experiencing them have often arrived in these situations or circumstances by no fault of their own. Essentially, they are describing the disproportion of harms experienced by those in society who are structurally disadvantaged, including those PWUD. Participants overwhelmingly indicated that drugs themselves are not the issue. As one participant explained, it is not a "meth crisis", it is a "housing crisis", it is a "legacy of colonialism crisis", it's a "mental health crisis". These are the crises they said need to be addressed. This is consistent with the messaging from CCPAM (2019), that the so-called drug "problem" is a symptom of deeper unaddressed societal issues. This finding is well supported in the literature. As noted by Falk-Rafael & Betker (2021), social injustices are so well embedded in society that they are practically hidden while they continue to be maintained through neoliberalism and individualism. In short, some people in society benefit from the current conditions and structures in place, while others remain disadvantaged by the same conditions. In their study, Falk-Rafael & Betker (2021) found that public health nurses in southern Ontario are witnessing these social injustices in their practice

and are compelled to address them. Similarly, McMenemy et al. (2021) found that street nurses in Ottawa were concerned about the social inequities experienced by their clients, such as lack of housing and mental health services.

Participants described how people experiencing drug-related harms are blamed for their drug use behaviour which is sometimes viewed as a moral issue. This victim-blaming ideology is a systemic barrier to care. Marshall (2018) describes this view is causing significant harm to PWUD. It perpetuates drug use stigma and defaults to "just say no" and abstinence-based approaches which have been proven ineffective and even harmful for many PWUD, particularly those who are structurally disadvantaged (CCPAM, 2019; Stancliff et al., 2015). Moreover, within this individualistic "pull yourself up by your bootstraps" framework, underlying social issues and inequities tend to be ignored while interventions to address drug-related harms continue to focus on individual behaviour, with limited success (CCPAM, 2019; Tootle et al., 2015). This focus on individualistic interventions has also been described as a consequence of the disease model perspective of addiction, rooted in biomedicine (Tootle et al., 2015). Pauly (2008a) stresses the need to shift the focus from individuals and towards changing social structures and policies that influence harm, especially those underpinned by neoliberal values. Tootle et al. (2015) also recommend prioritizing structural interventions over individualistic ones, favouring social medicine over biomedicine.

Drug use stigma was identified by the majority of participants as a key issue contributing to drug-related harms experienced by PWUD. Importantly, drug use stigma is reinforced by societal norms, organizational policies (PHAC, 2020, Pauly et al., 2015) and repressive drug laws (CDPC, 2012). The role of stigma and discrimination in contributing to significant harms experienced by PWUD is well established (Iammarino & Pauly, 2021; PHAC, 2020; Pauly et al.,

2015; Winters & Harris, 2019). Due to stigma, PWUD may receive inadequate care in the healthcare setting. Ivsins & Yake (2018) found that PWUD may receive inadequate pain management due to drug use stigma in the healthcare setting. In particular, nurses may hold negative attitudes when caring for PWUD, with the effect of reducing the quality of care being provided (Pauly et al., 2007). Notably, some participants shared that they either witnessed or heard about the negative effects of drug use stigma in their practice. Some explained that this issue is more significant in the hospital-based setting than in community settings, although there is no evidence to support this claim. They articulated that nurses working in acute care settings tend to focus on the presenting issue at hand and may not have the time or resources to use a compassionate approach when caring for PWUD. Conversely, they said the community health setting is conducive to a more non-judgmental and caring environment which was identified as a facilitator to addressing drug-related harms by participants in this study. Client-centred, non-judgmental and culturally safe approaches are used by nurses at Insite, a supervised consumption facility in Vancouver that has had a number of positive outcomes since it opened (Lightfoot et al., 2009). Nurses build trusting and therapeutic alliances with clients, while providing primary nursing care that is guided by a harm reduction philosophy. Conversely, studies indicate that stigma is a key barrier for PWUD in accessing health care services (Iammarino & Pauly, 2021; Pauly, 2008a, 2008b; Urbanoski et al., 2020; Winters & Harris, 2019). Because drug use stigma can be reflected within workplace cultures, the practice setting appears to be an important site of change. A number of participants shared addressing drug use stigma as part of their visions for a more inclusive health care system. Efforts to reduce drug use stigma within the Canadian healthcare system are warranted (PHAC, 2020; Winters & Harris, 2020). Iammarino & Pauly

(2021) also highlight the need for destigmatizing care in nursing practice with harm reduction as a guiding philosophy.

Criminalization was identified by participants as an approach that is harming PWUD. For example, someone in possession of illegal drugs might be charged with a criminal offense, which can have devastating consequences such as facing a criminal conviction (CCSUA, 2018; Vearrier, 2010) and also losing employment and income (CDPC, 2012; WRHA, 2016). Furthermore, there is an increased risk of contracting blood-borne infections in correctional facilities due to needle sharing (Bonnycastle, 2011; CDPC, 2012; CPHA, 2014; CNA, 2017b; Stone et al., 2018), and an increased risk of drug poisoning after release (Kleinman & Morris, 2021). Criminalization of personal drug use also results in unsafe use, the spread of STBBIs, and further harms such as infections (CCSUA, 2018; CDPC, 2012; CPHA, 2014). Interestingly, in March 2022, the City of Winnipeg had the opportunity to decriminalize possession of small amounts of drugs for personal use and city council voted against it (Pursaga, 2022). Another consequence of criminalization is its association with organized crime and its role in an unsafe supply of drugs (CDPC, 2012). A prohibitionist approach to substance use has not worked in decreasing drug use and its harms (CPHA, 2014; CDPC, 2012). As a result, some countries have recognized the failure of a criminalizing approach to substance use and have implemented different strategies to reduce drug-related harms (CPHA, 2014; Krausz et al., 2021). Many public health leaders agree that decriminalization is a key public health approach to address drug-related harms (CCSUA, 2018). Canadian organizations at the epicentre of the overdose crisis, such as the Vancouver Area Network of Drugs users (VANDU), have been advocating for decriminalization for many years, and even more urgently now during the COVID-19 pandemic (Office of the Provincial Health Officer, n.d.; VANDU et al., 2021). However, tension exists

between those who favour a criminal justice approach and those who espouse a public health approach to problematic drug use and drug-related harms. As well, there are ongoing debates among politicians in Canada. Notably, here in Manitoba, the provincial government has repeatedly refused, despite being presented with evidence and opportunities, to incorporate the full spectrum of harm reduction approaches for people experiencing problematic substance use, resulting in Manitoba being the only province west of the Maritimes that lacks a supervised consumption services despite rising rates of drug poisonings and deaths (Coubrough, 2021a; Coubrough, 2021b; Government of Canada, 2020b).

In Canada, biomedical-oriented healthcare services continue to be prioritized over services that aim to address social determinants of health and health inequities (Marcellus et al., 2022). Drug use prevention and abstinence treatment-based services for problematic drug use are often prioritized over harm reducing and equity-oriented approaches. Unfortunately, these approaches fail to address root causes of drug-related harms and their inequitable impacts. Notably, treatment-based services are deeply criticized for solely focusing on physiology and individual behaviour, ignoring the influence of social context (CCPAM, 2019; Goodyear, 2021; Jiao, 2019). In addition, the goal of drug use treatment is often sobriety which is not realistic or meaningful for many PWUD (CCPAM, 2019). Conversely, an approach of "meeting people where they're at" (Lightfoot et al., 2009; PHAC, 2020; RNAO, 2015; Sue, 2021) acknowledges that not everyone is ready or even wanting treatment and also acknowledges that there are also many perceived benefits to drug use and not all use should be considered problematic. In fact, a global study showed that only 11.6% of PWUD indicated that their drug use was problematic in 2016 (GCDP, 2017). A recent study by Ivsins & Yake (2020) found that there are many perceived benefits of drug use among marginalized PWUD, such as pain relief and easing mental

health issues. For these reasons, participants in the present study agreed with public health leaders who favour preventing drug-related harms, rather than requiring treatment. Unfortunately, the problematization of drug use as a black-and-white issue may be a symptom of the dominance of the biomedical perspective within the healthcare and research realm of Western countries.

The Western-based biomedical perspective is also strong within the nursing discipline; this perspective is described as the need to cure or "fix" people's problems (Lago et al., 2017; Morley et al., 2020; Pauly, 2008b). The challenge alluded to by study participants is that they were rooted in the biomedical perspective due to their training and acute care experiences, but they appreciated the value in a public health perspective. The reductionist biomedical model was viewed as failing to address root causes of problematic drug use, whereas a public health perspective was seen as a more nuanced approach to addressing root causes. Despite participants working in the community setting, which would seem to be a natural fit for a public health perspective, the biomedical perspective prevailed, in many workplaces. For instance, some participants expressed the view of addictions as a chronic disease, while simultaneously acknowledging the social roots of substance use disorders. Consequently, much of the care provided by CHNs also tends to be treatment focused, in line with biomedical framework. Nonetheless, participants clearly articulated the need to address root causes with "upstream" or system level solutions. It appears that they gained this perspective through their personal and work experiences with drugs and people who use them. That is, the majority said they gained a better understanding around drugs and drug-related harms when they started working in their fields. Their nursing education appeared to have little influence on their views. Similarly, Falk-Rafael & Betker (2012) found that public health nurses gained much more nuanced perspectives

with years working in the community while witnessing social injustices experienced by their clients. Workplace culture and support has also been identified as a formative factor on CHN's perspectives and roles when caring for PWUD (Ford et al., 2009; Marcellus et al., 2022; Pauly, 2008b). Likewise, participants in this study identified a supportive workplace with managers and team members all working to address drug-related harms. It is therefore important to have a shared mission, values and objectives among healthcare teams, as well as a government-supported mandate to work not just at the level of the individual, but at the system level as well.

Overall, participants felt that the government response to the harms associated with drug use was very poor and fragmented with healthcare services being stretched beyond their limits. This is consistent with reports indicating that services for mental health and addictions in Manitoba are fragmented and difficult to access in a timely manner (CCPAM, 2019; IDTF, 2017; VIRGO, 2018). Many also disapproved of the provincial government's inaction and resistance in the implementation of harm reduction approaches such as a supervised consumption service (CRISM, 2017). This resistance was also noted in CCPAM's (2019) State of the Inner City report and identified by its absence in the VIRGO report (VIRGO, 2018) and the newly released "Pathway" report from the Government of Manitoba (Manitoba Health, 2022). Instead of implementing evidence-informed strategies, the provincial government continues to rely on outdated approaches that have been proven ineffective. The lack of government response to the overdose crisis was also found to be concerning in light of the COVID-19 pandemic, which prompted a full-blown system response. Some scholars have also noted that the response to the COVID-19 pandemic has taken precedence over the "drug crisis". Thorne (2021) noted in a recent editorial:

> "Opioid use is a fact of life. It should not, however, be a death sentence. Lets collectively give some serious thought to what we have learned from mounting a massive strategic response to COVID-19 that might be fully applicable to this second pandemic".

Krausz et al. (2021) also expressed that a tremendous amount of funds have been allocated to the COVID-19 pandemic response when compared with the limited resources allocated to the overdose crisis. Arguably, the response to the COVID-19 pandemic has taken precedence because everyone is affected by it, but not everyone is equally affected when it comes to drug-related harms. Notably, certain groups of people, such as those who are structurally disadvantaged or oppressed, tend to experience drug-related harms disproportionately and more severely when compared to the rest of the population (CCPAM, 2019; CNA, 2017b; McNeil et al, 2016; Milaney et al., 2021). However, responses continue to focus more on individual drug use behaviour rather than addressing these inequities (CCPAM, 2019; Drucker et al., 2016). Ultimately, participants in this study are calling for an improved response to address drug-related harms. They stress the need for "upstream" or system level solutions combined with an increase in downstream services.

Participants noted that harm reduction, both as an ideology and a strategy, was lacking throughout the healthcare system. Harm reduction was unevenly understood across the healthcare system and was most often depicted as a type of technical intervention that aimed to change individual drug use behaviour (such as the distribution of naloxone and needles). In a broader view, harm reduction is conceptualized as a perspective acknowledging that drug-related harms are shaped by social context and therefore experienced differently and disproportionately by certain groups of people (Goodyear, 2021; WRHA, 2016). Thus, it is conveyed as an approach that aims to address health inequities. Despite this broader understanding, harm

reduction is critiqued in the literature for doing little to address the social determinants of health or root causes of drug-related harms (CNA, 2017a; Drucker et al., 2016; Iammarino & Pauly, 2020; ICAD & CAAN, 2019; Pauly, 2008a; Porter, 2020). Notably, conceptual tension exists between harm reduction as a technical solution versus a contextualized social practice (Denis-Lalonde, 2019; Goodyear, 2021; Jiao, 2019). Jiao (2019) explains that harm reduction as a technical approach rooted in biomedicine has measurable outcomes but ignores the social conditions that influence harms. On the other hand, harm reduction as a social approach aims to address these social conditions but is time-consuming and costly with unpredictable outcomes (Jiao, 2019). Arguably, harm reduction is conceptualized to fit the narrative of one's position or ideology. What remains important is that harm reduction, as a downstream measure, save lives and should be available across the healthcare system. However, more attention is needed to address the social conditions that influence drug-related harms.

In the present study, participants found themselves in an awkward position of, while providing primarily individual level care, knowing that the healthcare system is not only inadequate to address needs but that it's also an inherently limited system that struggles to support people with complex needs like drug use, or to make real changes to social root causes or problematic drug use. Consequently, many participants described feeling frustrated and some even powerless. They saw the need for upstream or system level solutions but lacked the means to carry out system level roles as they are placed within a healthcare system that provides mainly downstream or individual level services. Further, many of the systemic interventions required to address root causes of drug harms do not lay within the purview of the health sector. Other social institutions such as housing and shelter, child protection, income and employment, education,

criminal justice and drug policy can have a larger impact on living conditions than health sector interventions.

For some participants, the inability to respond to human need generated moral distress. According to Nathaniel (2003, 2006), moral distress is linked to nurses' beliefs about their professional responsibilities as nurses. Importantly, participants in this study expressed a strong moral responsibility to tackle issues relating to drug-related harms and its inequitable impacts. In Nathaniel's grounded theory of moral reckoning in nursing (2006), nurses may find themselves in a situational bind if these beliefs conflict with organizational norms. Emotional and behavioural reactions occur as a result of these situational binds until a stage of resolution is reached (Nathaniel, 2003, 2006). In this stage, nurses either choose to make a stand or give up (Nathaniel, 2003, 2006). That nurses working with structurally disadvantaged groups of people may experience burnout and moral distress is not new (Falk-Rafael & Betker, 2012; Marcellus et al., 2022; McMenemy et al., 2021). Notably, Marcellus et al. (2022) identified emotional responses, including moral distress, among public health practitioners when attempting to do public health work within a biomedical focused healthcare environment. Similarly, to the present study, emotional responses were directed at the system and participants pointed out the inadequacies of the governmental response and the healthcare system in responding to the "drug problem".

A striking finding of the present study is that when participants carried out their job descriptions, which were mainly "downstream" or individual level roles, they experienced a misalignment in their values and beliefs. They felt they were performing their roles within a broken system, leading to ineffectual care. This misalignment led to moral distress for some. In turn, some participants turned to action through advocacy by joining boards and committees or

envisioning themselves as advocates. Advocating and "doing whatever it takes" have been identified as actions among public health practitioners in response to ethical challenges in their practice (Marcellus et al., 2022). These actions sometimes require CHNs to work around barriers, sometimes bending the rules (Marcellus et al., 2022) or to work on their own time to advocate for change (Falk-Rafael & Betker, 2012). As noted by Falk-Rafael & Betker (2012), organizational and governmental policies act as barriers for public health nurses, leading to ethical dilemmas and moral distress. Organizational barriers hindering population-focused health promotion were also identified among public health nurses in a study by Cohen (2006). These barriers were largely related to acute/individual care being prioritized over population health promotion. Notably, participants in the present study identified a number of organizational barriers such as poor communication and continuity of care across programs, and rules and policies perceived to restrict their roles. They said change is very slow in the healthcare environment with a reliance on quantitative data to inform decisions regarding changes.

Lastly, the Community Health Nurses of Canada (2019) and the Canadian Public Health Association (CPHA) provide frameworks of competencies for community health nurses. Many competencies involve addressing social determinants of health and achieving social justice. Study participants shared a number of visions that aligned with these competencies. However, their ability to carry out system level roles that aligned with these competencies was limited due to their role descriptions focusing on care at the individual level, suggesting a disconnect between the theoretical roles and competencies of CHNs in theory and in practice. There are a number of possible explanations for this disconnect at individual, organizational, and systems levels. Cohen et al. (2013) developed a framework for organizational capacity for public health equity action that includes internal and external facilitators such as knowledge, skills, will,

attitudes, community engagement, enabling infrastructure, and champions that act both inside and outside of the organization. This study was not designed to fully explore barriers and facilitators to fulfilling the broad CHN role in addressing drug harms, however it is apparent that CHNs are described in theory as the healthcare system's agents of social change in a system where change is often not supported, and CHNs are not positioned organizationally to leverage change. It is no wonder some feel frustrated and unsupported and expressed feelings of moral distress as they felt they knew the best course of action but were unable to act upon it.

Limitations

There are a number of limitations in this study. Some of these limitations include conditions or circumstances that affected the findings which are related to the researcher herself and the research methodology while others are related to the COVID-19 pandemic. Limitations of the researcher included biases as a result of preconceived ideas about the study topic and the researcher's cultural background. These biases could affect analysis, and interpretation of the findings (reflexivity and debriefings were used to counteract these potential biases). Due to public health restrictions, interviews were conducted virtually using Zoom technology rather than in person (Zoom Video Communications Inc., 2022). Arguably, virtual interviews are less personal than face to face interviews and participants may have shared less detailed or intimate information about their experiences and perspectives. Another limiting factor had to do with recruitment difficulties in the midst of a pandemic. Recruitment efforts were made to target a wide range of community health organizations in Winnipeg. Although participants were recruited from a variety of organizations, the researcher was unable to recruit participants from some key organizations. One organization decided not to share the letter of invitation with their staff. Furthermore, participants recruited in this study were mostly white, and therefore an

Indigenous perspective was missing. Finally, the findings of this study may be context dependent, as the study was conducted in Winnipeg and the experiences of nurses in other regions may differ.

Recommendations

There are a number of recommendations derived from this study. Most importantly, CHNs need to be heard and supported. Efforts should be made to support CHNs to practice at their full scope, so that societal- and system-level changes can be pursued. This may involve securing protected work time for CHNs in community and system level work. CHNs are well positioned to address some of the barriers to care described that arise from poor health program communication, coordinator and continuity of care, by way of networks, coalitions, and communities of practice. In addition, CHNs must be involved in decision-making around their roles and interventions.

Efforts must be made to address moral distress when CHNs are caught between their commitment to social justice and organizational constraints. For example, Marcellus et al. (2022) said practice-oriented frameworks are needed to alleviate moral distress and guide ethical practice. They suggest providing time and spaces where public health practitioners can be supported to engage in dialogue about ethical challenges that arise in their practice. In turn, this could alleviate moral distress and create new opportunities for action. Leaders in the workplace, such as advanced practice nurses, can assist with this process as their roles often involve supporting and educating nursing staff.

Organizations should also re-evaluate their commitment to health equity. Current healthcare environments are not highly amenable to change (Marcellus et al., 2022), and social change (e.g., redressing poverty, improving housing conditions) may lay outside the reach of

health system to leverage. Instead, CHNs are forced to push the boundaries through "workarounds" or by pushing a social justice agenda on their own time and with their own resources. Organizational change is also needed to address stigma towards PWUD. Nursing education can also play a role in system change. CHNs demonstrated a deep understanding of the social roots of problematic drug use, and can contribute to education of students and health care providers. Pauly (2008b) recommended the development of nursing curricula to enhance nursing student's knowledge of harm reduction and the social conditions that influence the lives of those who are structurally disadvantaged. Importantly, nursing education should include information about the effects of colonialism on the health of Indigenous peoples in Canada along with cultural competency training as noted in the Truth and Reconciliation Commission of Canada: Calls to Action (2015). Greater Indigenous and BIPOC representation in the CHN and health system workforce can also be supported through multiple approaches.

Lastly, future research is needed to explore how to better support CHNs in performing system level roles. This may involve exploring organizational barriers from the perspective of other health system players. Core public health competencies and roles are described, however, more practical guidelines and support within organizations are needed. A first step could involve using existing frameworks such as the Conceptual Framework of Organizational Capacity for Public Health Equity Action (OC-PHEA), to assess organizational capacity to address health inequities (Cohen et al., 2013).

Conclusion

CHNs are well positioned to address drug-related harms as they work closely with PWUD. They witness firsthand the inequities experienced by PWUD in our community, especially those who are structurally disadvantaged. Moreover, they have witnessed an

exacerbation of drug-related harms during the COVID-19 pandemic. They provide a number of individual level roles when caring for PWUD. However, they have identified the need for system level solutions to address root causes of problematic drug use and other key issues contributing to drug-related harms and their inequitable impacts. Providing care from a public health perspective in a biomedical focused healthcare system has proven to be ethically challenging for CHNs. Given the limitations of their roles imposed by the system within their work, they require support to perform these system level roles. If given the opportunity and support, CHNs may become effective agents of social change within healthcare and the public.

References

Addictions Foundation of Manitoba [AFM]. (2017). *Crystal Meth in Manitoba.* Retrieved from: https://makeconnections.ca/wp-content/uploads/2018/03/INFOGRAPHIC-CRYSTAL-METH-in-Manitoba-January-30-2018.pdf

Addictions Foundation of Manitoba [AFM]. (2018a). *AFM Adult Services 2017-2018*. Unpublished manuscript.

Addictions Foundation of Manitoba [AFM]. (2018b). *AFM Overview 2017-2018*. Unpublished manuscript.

Addictions Foundation of Manitoba [AFM]. (2018c). *AFM Youth Services 2017-2018*. Unpublished manuscript.

Addictions Foundation of Manitoba [AFM]. (2019a). *AFM Adult Services 2018-2019*. Unpublished manuscript.

Addictions Foundation of Manitoba [AFM]. (2019b). *AFM Overview 2018-2019*. Unpublished manuscript.

Addictions Foundation of Manitoba [AFM]. (2019c). *AFM Youth Services 2018-2019*. Unpublished manuscript.

Addictions Foundation of Manitoba [AFM]. (2021). *2020-2021 Annual Report.* Retrieved from: https:// afm.mb.ca/wp-content/uploads/2021/10/AFM-Annual-Report-2020-2021.pdf

Ali, F., Russell, C., Nafeh, F., Rehm, J., Leblanc, S., & Elton-Marshall, T. (2021). Changes in substance supply and use characteristics among people who use drugs (PWUD) during the COVID-19 global pandemic: A national qualitative assessment in Canada. *International Journal of Drug Policy. 93.* 1-8. DOI: 10.1016/j.drugpo.2021.103237

Baba, L. (2013). *Cultural safety in First Nations, Inuit and Metis Public Health: Environmental scan of cultural competency and safety in education, training and health services.* Retrieved from: https://www.ccnsa-nccah.ca/docs/emerging/RPT-CulturalSafetyPublicHealth-Baba-EN.pdf

Babor, T. F., McRee, B. G., Kassebaum, P. A., Grimaldi, P. L., Ahmed, K., & Bray, J. (2007). Screening, brief intervention, and referral to treatment (SBIRT): Toward a public health approach to the management of substance abuse. *The Haworth Press Inc*, *28*(3). 7-30. doi:10.1300/J465v28n03_03

Bains, C. (2021). *$3.5M in funding for 'vending machines' that dispense safer drugs to prevent ODs*. Global News. Retrieved from: https://globalnews.ca/news/7674061/mysafe-drug-vending-machines-opioids/

Bardwell, G., Collins, A. B., McNeil, R., & Boyd, J. (2017). Housing and overdose: an opportunity for the scale-up of overdose prevention interventions? *Harm Reduction Journal*, *14*(77). 1-4. doi:10.1186/s12954-017-0203-9

Betsos, A., Valleriani, J., Boyd, J., Bardwell, G., Kerr, T., & McNeil, R. (2021). "I couldn't live with killing one of my friends or anybody": A rapid ethnographic study of drug sellers' use of drug checking. *International Journal of Drug Policy*, *87*. 1-20. doi:10.1016/j.drugpo.2020.102845

Biggar, E., Papamihali, K., Leclerc, P., Hyshka, E., Garham, B., Taylor, M., Payer, D., Maloney-Hall, B., & Buxton, J. A. (2021). Towards cross-Canada monitoring of the unregulated street drug supply. *BMC Public Health*, *21*(1678). 1-10. doi:10.1186/s12889-021-11757-x

Bonnycastle, K. D., & Villebrun, C. (2011). Injecting risk into prison sentences: A quantitative analysis of a prisoner-driven survey to measure HCV/HIV seroprevalence, risk practices, and viral testing at one Canadian male federal prison. *Prison Journal, 91*(3), 325-346. https://doi.org/10.1177/0032885511409893

Bourque, S., Pijl, E. M., Mason, E., Manning, J., & Motz, T. (2019). Supervised inhalation is an important part of supervised consumption services. *Canadian Journal of Public Health, 110*(2), 210-215. doi: 10.17269/s41997-019-00180-w

Boyd, S. (2021). Heroin and the illegal drug overdose death epidemic: A history of missed opportunities and resistance. *International Journal of Drug Policy, 91*. 1-11. doi:10.1016.j.drugpo.2020.102938

Bozat-Emre, S., Marshall, S. G., Zhong, C., & Relmer, J. (2018). Lessons learned from launching the Manitoba Take-Home Naloxone Program. *Health Promotion and Chronic Disease Prevention in Canada. 38*(6). 252-255. doi: 10.24095/hpcdp.38.6.06

Buchheit, B. M., Crable, E. L., Lipson, S. K., Drainoni, M-L., & Walley, A. Y. (2021). "Opening the door to somebody who has a chance." - The experiences and perceptions of public safety personnel towards a public restroom overdose prevention alarm system. *International Journal of Drug Policy*. *88*. 1-5. doi: 10.1016/j.drugpo.2020.103038

Campbell, S. M., Ulrich, C. M., & Grady, C. (2018). A broader understanding of moral distress. In *Moral distress in the health professions* (pp. 59-77). Springer, Cham.

Canadian Centre for Policy Alternatives Manitoba. (2016). *Ending homelessness? A critical examination of Housing First in Canada and Winnipeg.* Retrieved from: https://www-deslibris-ca.uml.idm.oclc.org/ID/10049119

Canadian Centre for Policy Alternatives Manitoba. (2019). *Forest for the trees: Reducing drug and mental health harms in the inner city of Winnipeg.* Retrieved from: https://www.policyalternatives.ca/publications/reports/state-inner-city-report-2019

Canadian Centre on Substance Use and Addiction [CCSUA]. (2014). *Substance use prevention and health promotion.* Retrieved from: https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Substance-Use-Prevention-Health-Promotion-Toolkit-2014-en.pdf

Canadian Centre on Substance Use and Addiction [CCSUA]. (2017). *Moving toward a recovery-oriented system of care.* Retrieved from: https://ccsa.ca/sites/default/files/2019-04/CCSA-Recovery-Oriented-System-of-Care-Resource-2017-en.pdf

Canadian Centre on Substance Use and Addiction [CCSUA]. (2018). *Decriminalization: Options and Evidence*. Retrieved from: Decriminalization: Options and Evidence (Policy Brief) (ccsa.ca)

Canadian Centre on Substance Use and Addiction [CCSUA]. (2019). *Changes in stimulant use and related harms: Focus on Methamphetamine and Cocaine.* Retrieved from: https://www.ccsa.ca/sites/default/files/2019-05/CCSA-CCENDU-Stimulant-Use-Related-Harms-Bulletin-2019-en.pdf

Canadian Centre on Substance Use and Addiction [CCSUA]. (2020). *Changes related to COVID-19 in the illegal drug supply and access to services, and resulting health harms (CCENDU Alert).* Retrieved from: https:// www.ccsa.ca/changes-related-covid-19-illegal-drug-supply-and-access-services-and-resulting-health-harms

Canadian Community Epidemiology Network on Drug Use [CCENDU]. (2015). *Winnipeg 2009-2012 Report.* Retrieved from: http://afm.mb.ca/wp-content/uploads/2015/12/Winnipeg-2009-2012-CCENDU-Report.pdf

Canadian Drug Policy Coalition [CDPC]. (2012). *Changing the Frame: A New Approach to Drug Policy in Canada.* Retrieved from: https://www.drugpolicy.ca/wp-content/uploads/2015/02/CDPC_report_eng_v14_comp.pdf

Canadian Institute for Health Information [CIHI]. (2018). *Opioid-related harms in Canada.* Ottawa. Retrieved from: https://secure.cihi.ca/free_products/opioid-related-harms-report-2018-en-web.pdf

Canadian Institute for Health Information [CIHI]. (2019). *Opioid prescribing in Canada: How are Practices Changing?* Retrieved from: https://www.cihi.ca/sites/default/files/document/opioid-prescribing-canada-trends-en-web.pdf

Canadian Nurses Association [CNA]. (2017a). *Code of Ethics for Registered Nurses.* Retrieved from: https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/code-of-ethics-2017-edition-secure-interactive

Canadian Nurses Association [CNA]. (2017b). *Harm reduction & illicit substance use: Implications for nursing.* Retrieved from: https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/harm-reduction-and-illicit-substance-use-implications-for-nursing.pdf?la=en

Canadian Public Health Association [CPHA]. (2010). *Public health-community health nursing practice in Canada.* Retrieved from: https://www.cpha.ca/sites/default/files/assets/pubs/3-1bk04214.pdf

Canadian Public Health Association [CPHA]. (2014). *A new approach to managing illegal psychoactive substances in Canada.* Ottawa. Retrieved from: https://www.cpha.ca/sites/default/files/assets/policy/ips_2014-05-15_e.pdf

Canadian Substance Use Costs and Harms Scientific Working Group. (2018). *Canadian substance use and costs and harms in the provinces and territories (2007-2014).* Prepared by the Canadian Institute for Substance Use Research and the Canadian Centre on Substance Use and Addiction. Ottawa, Ont.: Canadian Centre on Substance Use and Addiction. Retrieved from: https://www.ccsa.ca/sites/default/files/2019-04/CSUCH-Canadian-Substance-Use-Costs-Harms-Report-2018-en.pdf

Campbell-Heider, N., Tuttle, J., Bidwell-Cerone, S., Richeson, G. T., & Colling, S. E. (2003). The buffering effects of connectedness: Teen Club intervention for children of substance abusing families. *Journal of Addictions Nursing*, *14*(4). 175-182. doi: 10.1080/10884600390251175

Chandler, G. E., Kalmakis, K. A., & Murtha, T. (2021). Screening adults with substance use disorder for adverse childhood experiences. *Journal of Addictions Nursing, 29*(3), 172-178. doi: 10.1097/JAN.0000000000000233

Chang, J., Shelly, S., Busz, M., Stoicescu, C., Iryawan, A. R., Madybaeva, D., de Boer, Y., & Guise, A. (2021). Peer driven or driven peers? A rapid review of peer involvement of people who use drugs in HIV and harm reduction services in low- and middle-income countries. *Harm Reduction Journal, 18*(1), 15. doi: 10.1186/s12954-021-00461-z

Chen, Y., Kubzansky, L. D., & VanderWeele, T. J. (2019). Parental warmth and flourishing in mid-life. *Social Science & Medicine*, *220*. 65-72. doi: 10.1016/j.socscimed.2018.10.026

Cohen, B. (2006). Barriers to population-focused health promotion: the experience of public health nurses in the province of Manitoba. *Canadian Journal of Nursing Research. 38*(3). 52-67.

Cohen, B. E., Schultz, A., McGibbon, E., VanderPlaat, M., Bassett, R., GermAnn, K., ... & Fuga, L. A. (2013). A conceptual framework of organizational capacity for public health equity action (OC-PHEA). *Canadian Journal of Public Health*, *104*(3), e262-e266.

Comack, E. (2012). *Racialized Policing: Aboriginal People's Encounters with the Police*. Fernwood Publishing.

Community Health Nurses of Canada [CHNC]. (2019). *Canadian community health nursing professional practice model & standards of practice.* Retrieved from: https://www.chnc.ca/standards-of-practice

Coubrough, J. (2021a). Drug overdose deaths in Manitoba surge by 87% in 2020. *CBC News*. Retrieved from: https://www.cbc.ca/news/canada/manitoba/manitoba-drug-overdose-2020-wfpcbc-cbc-1.5994178

Coubrough, J. (2021b). Overdose deaths continue to climb in Manitoba, renewing calls for government action. *CBC News*. Retrieved from: https://www.cbc.ca/news/canada/manitoba/manitoba-overdose-deaths-2020-1.5937663

Creswell, J. (1998). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches.* Thousand Oaks: Sage publication, 139-165.

CRISM. (2017). *Manitoba Policy Analysis Case Report. CHARPP Project.* Retrieved from: https://crismprairies.ca/wp-content/uploads/2018/06/Manitoba.pdf

CRISM. (2022). *Opioid-Agonist Therapy (OAT) and Crytal Meth Guidelines for Community-based and Residential Treatment Centres who Serve First Nations Clients.* Retrieved on April 29, 2022 from: https://crism.ca/opioid-agonist-therapy-oat-treatment-protocols-standards-strategies-for-community-based-and-residential-treatment-centres-who-serve-first-nations-clients-who-misuse-opioids/

Csete, J., & Elliott, R. (2020). Consumer protection in drug policy: The human rights case for safe supply as an element of harm reduction. *International Journal of Drug Policy*, 102976. doi: 10.1016/j.drugpo.2020.102976

Csete, J., & Wolfe, D. (2017). Seeing through the public health smoke-screen in drug policy. *International Journal of Drug Policy*, *43*. 91-95. doi: 10.1016/j.drugpo.2017.02.016

Day, C. A., Islam, M. M., White, A., Reid, S. E., Hayes, S., & Haber, P. S. (2011). Development of a nurse-led primary healthcare service for injecting drug users in inner-city Sydney. *Australian Journal of Primary Health*, *17*. 10-15. doi: 10.1071/PY10064

Denis-Lalonde, D., Lind, C., & Estefan, A. (2019). Beyond the Buzzword: A Concept Analysis of Harm Reduction. *Research & Theory for Nursing Practice, 33*(4), 310-323. doi: 10.1891/1541-6577.33.4.310

Drucker, E., Anderson, K., Haemmig, R., Heimer, R., Small, D., Walley, A., Wood, E., & van Beek, I. (2016). Treating addictions: Harm reduction in clinical care and prevention. *Journal Of Bioethical Inquiry, 13*(2), 239-249. doi: 10.1007/s11673-016-9720-6

Drucker, E., & Crofts, N. (2017). Are we anywhere near there yet? The state of harm reduction in North America in 2017. *Harm Reduction Journal, 14*, 1-4. doi: 10.1186/s12954-017-0155-0

EQUIP Health Care. (2017). Key Dimensions of Equity-Oriented Care: 10 Strategies to Guide Organizations in Enhancing Capacity for Equity-Oriented Health Care. Retrieved from: www.equiphealthcare.ca

Emerson, B., & Haden, M. (2021). A public health based vision for the management and regulation of opioids. *International Journal of Drug Policy*, *91*. 1-7. doi: 10.1016/j.drugpo.2021.103201

Falk-Rafael, A., & Betker, C. (2012). Wtinessing social injustice downstream and advocating for health equity upstream: The "trombone slide" of nursing. *Advances in Nursing Science*, *35*(2). 98-112. doi: 10.1097/ANS.0b013e31824fe70f

Fischer, B., Murphy, Y., Rudzinksi, K., & MacPherson, D. (2016). Illicit drug use and harms, and related interventions and policy in Canada: A narrative review of select key indicators and developments since 2000. *International Journal of Drug Policy*, *27*. 23-35. doi: 10.1016/j.drugpo.2015.08.007

Fischer, B., O'Keefe-Markman, C., Lee (Min-Hye), A., & Daldegan-Bueno, D. (2021). 'Resurgent', 'twin' or 'silent' epidemic? A select data overview and observations on increasing psycho-stimulant use and harms in North America. *Substance Abuse Treatment, Prevention, and Policy*, *16*(17). 1-11. doi: 10.1186/s13011-021-00350-5

Ford, R., Bammer, G., & Becker, N. (2009). Improving nurses' therapeutic attitude to patients who use illicit drugs: Workplace drug and alcohol education is not enough. *International Journal of Nursing Practice*, *15*. 112-118. doi: 10.1111/j.1440-172X.2009.01732.x

Frost, M. C., Sweek, E. W., Austin, E. J., Corcorran, M. A., Juarez, A. M., Frank, N. D., Prohaska, S. M., LaKosky, P. A., Asher, A. K., Broz, D., Jarlais, D. C. D., Williams, E. C., & Glick, S. N. (2021). Program adaptations to provide harm reduction services during the COVID-19 pandemic: A qualitative study of syringe services programs in the U.S. *AIDS And Behavior*. doi: 10.1007/s10461-021-03332-7

Gagnon, M., Gauthier, T., Adan, E., Banninger, A., Cormier, L., Gregg, J. K., Gill, S., Horsburgh, K., Kreutzmann, P., Latimer, J., Le Bourhis, G., Livgard, C., PArker, D., Reiremo, T., Telegdi, E., Thorner, T., & White, M. (2019). International consensus

statement on the role of nurses in supervised consumption sites. *Journal of Mental Health and Addiction Nursing*, *3*(1). 22-31. doi: 10.22374/jmhan.v3i1.35

Gagnon, M., & Hazlehurst, E. (2020). How do nursing organizations measure up on harm reduction? An environmental scan. *Canadian Journal of Nursing Research*, 0844562120914425. doi: 10.1177/0844562120914425

Galai, N., Sirirojn, B., Aramrattana, A., Srichan, K., Thomson, N., Golozar, A., . . . Celentano, D. D. (2018). A cluster randomized trial of community mobilization to reduce methamphetamine use and HIV risk among youth in Thailand: Design, implementation and results. *Social Science and Medicine*, *211*. 216-223. doi: 10.1016/j.socscimed.2018.06.013

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, *13*. 1-8. doi: 10.1186/1471-2288-13-117

Global Commission on Drug Policy [GCDP]. (2017). *The World Drug Perception Problem.* Retrieved from: https://www.globalcommissionondrugs.org/reports/changing-perceptions

Gold, F. (2009). Street Nursing. *American Journal of Nursing, 109*(7). 28-32. doi: 10.1097/01.NAJ.0000357165.17895.67

Goodyear, T. (2021). (Re)politicizing harm reduction: Poststructuralist thinking to challenge the medicalization of harms among people who use drugs *Aporia, 13*(1). 26-35. doi: 10.18192/aporia.v13i1.5272

Government of Canada. (2017). *Controlled and illegal drugs.* Retrieved from: https://www.canada.ca/en/health-canada/services/substance-use/controlled-illegal-drugs.html

Government of Canada. (2019a). *About the Good Samaritan Drug Overdose Act*. Retrieved from: https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/about-good-samaritan-drug-overdose-act.html

Government of Canada. (2019b). *Canadian Tobacco, Alcohol and Drugs Survey (CTADS): Summary of Results from 2017.* Retrieved from: https://www.canada.ca/en/health-canada/services/canadian-tobacco-alcohol-drugs-survey/2017-summary.html

Government of Canada. (2020a). *Opioid-related harms in Canada (June 2020).* Retrieved on June 17, 2020 from: https://health-infobase.canada.ca/substance-related-harms/opioids/

Government of Canada. (2020b). *Supervised Consumption Sites: Status of Applications.* Retrieved on April 19, 2022 from: https: https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html

Government of Canada. (2021). *Opioid- and stimulant-related harms in Canada (December 2021).* Retrieved on November 3, 2021 from: https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/

Government of Canada. (2022). *Active Projects.* Retrieved on April 29, 2022 from: https:// www.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy/funding/substance-use-addictions-program/active-projects.html#wb-auto-4

Government of Manitoba (2017). *Surveillance of opioid misuse and overdose in Manitoba: Baseline Report.* Retrieved from: https://www.gov.mb.ca/health/publichealth/surveillance/docs/opioid/baseline_opioid.pdf

Government of Manitoba (2018). *Annual Statistical Update: HIV in Manitoba.* Retrieved from: https://www.gov.mb.ca/health/publichealth/surveillance/hivaids/docs/dec2017.pdf

Government of Manitoba (2019a). *Manitoba Sexually Transmitted and Blood-Borne Infections Strategy 2015-2019.* Retrieved from: https://www.gov.mb.ca/health/publichealth/cdc/docs/stbbi_strategy.pdf

Government of Manitoba (2019b). *Problematic substance use and related harms in Manitoba: April 1 - June 30, 2019.* Retrieved from: http://www.manitoba.ca/health/publichealth/surveillance/docs/2019q2report_20191203_sd.pdf

Government of Manitoba (2019c). *Problematic substance use and related harms in Manitoba: January 1 - March 31, 2019.* Retrieved from: http://www.manitoba.ca/health/publichealth/surveillance/docs/2019q1report_20191203_sd.pdf

Government of Manitoba (2019d). *Surveillance of opioid misue and overdose in Manitoba: October 1 – December 30, 2018.* Retrieved from: https://www.gov.mb.ca/health/publichealth/surveillance/docs/opioid/2018/q4_opioid.pdf

Greenwald, G. (2009). *Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies*. Cato Institute.

Greer, A. M., Buxton, J. A., Pauly, B., & Bungay, V. (2021). Organizational support for frontline harm reduction and systems navigation work among workers with living and lived experience: qualitative findings from British Columbia, Canada. *Harm Reduction Journal, 18*(1), 60. doi: 10.1186/s12954-021-00507-2

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology. 29*(2) 75-91. Retrieved from: https://www.jstor.org/stable/30219811

Harm Reduction International (2020). *What is harm reduction?* Retrieved on June 16, 2020 from: https://www.hri.global/what-is-harm-reduction

Harris., R. A., Mandell, D. S., Kampman, K. M., Bao, Y., Campbell, K., Cidav, Z., Coviello, D. M., French, R., Livesey, C., Lowenstein, M., Lynch, K. G., McKay, J. R., Oslin, D. W., Benjamin Wolk, C., Bogner, H. R. (2021). Collaborative care in the treatment of opioid use disorder and mental health conditions in primary care: A clinical study protocol. *Contemporary Clinical Trials, 103*. doi: 10.1016/j.cct.2021.106325

Health Canada (2018). *Background document: Public consultation on strengthening Canada's approach to substance use issues.* Retrieved from: https://www.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy/strengthening-canada-approach-substance-use-issue.html

Herron, J. L., & Venner, K. L. (2022). A systematic review of trauma and substance use in American Indian and Alaska Native individuals: Incorporating cultural considerations. *Journal of racial and ethnic health disparities*. doi:10.1007/s40615-022-01250-5

House of Commons (2019). *Impacts of methamphetamine abuse in Canada: Report of the standing committee on health.* Retrieved from: https://www.ourcommons.ca/Content/Committee/421/HESA/Reports/RP10533589/hesarp26/hesarp26-e.pdf

Hunt, S. (2015). *Review of Core Competencies for Public Health: An Aboriginal Public Health Perspective.* Retrieved from: https://www.ccnsa-nccah.ca/docs/context/RPT-CoreCompentenciesHealth-Hunt-EN.pdf

Illicit Drug Task Force [IDTF] (2019). *Recommendations to reduce the use and effects of illcit drugs within Manitoba's communities.* Retrieved from: https://www.winnipeg.ca/cao/pdfs/2019-Illicit-Drug-Task-Force-Report.pdf

Iammarino, C., & Pauly, B. (2021). Harm reduction as an approach to ethical nursing care of people who use illicit substances: An integrative literature review of micro and meso influences. *Drugs: Education, Prevention and Policy*, *28*(6). 533-546. doi: 10.1080/09687637.1840515

Inanlou, M., Bahmani, B., Farhoudian, A., & Rafiee, F. (2020). Addiction recovery: A systematized review. *Iran J Psychiatry*, *15*(2). 172-181. doi: 10.18502/ijps.v15i2.2691

Interagency Coalition on AIDS and Development [ICAD] & Canadian Aboriginal Aids Network [CAAN] (2019). *Indigenous harm reduction = Reducing the harms of colonialism.* Retrieved from: www.icad-cisd.com/pdf/Publications/Indigenous-Harm-Reduction-Policy-Brief.pdf

Ivsins, A., Boyd, J., Mayer, S., Collins, A., Sutherland, C., Kerr, T., & McNeil, R. (2021). "It's helped me a lot, just like to stay alive": A qualitative analysis of outcomes of a novel Hydromorphone tablet distribution program in Vancouver, Canada. *Journal of Urban Health*, *98*(1). 59-69. doi: 10.1007/s11524-020-00489-9

Ivsins, A., & Yake, K. (2018). Looking beyond harm: Meaning and purpose of substance use in the lives of marginalized people who use drugs. *Drugs: Education, Prevention and Policy*, *27*(1). 27-36. doi: 10.1080/09687637.2018.1497145

Jiao, S. (2019). Harm reduction: Philosophical drivers of conceptual tensions and ways forward. *Nursing Inquiry, 26*(2), 1-6. doi: 10.1111/nin.12286

Jones, H., & Arms, T. (2018). Opioids: Literature findings and recommendations. *Journal of Psychosocial Nursing*, *56*(9). 17-24. doi: 10.3928/02793695-20180703-01

Kleinman, R. A., & Morris, N. P. (2021). Rethinking the criminalization of personal substance use and possession. *Journal of General Internal Medicine, 36*(2), 1-3. doi: 10.1007/s11606-021-06628-5

Koch, B., & Keilty, J. (2018). Project Safe Audience: Two nursing students launch a harm reduction project targeting high-risk behaviours at rave events in Winnipeg's underground music scene. *Canadian Nurse. 114*(1). 22-24. Retrieved from: www.community.cna-aiic.ca/dev-cn-en/blogs/cn-content/2018/02/07/project-safe-audience

Kolodny, A., Courtwright, D. T., Hwang, C. S., Kreiner, P., Eadie, J. L., Clark, T. W., & Alexander, G. C. (2015). The prescription opioid and heroin crisis: A public health approach to an epidemic of addiction. *Annual Review of Public Health*, *36*(1). 559-574. doi: 10.1146/annurev-publhealth-031914-122957

Kovitwanichkanont, T., & Day, C. A. (2018). Prescription opioid misuse and public health approach in Australia. *Substance Use & Misuse*, *53*(2). 200-205. doi: 10.1080/10826084.2017.1305415

Krausz, R. M., Wong, J. S. H., Westenberg, J. N., Choi, F., Schutz, C. G., & Jang, K. L. (2021). Canada's response to the dual public health crisis: A cautionary tale. *The Canadian Journal of Psychiatry*, *66*(4). 349-353. doi: 10.1177/0706743721993634

Kristjansson, A. L., Mann, M. J., Sifgusson, J., Thorisdottir, I. E., Allegrante, J. P., & Sigfusdottir, I. D. (2020a). Development and guiding principles of the Icelandic Model

for preventing adolescent substance use. *Health Promotion Practice*, *21*(1). 62-69. doi: 10.1177/1524839919849032

Kristjansson, A. L., Mann, M. J., Sifgusson, J., Thorisdottir, I. E., Allegrante, J. P., & Sigfusdottir, I. D. (2020b). Implementing the Icelandic Model for preventing adolescent substance use. *Health Promotion Practice*, *21*(1). 70-79. doi: 10.1177/1524839919849033

Kulbok, P. A., Thatcher, Esther, Park, Eunhee, Meszaros & Peggy, S. (2012). Evolving public health nursing roles: Focus on community participatory health promotion and prevention, *Online journal of Issues in Nursing*, *17*(2). 1-1. doi: 10.3912/OJIN.Vol17No02Man01

Kulikowski, J., & Linder, E. (2018). Making the case for harm reduction programs for injection drug users. *Nursing 2018, 48*(6). 46-51. doi: 10.1097/01.NURSE.0000532745.80506.17

Lago, R. R., Peter, E., & Bogus, C. M. (2017). Harm reduction and tensions in trust and distrust in a mental health service: A qualitative approach. *Substance Abuse Treatment, Prevention, and Policy. 12.* 1-9. doi: 10.1186/s13011-017-0098-1

Lam, V. (2021). As a doctor, I was taught 'first do no harm.' That's why I have concerns with the so-called 'safe supply' of drugs. *The Globe and Mail*. Retrieved from: https://www.theglobeandmail.com/opinion/article-as-a-doctor-i-was-taught-first-do-no-harm-thats-why-i-have-a-problem/

Lanzillotta-Rangeley, J., Leslie, J., Little, M., Stem, J., Asselin, E., & Kurahovic, M. (2020). Educational program to increase substance use disorder knowledge and decrease stigma in first-year nursing students. *Pain Management Nursing, 21*(5), 435-440. doi: 10.1016/j.pmn.2020.05.002

Lassi, Z. S., Salam, R. A., Das, J. K., Wazny, K., & Bhutta, Z. A. (2015). An unfinished agenda on adolescent health: Opportunities for interventions. *Seminars in Perinatology, 39*. 353-360. doi: 10.1053/j.semperi.2015.06.005

Lightfoot, B., Panessa, C., Hayden, S., Thumath, M., Goldstone, I., & Pauly B. (2009). Gaining insite: Harm reduction in nursing practice. *Canadian Nurse, 105*(4). 16-22. Retrieved from: https://www.canadian-nurse.com/blogs/cn-content/2009/04/01/gaining-insite-harm-reduction-in-nursing-practice

Limbu, B. (2008). The role of community-based nurses in harm reduction for HIV prevention: A South East and South Asia case study. *International Journal of Drug Policy, 19*(3). 211-213. doi: 10.1016/j.drugpo.2008.02.015

Maina, G., Marshall, K., & Sherstobitof, J. (2021). Untangling the complexities of substance use initiation and recovery: Client reflections on opioid use prevention and recovery from a social-ecological perspective. *Substance Abuse: Research and Treatment, 15*, 1-9. doi: 10.1177/11782218211050372

Manitoba Health. (2022). *A Pathway to Mental Health and Community Wellness: A Roadmap for Manitoba*. Retrieved from: https://gov.mb.ca/mh/docs/roadmap.pdf

Marcellus, L., Pauly, B., Martin, W., Revai, T., Easton, K., & MacDonald, M. (2022). Navigating conflicting value systems: a grounded theory of the process of public health equity work in the context of mental health promotion and prevention of harms of substance use. *BMC Public Health, 22*(210). 1-14. doi: 10.1186/s12889-022-12627-w

Marshall, S. G. (2018). *Social context matters: A focused ethnography of Talwin and Ritalin injection in Winnipeg, Manitoba* (Doctoral dissertation). Retrieved from University of Manitoba Libraries MSpace.

Maynard R., & Jozaghi E. (2021). The drug war must end: The right to life, liberty and security of the person during the COVID-19 pandemic for people who use drugs. *Harm Reduction Journal, 18*(22). 1-2. DOI: 10.1186/s12954-021-00474-8

McCall, J., & Pauly, B. (2019). Sowing a seed of safety: Providing culturally safe care in acute care settings for people who use drugs. *Journal of Mental Health and Addiction Nursing, 3*(1). 1-7. DOI: 10.22374/jmhan.v3i1.33

Malleck, (2015). When Good Drugs Go Bad: Opium, Medicine, and the Origins of Canada's Drug Laws. UBC Press. Vancouver BC. Retrieved from: https://www.ubcpress.ca/asset/9359/1/9780774829199.pdf

Manitoba Youth Health Survey Report, Partners in Planning for Healthy Living 2012-2013 (2014). Winnipeg, MB. Retrieved from: https://wrha.mb.ca/wp-content/site-documents/community/publichealth/files/WCRHA-Metro.pdf

MacArthur, G. J., Harrison, S., Caldwell, D. M., Hickman, M., & Campbell, R. (2015). Peer-led interventions to prevent tobacco, alcohol and/or drug use among people aged 11-21 years: A systematic review and meta-analysis. *Addiction*, *111*(3). 391-407. doi: 10.1111/add.13224

McFaull, S, R., Champagne, A., Thompson, W., Bang, F. (2020). Injuries and poisonings associated with methamphetamine use: sentinel surveillance, the electronic Canadian Hospitals Injury Reporting and Prevention Program (eCHIRPP), 2011–2019. *Health Promotion and Chronic Disease Prevention in Canada. 40*(4). 126-129. doi: 10.24095/hpcdp.40.4.04

McMenemy, C., Rolfe, D., Van Herk, K., Wait, C., Jamison, B., Quesnel, S., Laroque, C., Muckle, W., & Gifford, W. (2021). Holistic supports for street nurses and front-line

workers during the COVID-19 pandemic. *Nursing Leadership. 34*(2). 75-85. doi: 10.12927/cjnl.2021.26527

McNeil, R., Kerr, T., Pauly, B., Wood, E., & Small, W. (2016). Advancing patient-centered care for structurally vulnerable drug-using populations: A qualitative study of the perspectives of people who use drugs regarding the potential integration of harm reduction interventions into hospitals. *Addiction, 111*(4), 685-694. doi: 10.1111/add.13214

Measham, F., & Turnbull, G. (2021). Intentions, actions and outcomes: A follow up survey on harm reduction practices after using an English festival drug checking service. *International Journal of Drug Policy, 95*, 1-10. doi: 10.1016/j.drugpo.2021.103270

Menschner, C., & Maul, A. C. (2016). *Key Ingredients for Successful Trauma-Informed Care Implementation*.

Milaney, K., Passi, J., Zaretsky, L., Liu, T., O'Gorman, C. M., Hill, L., & Dutton, D. (2021). Drug use, homelessness and health: responding to the opioid overdose crisis with housing and harm reduction services. *Harm Reduction Journal, 18*(1), 92. doi: 10.1186/s12954-021-00539-8

Miler, J. A., Carver, H., Masterson, W., Parkes, T., Maden, M., Jones, L., & Sumnall, H. (2021). What treatment and services are effective for people who are homeless and use drugs? A systematic 'review of reviews'. *PLoS ONE. 16*(7). 1-23. doi: 10.1371/journal.pone.0254729

Morley, G., Chumbley, G. M., & Briggs, E. V. (2020). 'You wouldn't do that to an animal, would you?' Ethical issues in managing pain in patients with substance dependence. *British Journal of Pain. 14*(3). 195-205. doi: 10.1177/2049463719888551

Morse, J. M., & Field, P. A. (1995). *Qualitative Research Methods for Healthcare Professionals*. SAGE Publications.

Murphy, Y., Wilson, E., Goldner, E. M., & Fischer, B. (2016). Benzodiazepine use, misuse, and harm at the population level in Canada: a comprehensive narrative review of data and developments since 1995. *Clinical drug investigation*, *36*(7), 519-530. doi: 10.1007/s40261-016-0397-8

Nash, A. J., Marcus, M. T., Cron, S., Scamp, N., Truitt, M., & McKenna, Z. (2017). Preparing nursing students to work with patients with alcohol or drug-related problems. *Journal of Addictions Nursing*. *28*(3). 124-130. doi: 10.1097/JAN.0000000000000175

Nathaniel, K. A. (2003). *A grounded theory of moral reckoning in nursing.* (Doctoral dissertation, West Virginia University, Morgantown, West Virgina). Retrieved from: https://researchrepository.wvu.edu/etd/9490

Nathaniel, K. A. (2006). Moral reckoning in nursing. *Western Journal of Nursing Research*. *28*(4). 419-438. doi: 10.1177/0193945905284727

Newhouse, R. (2019). How will we lead? Nursing actions to reduce health impact of addiction. *Nursing Outlook*, *67*. 501-502. doi: 10.1016/j.outlook.2019.07.002

Nguyen, T., & Buxton, J. A. (2021). Pathways between COVID-19 public health response and increasing overdose risk: A rapid review and conceptual framework. *International Journal of Drug Policy*, *93*. 1-6. doi: 10.1016/j.drugpo.2021.103236

Nikowane, A. M., & Saxena, S. (2004). Opportunities for an improved role for nurses in psychoactive substance use: Review of the literature. *International Journal of Nursing Practice*, *10*(3). 102-110. doi: 10.1111/j.1440-172X.2004.00471.x

Norman, R. (2001a). Have you got an attitude problem? Caring for illicit drug-using patients. *Contemporary Nurse*, *10*(1-2). 83-90. doi: 10.5172/conu.10.1-2.83

Norman, R. (2001b). National drug policy: Implications of the 'tough on drugs' ideology. *Collegian*, *8*(4). 22-26. doi: 10.1016/S1322-7696(08)60030-X

Norwood, C. W., Biviji-Sharma, R., Knotts, A., Omenka, I., Stone, C., & Purviance, D. (2015). Fighting prescription drug abuse through state policy. *Journal of Addictions Nursing*, *26*(4). 203-207. doi: 10.1097/JAN.000000000000097

Nowell, M. (2021). *Safe supply: What is it and what is happening in Canada?* CATIE.

Nowell, M., & Masuda, J. R. (2020). "You need to just provide health services:" navigating the politics of harm reduction in the twin housing and overdose crises in Vancouver, BC. *International Journal of Drug Policy, 82*, 1-8. doi: 10.1016/j.drugpo.2020.102774

Nutton, J., & Fast, E. (2015). Historical trauma, substance use, and Indigenous peoples: Seven generations of harm from a 'big event'. *Substance Use & Misuse, 50*(7), 839-847. doi: 10.3109/10826084.2015.1018755

Nyamathi, A., Branson, C., Kennedy, B., Salem, B., Khalilifard, F., Marfisee, M., Getzoff, D. & Leake, B. (2012). Impact of nursing intervention on decreasing substances among homeless youth. *The American Journal on Addictions*, *21*. 558-565. doi: 10.1111/j.1521-0391.2012.00288.x

Office of the Provincial Health Officer. (n.d.). *Stopping the Harm: Decriminalization of People who use Drugs in BC. Provincial Health Officer's Special Report*. Province of British Columbia. Retrieved from: stopping-the-harm-report.pdf (gov.bc.ca)

Paivinen, H., & Bade, S. (2008). Voice: Challenging the stigma of addiction; a nursing perspective. *International Journal of Drug Policy. 19*(3). 214-219. doi: 10.1016/j. drugpo.2008.02.011

Palombi, L., Olivarez, M., Bennett, L., & Hawthorne, A. N. (2019). Community Forums to address the opioid crisis: An effective grassroots approach to rural community engagement. *Substance Abuse: Research and Treatment*, *13*. 1-7. doi: 10.1177/1178221819827595

Pandey, A., Hale, D., Das, S., Goddings, A., Blakemore, S., & Viner, R. M. (2018). Effectiveness of universal self-regulation-based interventions in children and adolescents: A systematic review and meta-analysis. *JAMA Pediatrics. 172*(6). 566-575. doi: 10.1001/jamapediatrics.2018.0232

Pauly, B. (2008a). Harm reduction through a social justice lens. *International Journal of Drug Policy*, *19*. 4-10. doi: 10.1016/j.drugpo.2007.11.005

Pauly, B. (2008b). Shifting moral values to enhance access to health care: Harm reduction as a context for ethical nursing practice. *International Journal of Drug Policy*, *19*. 195-204. doi: 10.1016/j.drugpo.2008.02.009

Pauly, B., & Browne, A. J. (2015). Toward cultural safety: Nurse and patient perceptions of illciit substance use in a hospitalized setting. *Advances in Nursing Science*, *38*(2). 121-135. doi: 10.1097/ANS.0000000000000070

Pauly, B., Goldstone, I., McCall, J., Gold, F., & Payne, S. (2007). The ethical, legal and social context of harm reduction. *Canadian Nurse*, *103*(8). 19-23.

People with Lived Expertise of Drug Use National Working Group., Austin, T., & Boyd, J. (2021). Having a voice and saving lives: A qualitative survey on employment impacts of

people with lived experience of drug use working in harm reduction. *Harm Reduction Journal*, *18*. 1-12. doi: 10.1186/s12954-020-00453-5

Pereira, M., & Scott, J. (2017). Harm reduction and the ethics of drug use: Contemporary techniques of self-governance. *Health Sociology Review, 26*(1), 69-83. doi: 10.1080/14461242.2016.1184583

Pergolizzi, J. V., Raffa, R. B., & Rosenblatt, M. H. (2020). Opioid withdrawal symptoms, a consequence of chronic opioid use and opioid use disorder: Current understanding and approaches to management. *Journal of Clinical Pharmacy & Therapeutics, 45*(5), 892-903. doi: 10.1111/jcpt.13114

Peterkin, A., Laks, J., & Weinstein, Z. M. (2022). Current Best Practices for Acute and Chronic Management of Patients with Opioid Use Disorder. *Medical Clinics of North America, 106*(1), 61-80. doi: 10.1016/j.mcna.2021.08.009

Petrasko, J. (2022). *Safe Supply in Canada: Perspectives of Drug Policy Actors* [Masters Thesis, Carleton University]. Ottawa, ON, Canada.

Porta, M. (2014). A dictionary of epideimology. Sixth Edition. Oxford University Press. New York. Retrieved from: https://ebookcentral.proquest.com/lib/umanitoba/detail.action?docID=1679277

Porter, L. B. (2020). Harm reduction and moral desert in the context of drug policy. *Health Care Analysis, 28*(4), 362-371. doi: 10.1007/s10728-020-00411-z

Pride, T., Lam, A., Swansburg, J., Seno, M., Lowe, M. B., Bomfim, E., Toombs, E., Marsan, S., LoRusso, J., Roy, J., Gurr, E., LaFontaine, J., Paul, J., Burack, J. A., Mushquash, C., Stewart, S. H., & Wendt, D. C. (2021). Trauma-informed approaches to substance use

interventions with Indigenous peoples: A scoping review. *Journal of Psychoactive Drugs, 53*(5), 460-473. doi: 10.1080/02791072.2021.1992047

Public Health Agency of Canada [PHAC] (2019). *Updated Numbers on Opioid-Related Overdose Deaths in Canada*. Retrieved from: https://www.canada.ca/en/public-health/news/2019/04/updated-numbers-on-opioid-related-overdose-deaths-in-canada.html

Public Health Agency of Canada [PHAC] (2020). *A primer to reduce substance use stigma in the Canadian health system*. Retrieved from: https://www.canada.ca/en/public-health/services/publications/healthy-living/primer-reduce-substance-use-stigma-health-system.html

Pursaga, J. (2022). *Winnipeg drug decriminalization effort voted down.* Winnipeg Free Press. Retrieved from: https://www.winnipegfreepress.com/local/winnipeg-drug-decriminalization-effort-voted-down-576241562.html

Rassool, G., H., & Villar-Luis, M. (2004). Tackling drug and alcohol misuse in Brazil: Priorities and challenges for nurses. *International Nursing Review, 51*(4). 201-207. doi: 10.1111/j.1466-7657.2004.00248.x

Registered Nurses of Ontario [RNAO] (2015). *Engaging Clients Who Use Substances.* Retrieved from: https://rnao.ca/sites/rnao-ca/files/Engaging_Clients_Who_Use_Substances_13_WEB.pdf

Renstrom, M., Ferri, M., & Mandil, A. (2017). Substance use prevention: Evidence-based intervention. *Eastern Mediterranean Health Journal*, *23*(3). 198-205. doi:10.26719/2017.23.3.198

Rhodes, T. (2009). Risk environments and drug harms: A social science for harm reduction approach. *International Journal of Drug Policy, 20*(3), 193-201. doi; 10.1016/j.drugpo.2008.10.003

Rieder, T. N. (2021). Ending the war on drugs requires decriminalization. Does it also require legalization? *American Journal of Bioethics, 21*(4), 38-41. doi; 10.1080/15265161.2021.1891332

Rogers, C., Pakdaman, S., Forster, M., Sussman, S., Grigsby, T., Victoria, J., & Unger, J. (2022). Effects of multiple adverse childhood experiences on substance use in young adults: A review of the literature. *Drug and alcohol dependence, 234*, 109407. doi: 10.1016/j.drugalcdep.2022.109407

Roxburgh, A., Jauncey, M., Day, C., Bartlett, M., Cogger, S., Dietze, P., Nielsen, S., Latimer, J., & Clark, N. (2021). Adapting harm reduction services during COVID-19: Lessons from the supervised injecting facilities in Australia. *Harm Reduction Journal, 18*(1), 20. doi: 10.1186/s12954-021-00471-x

Russell, B. S., Hutchison, M., & Fusco, A. (2019). Emotion regulation outcomes and preliminary feasibility evidence from a mindfulness intervention for adolescent substance use. *Journal of Child & Adolescent Substance Abuse*, *28*(1). 21-31. doi: 10.1080/1067828X.2018.1561577

Salmond, S., & Allread, V. (2019). A population approach to America's opioid epidemic. *Orthopaedic Nursing*, *38*(2). 95-110. doi: 10.1097/NOR.0000000000000521

Santo, T., Campbell, G., Gisev, N., & Degenhardt, L. (2021). Exposure to childhood trauma increases risk of opioid use disorder among people prescribed opioids for chronic non-

cancer pain. *Drug and alcohol dependence, 230*, 1-8. doi: 10.1016/j.drugalcdep.2021.109199

Schofield, J., Dumbrell, J., Matheson, C., Parkes, T., & Bancroft, A. (2022, 2022/03/15sd). The impact of COVID-19 on access to harm reduction, substance use treatment and recovery services in Scotland: a qualitative study. *BMC Public Health, 22*(1), 1-10. doi: 10.1186/s12889-022-12873-y

Schuler, M. S., & Horowitz, J. A. (2020). Nursing students' attitudes toward and empathy for patients with substance use disorder following mentorship. *The Journal of Nursing Education, 59*(3), 149-153. doi: 10.3928/01484834-20200220-05

Scottish Governemnt (2016). *'What works' in drug education and prevention?* Retrieved from: http://www.edex.es/wp-content/uploads/What-works-in-prevention.pdf

Self, B., & Peters, H. (2005). Street outreach with no streets: in a new take on a proven program, a rural **st**reet nurse is taking an outreach program to the highways and byways of the B.C. interior, reaching people who otherwise might not have adequate access to services. *Canadian Nurse, 101*(1). 21-24.

Sharp, L. (2018). Medically supervised injecting centre in Melbourne will save lives. *The International Journal of Drug Policy*, *26*(2). 48-48.

Shier, M. L., & Turpin, A. (2017). A multi-dimensional conceptual framework for trauma-informed practice in addictions programming. *Journal of Social Service Research, 43*(5), 609-623. doi: 10.1080/01488376.2017.1364318

Sigfusdottir, I. D., Soriano, H. E., Mann, M.J., & Kristjansson, A. L. (2020). Prevention is possible: A brief history of the origin and dissemination of the Icelandic Prevention Model. *Health Promotion Practice*, *21*(1). 58-61. doi: 10.1177/15248399198863314

Simon, C. B., Klein, J. W., Bradley, K. A., & Oliver, M. (2021). Primary care patients with opioid use disorder have a high prevalence of pain and mental health and other substance use disorders. *Journal of General Internal Medicine. 36*, 1799-1801. doi: 10.1007/s11606-020-05820-3

Skewes, M. C., & Blume, A. W. (2019). Understanding the link between racial trauma and substance use among American Indians. *American Psychologist, 74*(1), 88-100. doi: 10.1037/amp0000331

Stancliff, S., Phillips, W. B., Maghsoudi, N., & Joseph, H. (2015). Harm reduction: Front line public health. *Journal of Addiction Diseases*, *34*(2/3). 204-219. doi: 10.1080/10550887.2015.1059651

Statistics Canada. (2019). *Police-reported crime statistics, 2018.* Retrieved from: https://www150.statcan.gc.ca/n1/daily-quotidien/190722/dq190722a-eng.htm

Stone, J., Fraser, H., Lim, A. G., Walker, J. G., Ward, Z., MacGregor, L., Trickey, A., Abbott, S., Strathdee, S. A., Abramovitz, D., Maher, L., Iversen, J., Bruneau, J., Zang, G., Garfein, R. S., Yen, Y.-F., Azim, T., Mehta, S. H., Milloy, M.-J., & Hellard, M. E. (2018). Incarceration history and risk of HIV and hepatitis C virus acquisition among people who inject drugs: A systematic review and meta-analysis. *Lancet Infectious Diseases, 18*(12), 1397-1409. doi: 10.1016/S1473-3099(18)30469-9

Sue, K. L. (2021). Supporting Any Positive Change: Harm Reduction as an Integral Pillar of Opioid Use Disorder Treatment. In S. E. Wakeman & J. D. Rich (Eds.), *Treating Opioid Use Disorder in General Medical Settings* (pp. 143-159). Springer International Publishing. doi: 10.1007/978-3-030-80818-1_10

Tarasuk, J., Zhang, J., Lemyre, A., Cholette, F., Bryson, M., & Paquette, D. (2020). National findings from the Track survey of people who inject drugs in Canada, Phase 4, 2017-2019. *Canadian Communicable Diseases Report. 46*(5). 138-148. DOI: 10.14745/ccdr.v46i05a07

Teodoro, I. P. P., Reboucas, V. C. F., Thorne, S. E., Souza, N. K. M., Brito, L. S. A., & Alencar, A. M. P. G. (2018). Intepretive description: A viable methodological approach for nursing research. *Escola Anna Nery. 22*(3). 1-8. Doi: 10.1590/2177-9465-EAN-2017-0287

Thorne, S. (2021). A tale of two pandemics. *Nursing Iquiry, 28*(2) 1-2. doi: 10.1111/nin12415

Thorne, S., Kirkham, S. R., & MacDonald-Emes, J. (1997). Intepretive description: A noncategorial qualitative alternative for developing nursing knowledge. *Research in Nursing & Health, 20*. 169-177. doi: 10.1002/(sici)1098-240x(199704)20:2<169::aid-nur9>3.0.co;2-i

Thorne, S., Kirkham, S. R., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods*. *3*(1). 1-11. doi: 10.1177/160940690400300101

Thorne, S., Stephens, J., & Truant, T. (2015). Building qualitative study design using nursing's disciplinary epistemology. *JAN. 72*(2). 451-460. doi: 10.1111/jan.12822

Tootle, W., Ziegler, J., & Singer, M. (2015). Individuals are continents; or, why it's time to retire the island approach to addiction. *Substance Use and & Misuse*, *50*. 1037-1043. doi: 10.3109/10826084.2015.1007684

Truth and Reconciliation Commission of Canada (2015). *Truth and Reconciliation Commission of Canada: Calls to Action.* Retrieved from: http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

Turner, S., Taillieu, T., Fortier, J., Salmon, S., Cheung, K., Afifi, T. O. (2018). Bullying victimization and illcit drug use among students in grades 7 to 12 in Manitoba. *Canadian Journal of Public Health*, *109*. 183-194. doi: 10.17269/s41997-018-0030-0

Tweed, E. J., Rodgers, M., Priyadarshi, S., & Crighton, E. (2018). "Taking away the chaos": A health needs assessment for people who inject drugs in public places in Glasgow, Scotland. *BMC Public Health*, *19*. 1-9. doi: 10.1186/s12889-018-5718-9

United Nations Office on Drugs and Crimes [UNODC] (2019). *2019 World Drug Report.* Retrieved from: https://wdr.unodc.org/wdr2019/

United Nations Office on Drugs and Crimes [UNODC] (2021). *2021 World Drug Report.* Retrieved from: https://www.unodc.org/unodc/en/data-and-analysis/wdr2021.html

United Nations Office on Drugs and Crimes [UNODC] and World Health Organization [WHO] (2018). *International Standards on Drug Use Prevention: Second Updated Edition.* Retrieved from: https://www.unodc.org/documents/prevention/standards_180412.pdf

Urbanoski, K., Pauly, B., Inglis, D., Cameron, F., Haddad, T., Phillips, J., Phillips, P., Rosen, C., Schlotter, G., Hartney, E., & Wallace, B. (2020). Defining culturally safe primary care for people who use substances: A participatory concept mapping study. *BMC Health Services Research*, *20*(1060). 1-12. doi: 10.1186/s12913-020-05915-x

Vancouver Area Network of Drug Users [VANDU], Western Aboriginal Harm Reduction Society [WAHRS], British Columbia Association People on Opiate Maintenance [BCAPOM], Maynard, R., & Jozahi, E. (2021). The drug war must end: The right to life,

liberty and security of the person during the COVID-19 pandemic for people who use drugs. *Harm Reduction Journal, 18*(21). 1-2. doi: 10.1186/s12954-021-00474-8

Vearrier, L. (2019). The value of harm reduction for injection drug use: A clinical and public health ethics analysis. *Disease-a-Month*, *65*. 119-141. doi: 10.1016/j.disamonth.2018.12.002

Vicknasigngam, B., Narayanan, S., Singh, D., & Chawarski, M. (2018). Decriminalization of drug use. *Current Opinion Psychiatry*, *31*(4). 300-305. doi: 10.1097/YCO.0000000000000429

Villar-Luis, M. A., & Rassool, G. H. (2004). Substance abuse in Latin American countries: Priorities, challenges, and actions. *Journal of Addiction Nursing*, *15*. 145-147, doi: 10.1080/108846004940491259

Villegas-Pantoja M. A., & Mendez-Ruiz, M. D. (2016). Nursing and substance use disorders in Mexico. *Nursing Sicence Quarterly*, *29*(2). 163-166, doi: 10.1177/0894318416630092

VIRGO Planning and Evaluation Consultants. (2018). *Improving Access and Coordination of Mental Health and Addiction Services: A Provincial Strategy for all Manitobans*. Retrieved from: https://www.gov.mb.ca/mh/mh/docs/mha_strategic_plan.pdf

Voon, P., Ti, L., Dong, H., Milloy, M.-J., Wood, E., Kerr, T., & Hayashi, K. (2016). Risky and rushed public crack cocaine smoking: The potential for supervised inhalation facilities. *BMC Public Health*, *16*(1). 1-9. doi: 10.1186/s12889-016-3137-3

Wallace, B., van Roode, T., Pagan, F., Hore, D., & Pauly, B. (2021). The potential impacts of community drug checking within the overdose crisis: qualitative study exploring the perspective of prospective service users. *BMC Public Health*, *21*(1156). 1-12. doi: 10.1186/s12889-021-11243-4

Wang, K., Burton, C. L., & Pachankis, J. E. (2018). Depression and substance use: Towards the development of an emotion regulation model of stigma coping. *Substance Use & Misuse, 53*(5), 859-866. doi: 10.1080/10826084.2017.1391011

Welsh, W. J., Hou, S. S.-Y., Shentu, Y., & Le Cook, B. (2018). Assessing the association between the strength of state policies on school drug prevention and substance use disorders. *Substance Use & Misuse*, *54*(4). 811-817. doi: 10.1080/10826084.2018.1544644

Wilkinson, R., Hines, L., Holland, A., Mandal, S., & Phipps, E. (2020). Rapid evidence review of harm reduction interventions and messaging for people who inject drugs during pandemic events: implications for ongoing COVID-19 response. *Harm Reduction Journal*, *17*(95). 1-10. doi: 10.1186/s12954-020-00445-5

Winnipeg Regional Health Authority [WRHA] (2016). *Position statement on harm reduction*. Retrieved from: http://www.wrha.mb.ca/community/publichealth/files/position-statements/HarmReduction.pdf

Winters, E., & Harris, N. (2020). The impact of Indigenous identity and treatment seeking intention on the stigmatization of substance use. *International Journal of Mental Health & Addiction, 18*(5), 1403-1415. https://doi.org/10.1007/s11469-019-00162-6

Zoom Video Communications Inc. (2022). *Security guide. Zoom Video Communications Inc*. Retrieved from: http://d24cgw3uvb9a9h.cloudfront.net/static/81625/doc/Zoom-Security-White-Paper.pdf

Appendix A

Letter of Permission

University of Manitoba | Rady Faculty of Health Sciences
College of Nursing

College of Nursing
Helen Glass Centre for Nursing
89 Curry Place
University of Manitoba
Winnipeg, Manitoba

Dear [insert name of director of organization]:

This letter is to request your permission and assistance in distributing an invitation to your staff in order to recruit participants for a qualitative research study, Addressing Drug-Related Harms: The Roles of Community Health Nurses, that I am undertaking as part of my Master of Nursing degree at the University of Manitoba. I am recruiting community health nurses with at least 6 months of work experience in their position in community health. For the purposes of this study, a CHN is a nurse who works in a community setting; however, a formal designation of 'CHN' is not required. Please see attached letter of invitation for more details about the research study.

If you agree to distribute the letter of invitation within your organization, please also provide any information regarding your process for granting research access to researchers.

If you have any questions about the research study or would like to discuss implications regarding research access, please feel free to call me on my cell phone or email me at decosseb@myumanitoba.ca. You may also contact my Academic Advisor, Dr. Benita Cohen, at Benita.cohen@umanitoba.ca.

This project has been approved by the Education and Nursing Research ethics board at the University of Manitoba. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator at 204-474-7122 o r humanethics@umanitoba.ca.

Thank you in advance,

Brigitte DeCosse RN, BN, MN student
Selkirk, MB

Appendix B

Letter of Invitation

University of Manitoba | Rady Faculty of Health Sciences
College of Nursing

College of Nursing
Helen Glass Centre for Nursing
89 Curry Place
University of Manitoba
Winnipeg, Manitoba

Dear Sir/Madam or Potential Participant:

This letter is to invite you to participate in a qualitative research study that I am undertaking as part of my Master of Nursing degree at the University of Manitoba. Drug-related harms have become a major public health concern in Canada. A noticeable rise in opioid-related harms as well as methamphetamine use have unfolded in the province of Manitoba and have increased during the COVID-19 pandemic. These trends have greatly impacted our community with many individuals and families experiencing harms, such as the loss of a loved one. Community health nurses (CHN) are well-positioned to address drug-related harms in their practice, but little is known about the nature of this practice in Canada.

The purpose of this study is to have a better understanding of CHNs' roles in addressing drug-related harms in a large urban region of Manitoba. CHNs' attitudes and beliefs about drug use, their current and potential roles in addressing this issue, and perceived barriers and facilitators that impact their roles will be explored. The impact of the pandemic on their work will also be explored.

If you have worked in your position as a CHN for at least 6 months, you are eligible to participate. For the purposes of this study, a CHN is a nurse who works in a community setting; however, a formal designation of 'CHN' is not required. Data will be collected using individual semi-structured interviews. Interviews will be conducted virtually, using Zoom video-conferencing software. If you agree to participate, an interview with you will be arranged at a time of your convenience and you will be provided with a consent form that you are asked to complete prior to the beginning of the interview. The interview will be approximately 45 minutes to one hour in duration. It will begin with several demographic questions followed by open-ended questions. A list of these questions will be sent to you electronically one week before the interview. You will also be offered the opportunity to review key findings from your interview after it has been analyzed.

If you wish to participate or have further questions about the research study, please feel free to call me on my cell phone or email me at decosseb@myumanitoba.ca. You may also contact my Academic Advisor, Dr. Benita Cohen, at Benita.cohen@umanitoba.ca. Please note that the individual who provided you with this invitation will not know if you have chosen to participate in this study.

This project has been approved by the Education and Nursing Research ethics board at the University of Manitoba. If you have any concerns or complaints about this project you may

contact any of the above-named persons or the Human Ethics Coordinator at 204-474-7122 or humanethics@umanitoba.ca.

Thank you in advance,

Brigitte DeCosse RN, BN, MN student

Selkirk, MB

Appendix C

Notice for Community Health Nurses of Manitoba

University of Manitoba | Rady Faculty of Health Sciences
College of Nursing

College of Nursing
Helen Glass Centre for Nursing
89 Curry Place
University of Manitoba
Winnipeg, Manitoba

Attention all community health nurses:

If you have worked in your position as a community health nurse in Winnipeg for at least 6 months, you are eligible to participate in the following qualitative research study:

Study background:

Drug-related harms have become a major public health concern in Canada. A noticeable rise in opioid-related harms as well as methamphetamine use have unfolded in the province of Manitoba. These trends have greatly impacted our community with many individuals and families experiencing harms, such as the loss of a loved one. Community health nurses (CHN) are well-positioned to address drug-related harms in their practice, but little is known about the nature of this practice in Canada.

Purpose:

The purpose of this study is to have a better understanding of CHNs' roles in addressing drug-related harms in a large urban region of Manitoba. CHNs' attitudes and beliefs about drug use, their current and potential roles in addressing this issue, and perceived barriers and facilitators that impact their roles will be explored.

Methods:

Data will be collected using individual semi-structured interviews. Interviews will be conducted virtually, using Zoom video-conferencing software. The interview will be approximately 45 minutes to one hour in duration.

If you would like to receive further information about the study, please contact Brigitte DeCosse by cell phone or email at decosseb@myumanitoba.ca. You may also contact her Academic Advisor, Dr. Benita Cohen, at Benita.cohen@umanitoba.ca.

This project has been approved by the Education and Nursing Research ethics board at the University of Manitoba. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator at 204-474-7122 or humanethics@umanitoba.ca.

Appendix D

University of Manitoba | Rady Faculty of Health Sciences
College of Nursing

College of Nursing
Helen Glass Centre for Nursing
89 Curry Place
University of Manitoba
Winnipeg, Manitoba

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM: INDIVIDUAL INTERVIEW

Addressing Drug-Related Harms: The Roles of Community Health Nurses

Principal Investigator:
Brigitte DeCosse RN, BN
Graduate Student
Selkirk, MB
Email: decosseb@myumanitoba.ca

Academic Advisor:
Dr. Benita E. Cohen RN, PhD
Associate Professor
College of Nursing, Faculty of Health Sciences
University of Manitoba
381 Helen Glass Centre for Nursing
89 Curry Place, Winnipeg, MB, R3T 2N2
Email: Benita.Cohen@umanitoba.ca

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of this Study

This research study is being conducted to explore community health nurses' (CHN) perspectives of their roles in addressing drug-related harms in a large urban region of Manitoba. Attitudes and beliefs about drug use, their current roles, and potential roles in addressing this issue, and perceived barriers and facilitators that impact their roles will be explored.

Participants Selection

You are being asked to participate in this study because you have at least 6 months of experience working as a CHN in the community setting and will be able to provide important insights about the topic of this study.

Study procedures

- The method of data collection for this study will be individual interviews.
- Interviews will be conducted virtually using Zoom video-conferencing software.

- Hand-written field notes will also be taken by the researcher during interviews.
- Participation in the study will be for approximately 45 minutes to an hour.
- The principal investigator will be conducting the interviews.
- You will be asked some questions relating to your experiences and perspectives around drugs, your roles, and your visions in addressing drug-related harms. These questions will help us to better understand CHNs' perspectives about drugs, their roles and visions in addressing drug-related harms.
- The interviews will be audio-recorded, and the recordings will be transcribed by a professional transcriber to ensure accurate reporting of the information that you provide.
- The transcriber will sign an Oath of Confidentiality form stating that they will not discuss any item on the recording with anyone other than the researcher and her academic advisor.
- Study records (audio-files and transcripts) will be stored and accessed in a password protected shared drive by the researcher and her advisor during the study. After the study is completed, these records will be transferred to an encrypted USB key and kept in a locked file cabinet and office in the College of Nursing and destroyed within 3 years. All study records on the shared drive will be permanently deleted when the study ends.

Risks and Discomforts

This study poses minimal risk to you in your every day lives. You can refuse to answer any questions during interviews. Risks include confidentiality breach. This risk will be reduced by ensuring there is no identifiable information linked to you in reported findings, including within direct quotations. However, due to the small number of participants required for this study, anonymity cannot be completely guaranteed in the reporting of findings. Lastly, data will be properly and securely managed and stored.

Costs

There is no cost to you to attend the individual interview.

Confidentiality

Every effort will be made possible to keep your personal information confidential. Your name will not be used at all in the study data you provide. Instead, you will be asked to choose a preferred pseudonym and to avoid choosing a name of any other CHN in your agency or any other agency (that you are aware of). Real names, the matching pseudonyms, and contact information of participants will be kept in a secure file separated from the data collected. This information will be used to send you a summary report of the results of the study and to identify which data you have provided if you wish to correspond about the data provided. Results from this study will also be disseminated during a thesis defense and will be uploaded to MSpace for thesis submission. Results of this study may also be presented in a conference or publication. Your words may be quoted to highlight a specific point; however, no identifying information will be used in any reports and presentations. Any distinguishing details which may reveal your identity, work site, or identity of people spoken about during interviews will not be reported. Please be aware that, due to the small number of participants required for this study, anonymity cannot be completely guaranteed in the reporting of findings. Lastly, data will be properly and securely managed and stored. The collection and access to personal information will be in compliance with provincial and federal privacy legislations.

Transcribed audio-recordings will be used to prepare a thesis and other reports. All study records (audio-files, transcripts, electronic files and handwritten notes) will be kept for up to 3 years after the end of the study in a secure locked file cabinet and office. Only the principal investigator and her advisor will have access to them and know your name.
Some people or groups may need to check the study records to make sure all the information is correct. All of these people have a professional responsibility to protect your privacy.
These people or groups are:

- The Education and Nursing Research Ethics Board of the University of Manitoba which is responsible for the protection of people in research and has reviewed this study for ethical acceptability
- Quality assurance staff of the University of Manitoba who ensure the study is being conducted properly

All records will be kept in a locked secure area and only those persons identified will have access to these records. No information revealing any personal information such as your name, address or telephone number will leave the University of Manitoba.

Permission to Quote:
We may wish to quote your words directly in reports and publications resulting from this. With regards to being quoted, please check yes or no for each of the following statements:

Researchers may publish documents that contain quotations by me under the following conditions:	
☐ Yes ☐ No	I agree to be quoted directly if a made-up name (pseudonym) is used.

<u>Voluntary Participation/Withdrawal from the Study</u>
Your decision to take part in this study is voluntary. You may refuse to participate, or you may withdraw from the study without negative consequence to you by contacting the researcher. The deadline for withdrawal will be 30 days after your interview.

<u>Questions</u>
If any questions come up during or after the study, contact the principal investigator at the above-mentioned contact information. For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389

Consent:
Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study within the 30-day deadline and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Education and Nursing Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator at 204-474-7122 or humanethics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

Participant signature: _____ Date _____
(day/month/year)

Participant printed name: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent

Printed Name: _____ Date _____
(day/month/year)

Signature: _____

Role in the study: _____

Please provide your contact information below if you would like to receive a summary report of the study findings via Canada Post or electronically within 12 months of the end of the study:

Email: _____ and/or address: _____

Appendix E

Interview Questions

Demographic Questions:

- What is your age range?
  a) under 35 years old
  b) between 36 and 55 years old
  c) Over 56 years old
  d) Prefer not to say

- What is your gender?
  a) Male
  b) Female
  c) Other
  d) Prefer not to say

- What is your ethnicity?
- What is your level of education?
- What is your setting of practice?
- How many years of experience do you have working in community/public health/primary care?
- What geographical area do you serve?
- Do you provide harm reduction services?
- Have you received training in your workplace on the following: trauma-informed care, cultural safety, harm reduction?

Open-Ended Questions:

For the following open questions, the term drugs are referring to illegal drugs and non-prescriptive drug use and the term drug-related harms is referring to direct harms (i.e., overdose, death) and indirect harms (blood-borne infections, stigma, and violence).

1. What are your perspectives on drug use?
   - What were your thoughts of drugs before starting their nursing career?
   - What is your own experience with drugs and how did this shape your current views?
   - How do you perceive the "problem" or key issues around drugs?
2. What are your current roles in addressing drug-related harms in your practice?
   - In what ways do you currently address drug-related harms?
   - What are the factors that are facilitating/inhibiting your role(s) in addressing drug-related harms?
   - How has the COVID-19 pandemic impacted these roles?
3. What is your vision regarding your potential role(s) in addressing drug-related harms?
4. Is there anything else you would like to add before we end this interview?

Appendix F

University of Manitoba | Rady Faculty of Health Sciences College of Nursing

College of Nursing
Helen Glass Centre for Nursing
89 Curry Place
University of Manitoba
Winnipeg, Manitoba

Oath of Confidentiality

I, _____(PRINT NAME),

_____(PRINT ROLE: transcriptionist), agree to maintain full confidentiality with regard to any and all research-related documentation (e.g., transcripts; master list of participants, their contact information and code names; analytical notes) or other products (e.g., audio-recordings) related to the study: *Addressing Drug-Related Harms: The Roles of Community Health Nurses*. More specifically, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-recorded interviews, or in any associated documents;
2. To not make copies of any audio-recordings or computerized files of the transcribed interview texts;
3. To store all study-related digital audio-files, and materials in a safe, secure location as long as they are in my possession;
4. To return all digital audio-files and study-related documents to the Principal Investigator, Brigitte DeCosse, in a complete, secure, and timely manner after I no longer require them.
5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audio-recordings and/or files to which I will have access.

Name (printed) _____

Signature _____

Date: _____