ORIGINAL RESEARCH

Beyond "Meeting Them Where They Are At": How nursing students conceptualize harm reduction in their practice with people who use drugs

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ABSTRACT

Background and objective: All nurses encounter people who use drugs in their practice and their conceptualization of harm reduction can have a significant impact on health outcomes for this population. It is not known how nursing students conceptualize harm reduction within their practice, and what influences their development, perspective, and support of the concept. In this study, we explore how final year nursing students have conceptualized harm reduction as a part of their practice with people who use drugs.
Methods: Purposive sampling was used to recruit 11 nursing students for face-to-face interviews. The study was informed by a critical social theory lens and data were analyzed using thematic analysis.
Results: Three themes and nine sub-themes were identified. Participants believed that harm reduction was congruent with nursing practice. Contextually, participants navigated personal beliefs and experiences to understand harm reduction and nursing care for people who use drugs. Participants also negotiated systems and power dynamics, which formed a critical backdrop against which participants discussed beliefs related to harm reduction and care for people who use drugs.
Conclusions and implications: Successful conceptualization of harm reduction involves more than cognitive learning. Four recommendations are offered for educators to explore and prioritize educational approaches that support harm reduction as nursing practice to enable better care for people who use drugs.

Key Words: Harm reduction, Nursing education, Health care, Illegal drug use, Social care

1. INTRODUCTION

People who use drugs (PWUD), or people who use psychoactive substances in a non-prescribed manner, are encountered by registered nurses (RNs) in diverse practice settings. As a result, RNs' conceptualization of harm reduction (HR) can have a significant impact on health outcomes for this population.[1] Teaching HR in undergraduate nursing education is one way to equip nurses with knowledge about HR. We present the findings of a qualitative study that explored how final-year undergraduate nursing students at a western Canadian university conceptualized HR in their practice with PWUD. This thematic analysis[2] was informed by a critical social theory lens.

2. BACKGROUND AND LITERATURE REVIEW

HR is a concept that is increasingly applied in healthcare and social services, as well as law and policy development around the world. Broadly, HR can be interpreted as any

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approach that aims to reduce risk, promote safety, and prevent disease or disability, such as the use of seatbelts and helmets to reduce trauma resulting from collisions, sunscreen to reduce risk of sunburn and skin cancer, or condoms for the prevention of unplanned pregnancy and the transmission of sexually transmitted infections. The primary application of the concept of HR, however, is to minimize the risk of harms related to substance use. The use of the term "substance use" in this context is synonymous with "drug use" and refers to the non-prescribed use of legal and illegal psychoactive substances including pharmaceuticals. Substance use harms may be health-related, such as soft-tissue infections or the transmission of human immunodeficiency virus (HIV) and other blood borne pathogens; social, in that death or disability as a result of drug use affects families and communities; or economic and legal, in that a community struggling with substance use can experience tremendous harm related to justice system involvement, unemployment, theft, and violence.[1]

In trying to conceptualize HR, Hawk et al.[3] identified six principles of HR relevant to healthcare settings: humanism, pragmatism, individualism, autonomy, incrementalism, and accountability without termination (that is, patient cannot be "fired" from care for not achieving their goals). They argued that HR can be a universal precaution applied to anyone seeking care, not only those who disclose drug use, and these principles are closely related to those described by Harm Reduction International.[4] Kerber et al.[5] posited that HR care in a nursing context is characterized by an emphasis on safety, supplies, education, partnerships, and policy. A concept analysis by Denis-Lalonde et al.[6] defined HR as having seven key attributes: a focus on harms, the participation of PWUD, the promotion of human rights, a public health approach, value neutrality and non-judgment, practicality and pragmatism, and innovation and adaptability.

Though not an exhaustive list, some examples of established and emergent drug-related HR interventions include supervised consumption services, distribution of sterile drug use supplies, distribution of naloxone kits and education to prevent opioid poisoning, methadone and other opioid substitution therapies, drug checking services (pill/powder testing), and education about safer drug use.[7] While addiction treatment is a critical piece of care, it is not a realistic or desirable option for all PWUD, and HR approaches provide further health promoting options for these individuals without expectation that they will eventually begin treatment towards abstinence.[8] For example, a stably employed individual who developed an opioid dependency following an injury may not want to start a treatment program which could require them to lose several weeks of wages, or to become unemployed after disclosure to their employer. A HR approach for this individual would include safer drug use and overdose prevention education, as well as naloxone training and supplies, and possibly a referral to an opioid replacement therapy program that allows the person to continue using while minimizing risk of harm. A HR approach also recognizes the immense and ongoing personal, social, and economic impact of substance use, and presents a pragmatic way of reducing this impact for those for whom treatment is not a realistic or long-term solution. For example, providing opioid substitution therapy to someone experiencing chronic heroin addiction not only reduces the risk of accidental lethal overdose, it also reduces that person's need to finance their drug use through theft and violence, which harms the community and increases the risk of justice system involvement.[9,10,10]

Among the scientific, public health, and social policy communities, people hold strong ideas about addiction and substance use, and there are many misconceptions about HR.[11] Hyshka et al.[12] identified that HR policies governing health services are conceptually weak across Canada. They argued that "by endorsing harm reduction in name, but not in substance,"[12] these policies communicate to stakeholders a lack of support for HR and create barriers to expanding HR services. HR can be practiced by health and social care providers (HSCP) in diverse settings. This includes but is not limited to: nurses, nursing students, social workers, physicians, psychiatrists, medical students, pharmacists, outreach workers, and peer workers; however the lack of agreed-upon frameworks and policies for HR across disciplines has allowed for "harm reduction [to] mean many things to many people."[13] As such, little is known about nursing students' conceptualization of HR prior to entering practice, nor what factors might contribute to the development of this conceptualization.

3. METHODS

In this study, we sought to understand the conceptualization of a politicized social justice concept (HR care for PWUD) among final-year nursing students. Education and learning as well as the contexts in which nurses meet PWUD are influenced by considerations of power, language, and professional and social processes. In addition, perspectives on substance use and PWUD are ideology-laden and deeply rooted in sociocultural constructs. A critical social theory lens informed by Habermas[14,15] was used to explore this topic in a broad sociopolitical context and to expose issues that may otherwise remain hidden. Critical theory approaches have previously been employed while studying HR.[16] Embodying critical reflexivity (participant and researcher self-reflection) and engaging with the Habermasian theory of communica-

tive action (discourse free of authoritarian forces) throughout the data collection and analysis process were key facets of this critical nursing research. Ethics approval for this study was granted through the Conjoint Health Research Ethics Board (REB19-0655).

Purposive sampling was used to recruit 11 nursing students in the fourth and final year of their program at a university in Western Canada. Inclusion criteria included self-reported fluency in English and an anticipated program completion date of Spring 2020 or earlier. Prior professional, personal, or volunteer experience related to HR or substance use did not affect eligibility. There were no exclusion criteria. Participants selected their own pseudonyms for use in any publication and their demographics and characteristics are presented in Table 1.

Table 1. Participants demographics and characteristics

Gender (self-reported)	Female	10
	Male	1
	Other	0
Age in Years	21-22	5
	23-26	3
	27-44	3
Ethnicity*	White/Caucasian	10
	Other	2
Previous Post-Secondary Education	None	5
	Undergraduate coursework	3
	Degree, diploma, certification	3
Anticipated Areas for Practice After Graduation†	Acute Care (includes medicine, critical care, emergency, NICU, cardiology, pediatrics, internal medicine, labour and delivery, acute care)	9
	Women's Health (includes sexual health, perinatal, reproductive health, women's health)	3
	Community Health	2
	Mental Health	1

*Participants could self-report more than one ethnicity. †Most participants indicated more than one anticipated area of practice.

Data were collected using a semi-structured interview guide (see Appendix A) conducted by the first author in the fall of 2019. The interviews were audio-recorded and then transcribed using machine learning-powered software. Each transcript was reviewed for accuracy and anonymized before being shared with the participant via encrypted email. Ten participants reviewed their transcripts and provided comments and feedback; none opted to redact or retract their transcript.

Data were coded using Nvivo 12 and analyzed according to Braun and Clarke's[2] six stage thematic analysis (TA) method (see Figure 1). The themes were actively created through a process of reflexive engagement to provide a subjective, interpretive, and compelling account of the data.[17]

4. Results

Three themes and nine sub-themes were developed. The concentric ovals in the thematic map (see Figure 2) represent the three themes involved in participants' conceptualization of HR. Interplay between the themes is indicated by the dotted lines around the innermost two ovals. As such, the smallest one, which refers to the understanding of the concept of HR (conceptual), is being influenced by the social context of the participant (contextual). These are both being influenced by critical societal issues, indicated by the final and largest oval (critical). There were no significant outlying perspectives.

4.1 Theme 1 - Conceptual: Knowing harm reduction is nursing practice

In the innermost circle, the first theme indicates that conceptually, participants readily connected HR with nursing practice and expressed a reasonably developed understanding of the concept. Two sub-themes further delineate how participants connected HR to nursing.

4.1.1 *Harm reduction is congruent with nursing concepts*

Participants recognized that HR and nursing practice share many key concepts and thus felt the two were intrinsically connected at a theoretical level. "I think it comes down to just how we're taught things and [. . .] the client-first kind of approach, just sort of leads to harm reduction I think quite naturally" (Ally).

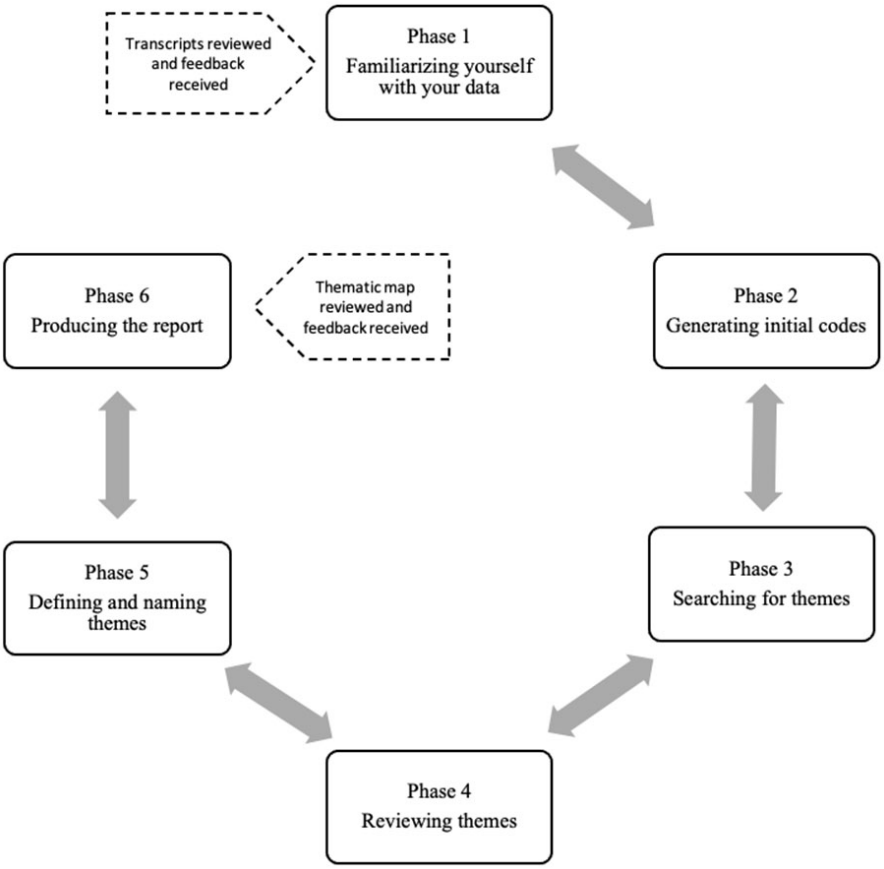

Figure 1. Thematic analysis process adapted from Braun and Clarke[2]

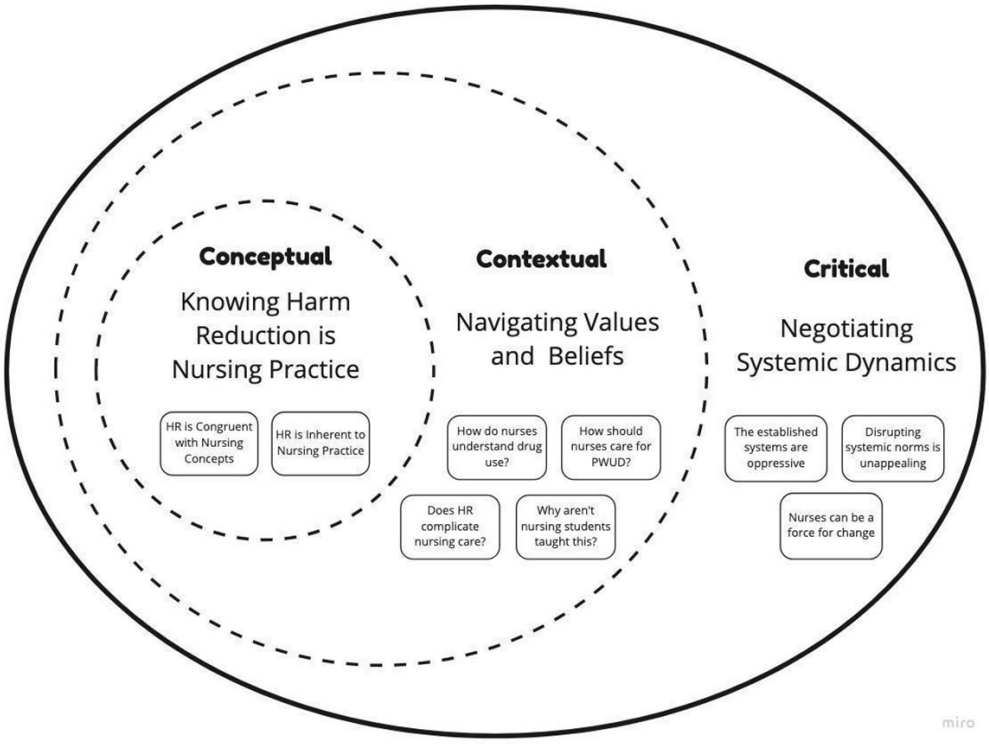

Figure 2. Thematic map

Participants easily found similarities between nursing practice and HR, including an emphasis on patient safety - "we practice safety all the time" (PC) - and nursing interventions for population health promotion and disease prevention: "I definitely think harm reduction falls under the category of health promotion. Because promoting safe drug use, promoting safe sex, all of those things, promoting safety measures for activities, they all fall under promoting population health" (Julian). In addition, participants felt that trust and relationship-building, nonjudgement, advocacy, and education were also integral concepts of both HR and nursing practice. One participant, Molly, used a well-known HR phrase "meeting them where they're at" to describe the client-centred approach that is central to nursing care.

4.1.2 *Harm reduction is inherent to nursing practice*

As participants explored how HR relates to nursing practice, they spoke in ways that suggested they saw HR as "inherent to [their] understanding of the profession" (Ally). They discussed that while the term HR itself might be newer to the nursing vernacular, it was an extension of concepts expressed by established nursing language, such as health promotion and "upstream interventions" (Julian). "I think it's been around and around, the whole concept of rehabilitation, meeting people where they are, and building or just being a guardian of safe passage" (Beverly). Participants recognized that nurses have been practising HR for a long time in contexts well beyond substance use and addiction. Unprompted, they conceptualized HR in the context of other activities involving risk, such as sex and sex work, and some discussed how everyday risk reduction strategies might be considered HR such as the use of helmets and seatbelts.

In a recent Canadian survey, when nursing students were asked to select between opposing statements, most respondents selected the statement consistent with a HR approach despite their limited exposure to the concept.[18] This echoes the participants' recognition that HR is applicable to a wide variety of behaviours (or conditions) that carry risk, and that trying to reduce the risk of harm is essential to nursing practice.

4.2 Theme 2 - Contextual: Navigating beliefs

The second theme involves contextualization, that is, how participants navigated their socially constructed values, beliefs, and experiences related to drug use and the people who use them, HR, and nursing as a profession. Although navigating beliefs is an internal process, it is based on what participants experience externally, such as witnessing poor treatment of PWUD or being personally affected by the drug use of a friend or family member. The explicit and implicit questions participants asked often highlighted tensions in how participants conceptualized HR within their professional practice.

4.2.1 *How do nurses understand drug use?*

Participants seemed to grasp that addiction and drug use are multifaceted, complex issues, yet they expressed beliefs that seem incongruent with their understanding. For example, participants felt that poor decision-making played a persistent role in problematic drug use while also viewing addiction as a biological brain disease or illness "that needs to be managed like any other illness" (Elizabeth). Participants said that despite the narrative that addiction is an inevitable outcome of drug use when combined with psycho-social challenges (e.g., poverty, homelessness, or other trauma) they recognized that PWUD often do exercise choice and autonomy. Participants consistently described addiction in terms of powerlessness and loss of control yet shared examples of PWUD exercising agency in their choices; navigating this contradiction seems to be at the core of the complexity and ambiguity of providing nursing care for PWUD.

4.2.2 *How should nurses care for PWUD?*

Participants shared many stories that demonstrated judgement and discrimination from HSCP towards PWUD. Participants tried to reconcile what they had observed with how they wanted to practice. "Some of the language that I've heard has been quite harsh from other nurses." (Elizabeth) When they observed nurses caring for PWUD with "not the kindest approach" (Tea), participants described feeling shame and guilt for not meeting the expectation that nurses be empathetic, kind, and client-centred in their approach. Some participants witnessed overt judgment, stigma, and discrimination towards PWUD: "They weren't even giving him the time of day to have a basic conversation with him about his life. Like he's just being discounted as a person" (Elizabeth).

The use of stigmatizing language by HSCPs may impede the development of effective therapeutic relationships with PWUD, reducing positive health outcomes for this population.[19] Several participants worried about the impact stigmatizing attitudes could have on patient care, up to withholding care entirely or at least fueling antagonistic attitudes between PWUD and "the system" (Julian). "I heard them say 'don't you take any crap from him', right in report [at shift change], 'don't take any abuse from him', so harshness was met with harshness" (Beverly). Julian believed that the concerns of PWUD are often not taken seriously because everything is assumed to be a consequence of their drug use.

4.2.3 *Does HR complicate nursing care?*

Participants perceived that HR care could be "complicated", "uncomfortable", "tricky", "challenging", "frustrating", and

"difficult". They felt that HR initiatives create ambiguity in expected outcomes and disrupt established care routines. HR requires shifting from a goal of controlling outcomes for PWUD towards viewing substance use as complex and addiction as a relapsing and chronic condition.[20,21] An example that was provided by a participant is a patient who is admitted to acute care and then continues to inject drugs despite the health care team's advice and best efforts to prevent them from doing so. This patient is perceived as disrupting care and may not "get better" in a way that would be satisfactory to the health care team.

Many participants discussed potential ethical concerns and moral distress when providing HR care to PWUD. Nursing students are well-versed in health promotion and want to feel like they are helping solve people's health concerns. "We know what's healthy for the body. And we want, in the best interest of the patient, for them to be dry, for them to be clean" (Ally). Participants express how difficult it would be to set aside their nursing-driven ideas of what they perceived to be best for the person in favour of taking a patient-driven approach: "I don't know where the line is" (Molly).

Controversy around HR often stems from a concern that the concept somehow enables or condones drug use[22] and HSCPs may consequently experience moral distress taking a HR approach with their patients. They may feel tension between doing what they feel is right for PWUD, while contending with prohibitionist drug policies and anti-drug ideologies.[20] In HR care, nurses and PWUD may not agree on care goals, and this could "take an emotional toll" (Julian) and lead to "a bit of burnout or a feeling of hopelessness" (Ally).

4.2.4 *Why aren't nurses taught this?*

Participants voiced that there was limited exposure to PWUD, HR, and substance use information in their nursing education. As Elizabeth explained, "most of our education is based on preventing using drugs [. . .] and even the stuff we have on treatment of addiction, it's the recovery model." Participants expressed wanting to learn more about the effects of drug use and what to look for during nursing assessment. They disclosed discomfort with not knowing which drugs are considered "downers" or "uppers" and how various drugs relate to patient behaviour and long-term health.

The literature also suggests that the preparation of nursing students warrants examination. In a survey of nursing students across Canada (n = 329), 20% of respondents stated they received no substance use education, while 43% stated they had received 1-5 hours.[18] More than half of respondents reported that they did not have working knowledge of illegal substances, and only 18% felt they had enough knowledge of illegal substances to effectively perform their role as nurses.[18]

In a British Columbia Centre for Disease Control assessment, only 42% of nurses were extremely comfortable with their substance use knowledge compared to 75% of (self-identified) frontline workers.[23] Participant Molly described feeling very unprepared to support a patient in her clinical placement: "one of my first experiences in the hospital was like, all right, this person's going through [alcohol] withdrawal. Now what? We didn't really cover this a ton in school. I don't know what to do." Researchers have consistently found inadequate knowledge and comfort with HR among HSCPs and identified a need for HR training specific to the provider's role and setting to enhance their knowledge and address attitudinal barriers to HR practice.[24,25]

This reported lack of knowledge and training reduces the quality of nursing care and may communicate to nurses that they do not need to know about care needs of PWUD. For example, Molly sarcastically noted that health care providers might think "oh well, if it was that important, maybe I would have learned it in school." Ricky felt that this curriculum gap was a result of judgemental perspectives held by faculty: "Why would we waste precious education time on someone who chose to do this to himself anyway? I never think that would be explicitly stated by anyone developing curricula or anything, but I think it's implicit enough." Participant JB felt that addiction, let alone HR, is still a stigmatized topic within the faculty and there would be benefits to having open conversations about drug use and the care of PWUD during the program. Opposition to HR is fuelled by stigma and discrimination towards PWUD, and HSCPs (including educators) are not immune to negative and stigmatizing views of PWUD.[26,27] Notably, a review of 30 years of research on attitudes towards PWUD suggested that nurses were found to be more judgemental than other HSCPs, though contributing factors were not discussed.[28]

In addition, participants felt that they did not have enough direct exposure to PWUD to feel competent and confident in their final year of nursing school. PWUD were viewed by instructors and staff nurses as undesirable patient assignments and poor learning opportunities for students. One participant was told that a patient was "not worth making your care plan about, because when he leaves, he's just going to use meth again" (Elizabeth). In contrast, participants felt there was a lot to learn from PWUD and that direct exposure would be more effective than a lecture on these topics. It has been suggested that education in substance use and addiction should include not only subject knowledge and skill development, but also real-world experience and exposure to

complex ethical issues.[29]

4.3 Theme 3 - Critical: Negotiating systemic dynamics

The final theme and outermost circle in the thematic map (see Figure 2) refers to the ongoing negotiation of systemic forces that influence participants' actions and perspectives towards HR and the nursing care of PWUD.

4.3.1 *The established systems are oppressive*

Participants reported a multitude of oppressive hierarchies and power dynamics in practice settings that led them to feel powerless as students entering professional nursing practice. Participants shared many stories about HSCPs lacking knowledge about HR or compassion for PWUD. While participants visibly cringed while relaying these anecdotes, they seemed reluctant to recognize their agency in these practice situations. Ricky expressed this as "know your role and shut your hole" while Elizabeth stated that "parts of us are a bit angry about the things that we see and that we have no power over changing as students." It becomes evident that nurses are taught to conform early on in their professional careers. Several intersecting factors made participants reluctant to challenge established systems, despite awareness that their hesitancy reinforces these power dynamics and the current systemic discrimination faced by PWUD. As described by participant Tea, "I think sometimes [women] don't always feel comfortable to speak and so we don't do so. And we kind of just wait and hope somebody else will say it. But I think that's not doing anybody any favours."

Along with the shame, guilt, and anger expressed by participants, there were significant insights into how and why outdated ideas and stigmatizing attitudes towards PWUD persist today. Ricky stated that people have been "simmered in that sauce for a long time." This includes nursing faculty members and instructors, which he felt had a "filtering effect of trending towards the status quo, [. . .] and not really thinking outside the norm enough," which deters students and new nurses from critically engaging with practices or perspectives perceived to be problematic or controversial.

4.3.2 *Disrupting systemic norms is unappealing*

Participants felt that taking on socio-political challenges such as HR advocacy would be unrealistic and undesirable. Elizabeth wondered "how am I going to remember that I want to make change when it's really hard just doing my job?" At the intersection of the reality of an understaffed healthcare system and this technological age where all crises are widely broadcasted and politicized, it is not surprising that participants reported feeling overburdened and under supported. "It's overwhelming right now because anywhere you look, there's like, this is a problem. This is a problem. This is a problem." (PC).

Participants were concerned about the lack of government support and funding for controversial and polarizing work. Beverly described politicians wanting to present their policies with "beautifully wrapped bows" but that a HR approach for PWUD does not provide that type of image-enhancing political opportunity. For similar reasons, participants described reluctance to vocally support HR. While many participants expressed wanting to be advocates for HR and for the care of PWUD, they also felt this might invite unwanted negative attention; "if you bring this up to certain people, I'm sure you'll get in an argument" (Wonder Woman). Participants recognized that HR and the care of PWUD might elicit challenging discussions and felt trepidation about taking this on: "I think I'll just feel comfortable or get to the point where I start feeling more comfortable with [having difficult conversations]. But I have to start. I should start now. I could start now" (Tea). Much of the participants' hesitancy to be "disruptive" to the status quo seemed to stem from the fear associated with their impending transitions to independent nursing practice.

Jessica felt that HR care could have a significant impact on patients and should be prioritized but was reluctant to follow through in her independent practice after she was advised by an instructor to "cover your ass" and focus on following orders. Another participant thought very few of their colleagues "spend any kind of time seriously thinking about [affecting policy change]" (Ricky) and thus it would not be realistic to expect students and new nurses to take on these larger responsibilities in the first place. As for themself, Ricky said,

I feel like that's going to be the biggest challenge, just trying to find that middle path, like trying to find where I'm going to be able to go to sleep at night thinking that I've actually done something, and not just like, totally alienating myself from a new environment, because I'm a disruptor or whatever, right?

4.3.3 *Nurses can be a force for change*

Despite the apprehension participants felt about their readiness to challenge systems they felt to be oppressive and problematic, participants also believed that nurses could lead change if they were willing to recognize and use their power as a professional collective. As a highly trusted profession, participants felt that the nursing profession has political power, and that this comes along with stewardship or a "sense of responsibility to see the flaws in the healthcare system" (Tea). Several participants expressed a desire to see nurses engaging in advocacy work and become more politically active, although many were unsure of existing RN representation in this area: "How many RNs are there in politics? I

don't know the answer to that, but I feel like that's just not a career path that many [nurses] think of" (Ally).

Despite the challenges faced by participants and more specifically in the field of HR, participants also described themselves to be hopeful, resilient, and persevering. Nursing students clearly are being exposed to bigger ideas about political advocacy and systemic change, and while they may not feel it is immediately applicable, there is evidence that it has become part of their professional identity. "I think that there's a massive role for nurses in that kind of [advocacy] work. I think it's one of the things they address in the program that there is an ability for nurses to be change agents on a larger scale" (Ricky). Most participants had internalized this to some degree and felt it was both intrinsic and necessary to the role of an RN.

Although participants felt that their nursing organization and governing body should be partially responsible for advocating for HR and issues specific to the health of PWUD, there was greater emphasis on the individual nurse's role: "we have to be on board and talking about [HR] with our friends and talking about it with our fellow nurses" (PC). While this grassroots-style approach can be very effective, participants did not seem confident in their professional nursing organizations to support or encourage this work.

5. DISCUSSION

Participants' conceptualization of HR was shaped by their academic knowledge on the topic and by their personal and professional beliefs about HR and PWUD. Throughout our analysis we found that students experienced significant tensions and often held contradictory views.

5.1 Thinking about power

Beyond their individual contexts, participants navigated systems, structures, and social dynamics related to their profession, HR, and the care of PWUD. They identified themselves as agents of change, but were hesitant to challenge norms, institutions, and power structures. While participants espoused the importance of nursing organizations' political representation to affect social change, most continued to place responsibility on individual nurses, including themselves, and were thus overwhelmed.

Participants also acknowledged contending with multiple systems they perceived to be oppressive to students, to nurses, and particularly to nursing students. As they negotiated these systems and hierarchies, participants felt overwhelmed and were apprehensive to consider being leaders or agents of change. They did, however, identify advocacy as a key aspect of nursing practice, but felt there was a lack of support and representation for nurses engaging in political action and/or advocacy work.

From a critical social theory lens, the role of social constructs and ideologies in the formation of knowledge for students cannot be overlooked. While many authors have concluded that nursing and HR practice are inherently political arenas,[22,30–32] attempting to unilaterally enforce an ideology may create division among professionals and counterproductively perpetuate discriminatory and exclusionary practices towards PWUD. Anderson et al.[33] described an imperative to "make visible the mutually constitutive social processes that shape individual experience." Ensuring that nurses' knowledge is constructed within this social and individual context will help provide insights into how health inequities are manifested,[33] without essentializing any singular narrative or viewpoint. This contextualized knowledge would be particularly valuable for nursing students as they think about and experience issues of power in their practice.

5.2 Experiences of tensions

Participants described HR conceptually and applied it to nursing practice on a theoretical level. This finding is surprising considering the limited exposure they reported receiving in their undergraduate education about the concept. Most expressed a desire to have learned more about substance use, HR, and the healthcare needs of PWUD during their education. Many authors have described how HR practice is congruent with Canadian Code of Ethics[1,34–38] and entry-to-practice competencies,[39–41] and yet tensions persist about HR and the care of PWUD. As many authors have indicated, undergraduate nursing education content related to substance use has been largely stagnant,[42,43] and most students reported feeling unprepared to practice HR or care for PWUD.[18,44–47] When participants expressed tension or discomfort with HR, it was when they attempted to contextualize the concept within their own lived experiences and personal beliefs. Participants at times expressed discomfort, uncertainty, and cognitive dissonance with some ideas, verbally or otherwise.

5.3 The necessity to unlearn

While most participants felt they would have benefited from additional content related to drug use in their undergraduate education and more opportunities to care for PWUD in their clinical placements, it is apparent that their perspectives about HR and PWUD had been shaped prior to academic education; therefore, there is a need to unlearn. Several researchers have demonstrated that course-based learning seems to change the attitude of HSCPs towards HR and PWUD, however they note that it is unclear whether this

translates to lasting changes in behaviour and practice.[48–50] It is also critical to better understand the notion of othering, particularly structural othering.[51] Structural othering helps us better understand how "macro-level conditions may lead to exclusionary practices."[51] Recognising this holds the potential for nurses to participate in achieving systemic change.

5.4 Recommendations

Our data indicate that developing students' conceptualization of HR requires more than knowledge acquisition. Four recommendations for educators arise from the analysis and discussion and our study findings contribute to the evidence required to support educators to explore and prioritize educational approaches that embed HR.

1) Curriculum content should be adapted to include drug information and reflect the dynamic needs of PWUD using the best available evidence.

2) Learning experiences need to engage students in critical personal reflection about their values and beliefs related to drug use, HR, and PWUD. This must involve an exploration of the students' individual, professional, and collective contexts in which they understand drug use and the role of HR in nursing. It is important to build intentional learning opportunities that would allow students to unlearn.

3) Exposure to PWUD should be sought in simulation and clinical placements and students need to be supported to navigate patient care using HR principles. Including PWUD in classrooms would challenge current power structures related to who holds knowledge and recognize experience as a form of knowledge.

4) An explicit focus on teaching HR from a socio-political perspective is needed to address the health equity gap for PWUD. As students transition to independent practice, this perspective can support students to assess and recognize situations where they can engage in advocacy work.

5.5 Strengths, limitations, and trustworthiness

The findings from this qualitative study offer detailed and specific insights into the phenomena studied. However, the small sample size, recruitment from a single university, and the lack of gender and ethnic diversity in the participants' sample means that the findings may not reflect the understanding and experiences of all undergraduate nursing students, particularly students from marginalized groups. Data were collected at a single point in time and thus a limitation of these findings is that they do not account for how conceptualization of HR may be changing over time.

Thematic analysis is considered a flexible method and as a result is commonly critiqued as lacking rigour.[2] To avoid conducting a study with poor rigour, we reviewed the "15-point checklist of criteria for good thematic analysis"[2] prior to selecting TA for this study and used this checklist as a reference point to assess rigour as we proceeded through the phases of TA. In addition, we consulted Nowell et al.'s[52] phase-by-phase TA considerations for establishing trustworthiness as described by Lincoln and Guba.[53] Several of these considerations were particularly impactful in enhancing the trustworthiness of this study, including documenting theoretical and reflective thoughts during data collection using memos, ongoing researcher triangulation during coding and theme development, and diagramming to make connections across themes. As TA is not a linear process, these checklists and considerations provided ongoing guidance. The coding framework and thematic diagram went through several iterations, and we relied on our detailed theme development notes to effectively organize codes, themes and sub-themes, and participant quotes. These notes serve as an audit trail for the decision-making process and consequently enhance rigour and trustworthiness of the research.

6. Conclusion

This study explored how final-year nursing students conceptualized HR, a complex, sociopolitical practice relevant to the health outcomes of PWUD. Participants demonstrated a beginning understanding of the concept, despite most denying specific exposure through course content or clinical experience. In discussing HR, participants used established nursing terminology such as health promotion, client-centred care, and patient safety, and as a result felt that their understanding of HR was inherent to the profession. Participant views became complicated as they attempted to navigate their personal and professional beliefs towards HR, drug use, and PWUD. To better prepare nursing students to practice HR and care for PWUD, nurse educators are encouraged to focus on broader socio-political contexts and encourage students to be critical of their values, beliefs, and experiences, both as individuals and professionals.

Conflicts of Interest Disclosure

The authors declare that there is no conflict of interest.

References

[1] Canadian Nurses Association. Harm reduction and illicit substance use: Implications for nursing. 2017. Available from: https://ohrn.org/resources/harm-reduction-and-illicit-substance-use-implications-for-nursing/

[2] Braun V, Clarke V. Using thematic analysis in psychology. Qualita-

tive Research in Psychology. 2006; 3: 77-101. https://doi.org/10.1191/1478088706qp063oa

[3] Hawk M, Coulter RWS, Egan JE, et al. Harm reduction principles for healthcare settings. Harm Reduction Journal. 2017; 14(70): 1-9. PMid:29065896 https://doi.org/10.1186/s12954-017-0196-4

[4] Harm Reduction International. What is harm reduction? 2019. Available from: http://www.hri.global/what-is-harm-reduction

[5] Kerber A, Donnelly TT, dela Cruz A. Harm reduction: A concept analysis. Journal of Mental Health and Addiction Nursing. 2020; 4(1): e14-e25. https://doi.org/10.22374/jmhan.v4i1.39

[6] Denis-Lalonde D, Lind C, Estefan A. Beyond the buzzword: A concept analysis of harm reduction. Research and Theory for Nursing Practice. 2019; 33(4): 310-323. PMid:31666391 https://doi.org/10.1891/1541.6577.33.4.310

[7] Boyd S, Carter CI, MacPherson D. More harm than good: Drug policy in Canada. Fernwood. 2016.

[8] Sharma M, Lamba W, Cauderella A, et al. Harm reduction in hospitals. Harm Reduction Journal. 2017; 14(1): 1-4. PMid:28583121 https://doi.org/10.1186/s12954-017-0163-0

[9] Mielau J, Vogel M, Gutwinski S, et al. New approaches in drug dependence: Opioids. Current Addiction Reports. 2021; 8(2): 298-305. PMid:34055568 https://doi.org/10.1007/s40429-021-00373-9

[10] Volkow ND, Frieden TR, Hyde PS, et al. Medication-assisted therapies — Tackling the opioid-overdose epidemic. New England Journal of Medicine. 2014; 370(22): 2063-2066. PMid:24758595 https://doi.org/10.1056/NEJMp1402780

[11] Beirness DJ, Notarandrea R, Jesseman R, et al. Reducing the harm of "Harm Reduction". Clinical Pharmacology & Therapeutics. 2008; 83(4): 523-525. PMid:18349874 https://doi.org/10.1038/sj.clpt.6100509

[12] Hyshka E, Anderson-Baron J, Karekezi K, et al. Harm reduction in name, but not substance: A comparative analysis of current Canadian provincial and territorial policy frameworks. Harm Reduction Journal. 2017; 14(50):1-14. PMid:28747183 https://doi.org/10.1186/s12954-017-0177-7

[13] Fry C, Treloar C, Maher L. Ethical challenges and responses in harm reduction research: A critique of applied communitarian ethics. Drug and Alcohol Review. 2005; 24: 449-459. PMid:16298840 https://doi.org/10.1080/09595230500263905

[14] Habermas J. Knowledge and human interests. Heinemann. 1972.

[15] Habermas J. Theory of communicative action. Beacon Press. 1984.

[16] Smith CBR, Marshall Z. Critical approaches to harm reduction: Conflict, institutionalization, (de-)politicization, and direct action. Nova Publishers. 2016. Available from: https://www.researchgate.net/publication/305383010_Critical_Approaches_to_Harm_Reduction_Conflict_Institutionalization_De-Politicization_and_Direct_Action

[17] Braun V, Clarke V. (Mis)conceptualising themes, thematic analysis, and other problems with Fugard and Potts' (2015) sample-size tool for thematic analysis. International Journal of Social Research Methodology. 2016; 19(6): 739-743. https://doi.org/10.1080/13645579.2016.1195588

[18] Gagnon M, Payne A, Denis-Lalonde D, et al. Substance use education in Canadian nursing programs: A student survey. Journal of Nursing Education. 2020; 59(9): 510-513. PMid:32865584 https://doi.org/10.3928/01484834-20200817-06

[19] Paquette CE, Syvertsen JL, Pollini RA. Stigma at every turn: Health services experiences among people who inject drugs. International Journal of Drug Policy. 2018; 57: 104-110. PMid:29715589 https://doi.org/10.1016/j.drugpo.2018.04.004

[20] Pauly B. Harm reduction through a social justice lens. International Journal of Drug Policy. 2008; 19(1): 4-10. PMid:18226520 https://doi.org/10.1016/j.drugpo.2007.11.005

[21] Tsai TI, Morisky DE, Chen YMA. Role of service providers of needle syringe program in preventing HIV/AIDS. AIDS Education and Prevention. 2010; 22(6): 546-557. PMid:21204630 https://doi.org/10.1521/aeap.2010.22.6.546

[22] Murphy N, Canales MK, Norton SA, et al. Striving for congruence: The interconnection between values, practice, and political action. Policy, Politics, & Nursing Practice. 2005; 6(1): 20-29. PMid:16443956 https://doi.org/10.1177/1527154404272145

[23] British Columbia Centre for Disease Control. BCCDC Needs assessment: Harm reduction curriculum. 2019. Available from: https://web.archive.org/web/20220121060452/https://www.mvaec.ca/downloads/needs-assessment.pdf

[24] Binswanger IA, Koester S, Mueller SR, et al. Overdose education and naloxone for patients prescribed opioids in primary care: A qualitative study of primary care staff. Journal of General Internal Medicine. 2015; 30(12): 1837-1844. PMid:26055224 https://doi.org/10.1007/s11606-015-3394-3

[25] Hill D, McAuley A. A comparative study of stakeholder views on take-home naloxone services. Journal of Substance Use. 2012; 17(5-6): 430-441. https://doi.org/10.3109/14659891.2011.595275

[26] Bartlett R, Brown L, Shatnell M, et al. Harm reduction: Compassionate care of persons with addictions. MedSurg Nursing. 2013; 22(6): 349-358. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4070513

[27] Cortina SC. Stigmatizing harm reduction through language. Journal of Addictions Nursing. 2013; 24(2): 102-107. PMid:24621488 https://doi.org/10.1097/JAN.0b013e3182929466

[28] Howard MO, Chung SS. Nurses' attitudes toward substance misusers II. Experiments and studies comparing nurses to other groups. Substance Use & Misuse. 2000; 35(4): 503-532. PMid:10741539 https://doi.org/10.3109/10826080009147470

[29] Rassool GH. Curriculum model, course development, and evaluation of substance misuse education for health care professionals. Journal of Addictions Nursing. 2004; 15: 85-90. https://doi.org/10.1080/10884600490450245

[30] Carnegie E, Kiger A. Being and doing politics: An outdated model or 21st century reality? Journal of Advanced Nursing. 2009; 65(9): 1976-1984. PMid:19694861 https://doi.org/10.1111/j.1365-2648.2009.05084.x

[31] Leslie H, McAllister M. The benefits of being a nurse in critical social research practice. Qualitative Health Research. 2002; 12(5): 700-712. PMid:11993565 https://doi.org/10.1177/104973202129120098

[32] Smith CBR. Harm reduction as anarchist practice: A user's guide to capitalism and addiction in North America. Critical Public Health. 2012; 22(2): 209-221. https://doi.org/10.1080/09581596.2011.611487

[33] Anderson JM, Rodney P, Reimer-Kirkham S, et al. Inequities in health and healthcare viewed through the ethical lens of critical social justice: Contextual knowledge for the global priorities ahead. Advances in Nursing Science. 2009; 32(4): 282-294. PMid:19934835 https://doi.org/10.1097/ANS.0b013e3181bd6955

[34] College and Association of Registered Nurses of Alberta. Integrating a harm reduction approach in nursing. 2018. Available from: https://nurses.ab.ca/docs/default-source/document

-library/practice-advice/integrating-a-harm-reduction-approach-to-nursing.pdf?sfvrsn=7fd2c21b_10

[35] Killarney A, Neuman M. Clinicians' perspectives and utilization regarding harm reduction in nursing practice in care of persons with addiction: A literature review. Poster presentation. Grace Peterson Nursing Research Colloquium, Chicago, IL, United States. 2017. Available from: https://via.library.depaul.edu/nursing-colloquium/2017/Summer_2017/9/

[36] Lightfoot B, Panessa C, Hayden S, et al. Gaining Insite: Harm reduction in nursing practice. The Canadian Nurse, 2009; 105(4): 16–22. Available from: www.canadian-nurse.com/en/articles/issues/2009/april-2009/gaining-insite-harm-reduction-in-nursing-practice

[37] Reutter L, Kushner KE. Health equity through action on the social determinants of health: Taking up the challenge in nursing. Nursing Inquiry. 2010; 17(3): 269-280. PMid:20712665 https://doi.org/10.1111/j.1440-1800.2010.00500.x

[38] Taylor M, Caine V. Exploring practices of harm reduction. Alberta RN, 2013; 68(4). Available from: http://www.nurses.ab.ca/content/dam/carna/pdfs/AB%20RN/2013/AB_RN_Winter_2013.pdf

[39] College and Association of Registered Nurses of Alberta. Entry-to-practice competencies for the practice of registered nurses. 2019. Available from: https://www.nurses.ab.ca/docs/default-source/document-library/standards/entry-to-practice-competencies-for-the-registered-nurses-profession.pdf?sfvrsn=15c1005a_12

[40] Canadian Council of Registered Nurse Regulators. Entry-Level Competencies (ELCs) for the Practice of Registered Nurses. 2019. Available from: https://www.ccrnr.ca/assets/ccrnr-rn-entry-level-competencies---2019.pdf

[41] Canadian Association of Schools of Nursing. Entry-to-practice mental health and addictions competencies for undergraduate nursing education. 2015. Available from: https://www.casn.ca/wp-content/uploads/2015/11/Mental-health-Competencies_EN_FINAL-Jan-18-2017.pdf

[42] Finnell DS, Savage CL, Hansen BR, et al. Integrating substance use content in an "overcrowded" nursing curriculum. Nurse Educator. 2018; 43(3): 128-131. PMid:28857953 https://doi.org/10.1097/NNE.0000000000000438

[43] Smothers Z, Reynolds V, McEachern M, et al. Substance use education in schools of nursing. Nurse Educator. 2018; 43(3): 136-139. PMid:28858952 https://doi.org/10.1097/NNE.0000000000000449

[44] O'Gara C, Keaney F, Best D, et al. Substance misuse training among psychiatric doctors, psychiatric nurses, medical students and nursing students in a South London psychiatric teaching hospital. Drugs: Education, Prevention and Policy. 2005; 12(4): 327-336. https://doi.org/10.1080/09687630500083691

[45] Pillon SC, Ramos LH, Villar-Luis MA, et al. Nursing students' perceptions of the curricula content on drug and alcohol education in Brazil: An exploratory study. Journal of Addictions Nursing. 2004; 15(3): 133-137. https://doi.org/10.1080/10884600490491231

[46] Rassool GH. The educational experiences and previous orientation of undergraduate nursing students in alcohol and drug: The English context. Journal of Addictions Nursing. 2007; 18(1): 47-52. https://doi.org/10.1080/10884600600995499

[47] Rassool GH, Villar-Luis M, Carraro TE, et al. Undergraduate nursing students' perceptions of substance use and misuse: A Brazilian position. Journal of Psychiatric and Mental Health Nursing. 2006; 13(1): 85-89. PMid:16441398 https://doi.org/10.1111/j.1365-2850.2006.00917.x

[48] Fenster J, Monti K. Can a course change social work students' attitudes toward harm reduction as a treatment option for substance use disorders? Alcoholism Treatment Quarterly. 2017; 35(1): 83-94. https://doi.org/10.1080/07347324.2016.1257895

[49] Goddard P. Changing attitudes towards harm reduction among treatment professionals: A report from the American Midwest. International Journal of Drug Policy. 2003; 14(3): 257-260. https://doi.org/10.1016/S0955-3959(03)00075-6

[50] Rassool GH, Rawaf S. Predictors of educational outcomes of undergraduate nursing students in alcohol and drug education. Nurse Education Today. 2008; 28(6): 691-701. PMid:18166248 https://doi.org/10.1016/j.nedt.2007.11.005

[51] Jacob JD, Gagnon M, Perron A, et al. Revisiting the concept of othering: A structural analysis. Advances in Nursing Science. 2021; 44(4): 280-290. PMid:33657021 https://doi.org/10.1097/ANS.0000000000000353

[52] Nowell LS, Norris JM, White DE, et al. Thematic analysis: Striving to meet the trustworthiness criteria. International Journal of Qualitative Methods. 2017; 16: 1-13. https://doi.org/10.1177/1609406917733847

[53] Lincoln Y, Guba EG. Naturalistic inquiry. Sage; 1985.