NURSING STUDENTS' BELIEFS ABOUT SUBSTANCE USE DISORDERS

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Abstract

Persons with substance use disorder (SUD) are subject to stigma and judgement. Stigma worsens clinical outcomes, undermines life opportunities, and decreases well-being of persons who use substances (Corrigan, Schomerus, Shuman, Kraus, Perlick et al., 2017). This meta-narrative reports on the beliefs of nine fourth year nursing students, using direct quotations to express salient beliefs about SUD, recovery, and nursing. Participants' beliefs evolved throughout the lifespan, with a significant shift in understanding occurring in response to education. SUD is seen as a biopsychosocial condition which is not a choice, but rather an attempt to cope with, or escape from, challenging life circumstances. Participants were reluctant to address stigma in their personal and professional lives. It is recommended nursing students are prepared to address workplace and societal stigma. Due to the effect of social environments outlined in symbolic interactionism, it is recommended to interview the same participants at graduation and in five years time.

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CHAPTER ONE: INTRODUCTION

This narrative inquiry reports on a group of nursing students' perceptions of substance use disorder (SUD), how these beliefs came to be, and the meaning of these ideas in nursing. The beliefs of this sample are described as participants depart from their academic institution, prior to their entry into the nursing profession. Beliefs are the cognitive structure which substantiate our expectations of the world around us, guiding our thoughts and behavior. This sample described beliefs about SUD which differed from the beliefs of some of the licensed Registered Nurses already in the workforce. The narratives here provide a wealth of information which would not have been captured with a validated quantitative measurement tool. This inquiry comes at a time when nursing organizations, such as Canadian Association of Schools of Nursing (CASN) and Registered Nurses Association of Ontario (RNAO) are working to the elevate quality of care for clients who use substances by producing professional resources. Within the last four years CASN and RNAO have made strides to support nurses to deliver ethical, evidence informed services by providing practice and education guidelines.

Background

Examination of Canadian nursing students' beliefs about SUD is long overdue. More than a decade ago, Marcellus (2007) called for examination of nursing curricula regarding addiction. Attention to nursing curricula is imperative, as health care professionals are known to lack education regarding this ubiquitous condition, and addiction theory continues to evolve (Marcellus, 2007). A recent review found 21% of undergraduate nursing programs in Canada lacked a mental health theory course and 28% did not have a mental health clinical placement [(Vandyk, 2015, as cited in Canadian

Federation of Mental Health Nurses (CFMHN), 2016)]. In an attempt to improve education, the CASN (2015) published the first mental health and addiction recommendations for Canadian nursing educators.

The prevalence of mental health conditions and addictions in Canada, in combination with the presence of stigma, establishes the need for nurses to be well educated on the topics. An estimated 1 in 5 Canadians lives with a mental health condition and/or addiction (Mental Health Commission of Canada [MHCC], 2013). Stigma remains an overwhelming barrier to care (CFMHN, 2014). Smith and Khanlou (2013) state nurses are the largest group of health care providers who collaborate in meeting the mental health care needs of Canadians. Addictions and SUDs are a specific aspect of mental health care.

Addictions are complex biopsychosocial conditions. The 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM5) differentiates addictions into two categories: substance-related disorders and non-substance related disorders (American Psychological Association [APA], 2013). Addictions which do not involve ingestion of a psychoactive substance are known as behavioural addictions (Kardefelt-Winther, Heeren, Schimmenti, Rooij, Maurage, et al., 2017). Both substance use disorder (SUD) and other behavioural addictions have "biological, chemical, neurological, psychological, medical, emotional, social, political, economic, and spiritual underpinnings" (Mate, 2009). Due to the complexity of the topic of addictions, the focus of this study will be limited to substance-related disorders and problems. SUDs are often accompanied by devastating personal consequences, making this condition a prominent concern for health professionals.

As the complexity of SUD merges with the inherent human suffering of the condition, the need for well educated health care personnel arises. To give an explanation of the complexity, biological nursing education on SUD should include neurochemistry, phamacokinetics, pathophysiology, and recent scientific discoveries. Education ought to extend to the historical, familial, cultural, social, political, and economic realms related to the SUD. Scholarship may also address relational, practical, and affective considerations relevant to SUDs and other addictions. There are many faucets to understanding SUDs.

To further complicate things, severe public and internalized shame and stigma negatively impact mental health and well-being of persons with SUD (Birtel, Wood, & Kema, 2017). Education is one strategy to reduce stigma while improving the clinical and social atmosphere for persons with addiction. As a means to ameliorate stigma, it is imperative health care providers and the general public appreciate the cost of SUDs on human lives. Educated and empathetic health care providers can help mitigate the pain and suffering associated with SUD through therapeutic interactions and meaningful public health initiatives.

Rational and Significance

Canadian Substance Use Costs and Harms Scientific Working Group (CSUCHSWG) (2018) states in 2014 substance use (SU) cost Canadians $38.4 billion, the equivalent of approximately $1,100 for every Canadian. Alcohol and tobacco account for 70% of these costs, with opioids contributing to 9.1% of the total cost, and cannabis contributing to 7.3% of the total costs (CSUCHSWG, 2018). Reverberations from SU are felt throughout families, health care, child and family services, law enforcement and the criminal justice system. SU also indirectly impacts the economy

through lost productivity (Canadian Center on Substance Use, 2016). Of the total cost of SU, 29% is spent in health care (CSUCHWG, 2018). The monetary and human capital cannot be compared to the toll on the human spirit.

As key players in the health care system, nurses have the ability to positively "influence clients' behaviour and public policy" (Chalmers, Seguire, and Brown, 2002, p. 17), reducing costs and suffering. Nurses' beliefs are of paramount concern because beliefs strongly influence behaviour, and can be irrational (Alcock, 1995). The innate human resistance to change beliefs (Alcock, 1995) increases the vital nature of understanding beliefs about SU. The Government of Canada (2018) describes stigma as negative attitudes or beliefs involving prejudice and discrimination which negatively impacts a person's quality of life while reducing the quality of help people with SU problems receive, worsening their condition. The beliefs of nurses will inevitably influence their actions and are an important consideration in health services for people with SUD.

Nurses who fully understand SUD and believe in recovery can ensure persons with SUD receive non-discriminatory, equitable care while acting as change agents at the system level, and advocating for prevention and treatment of SU problems based on current evidence. Moreover, nurses can design, support, conduct, and distribute research which aids in societal comprehension of SUD and other addictions. High quality health care and evidence informed public policy have the potential to heal the perils of SU and other behavioural addictions. This public health concern is surmountable. Other nations, such as Portugal, have been successful in improving the quality of care people receive and reducing the rates of SUD by changing drug policies (Hari, 2015). Education,

understanding, and empathy are required to transform the largely ineffective systems and services currently in existence.

Research Problem

Future nurses should be prepared to use relational nursing practice skills to assist clients towards recovery (CASN, 2015). Persons with SUD may have reluctance about the recovery process, making it important that those from whom they seek guidance from believe recovery is possible. A therapeutic relationship between a nurse and a client is a goal directed, interpersonal connection based on the best interest and clinical outcome for the client (RNAO, 2006). Therefore, if a nurse believes recovery is possible, goal setting is more likely to flow in this direction. CASN (2015) encourages a recovery oriented perspective, where clients are supported to find choice, meaning, and purpose in their lives. RNAO (2017) states that clinical dialogue should facilitate hope and educate clients about "realistic possibilities and the probability of recovering to the point of having a good quality of life" (p. 64). SUD remains to be a highly moralized condition (Frank & Nagel, 2017). What beliefs are held by nurses at the end of their nursing education?

Education on SUD can positively impact attitudes (Martinez & Murphy-Parker, 2003), while in some instances it does not (Crapanzano, Vath, & Fisher, 2014). Unfortunately, it remains common for health care providers to have negative attitudes which compromise their care delivery (van Boekel, Brouwers, Weeghel, & Garresten 2013). For these reasons, there is a calling to understand the lens through which Canadian nursing students see SUD.

Research Question

What beliefs about SUD and recovery do nursing students have? This inquiry reports on the development of beliefs of a small sample of fourth year nursing students. The understanding of these beliefs is shaped in relation to the students' personal lives, education, and experiences. Until now, this information was unknown. A qualitative design is chosen to honour the biopsychosocial complexity of both SUD and beliefs. Qualitative investigations require a deviation from the reductionist scientific perspective, allowing for nuanced findings.

Qualitative research, in this case narrative inquiry (NI), is inductive, relational, and contextual. NI allows for holistic comprehension of SUD. Kovach (2009) affirms NI is a useful mode of inquiry for researchers to appreciate the meaning of stories and multiple truths. Doane and Varcoe (2015) find nursing to often be concerned with multiple truths embedded in interpretations, experiences, and perspectives. NI as a methodology aligns with these nursing values and can speak to the complexity of SUD.

The examination of nursing students' beliefs about SUD is chosen for a variety of reasons. Fundamentally, the presence of stigma and misunderstanding surrounding SUD is highly problematic. Beliefs underpin attitudes and behaviours, leading to both subtle and overt actions (Brown, 2005). Stigma counters the philosophic foundation of the nursing profession (Naegle, 1989) and negatively impacts clients with SUD (Corrigan et al. 2017). Unfortunately, negative attitudes toward SUDs have been present in health care for decades (Gilchrist et al., 2011; Imhof, 1984; Naegle, 1989; Smith, 1992; Starkey, 1980). Deconstruction of beliefs will aid in identifying where nursing efforts are best directed as the profession works to reduce stigma. This information is timely as Canadian

nurse educators now have a consensus based framework outlining entry to practice mental health and addiction competencies (Appendix A) (CASN, 2015) for students.

Beliefs of nursing students, rather than nurses in the workforce, are of interest because education has been shown to influence attitude (Happel & Taylor, 1999; Martinez & Murphy-Parker, 2003; Rassool, 2004). The personal narratives told in this study express what SUD means within the context of nursing. Riessman (2008) states stories are connected to the social world, which in this case, is the world of Canadian nursing. A benefit of narrative inquiry (NI) is that narratives can encourage people to act (Riessman, 2008). Social justice and action is important in reducing stigma surrounding SUDs. Understanding beliefs of new nurses will inform nursing research, education, policy, and practice. This inquiry will contribute to nursing knowledge specific to SUD in Canada.

Theoretical Framework

Symbolic interactionism (SI) serves as the theoretical perspective to understand beliefs. Blumer (1969), the sociologist best known for SI, states beliefs are continually constructed through social interaction with the world. According to Blumer (1969) in order to avoid creation of a fictitious world, it is necessary to identify objects and their meanings as a means to understanding an individual's ever evolving worldview. Blumer (1969) further explains the development of beliefs and actions to be an interpretive social process in constant evolution. One's relation to a physical object, a social role, or an abstract concept such as a moral value are "formed, learned, and transmitted" based upon the socially constructed meaning we apply to the abstraction (Blumer, 1969, p. 12). Blumer's (1969) symbolic interactionism theory includes meaning, thought, language,

and action. Consideration of these factors supports the platform on which participants' socially constructed beliefs about SUD can be thoroughly understood.

This framework allows for deconstruction, dissection, and discussion of meanings, concepts, and themes as they relate to socially constructed beliefs. With a focus on human interactions, SI has been found to be useful in the examination of mental illness stigma (Link, Wells, Phelan, & Yang, 2015; Roe, Joseph, & Middleton, 2010). Link, Wells, Phelan, et al. (2015) find SI helpful to examine stigma as people tend to consider others' actions and reactions as a means to make one's own behaviour socially appropriate. SI gives consideration to thought, word, and deed as each arise within a social context. Persons with SUD suffer from social stigma (Center for Addiction and Mental Health [CAMH], 2007). Thus, according to SI, even if stigmatizing beliefs are not internalized, they may still influence thinking, beliefs, and actions. Application of SI to narratives allows for examination of possible stigma related to SUD.

Narratives are told in a linear way, but yet are relational. SI provides a lens for narratives to be examined relationally, with consideration given to the internal and external dialogue, and lived social experience. Both narrative inquiry (NI) and SI are interested in a lived contextualized reality while simultaneously acknowledging multiple truths. Stories can never be decontextualized from the narrator, their knowledge, and their relations (Kovach, 2009). SI orients the research in the past and present "multitudinous" (Blumer, 1969, p. 20) social world of the participant. SI recognizes that beliefs are a social phenomenon arising from and evolving in response to one's social world and the meanings assigned to objects (Blumer, 1969).

Cardinal principals of SI are thought, meaning, language, and action (Blumer, 1969). Narratives allow for appreciation of each facet of these SI principals, as narrators articulate the internal perception of objects and situations. Language "holds within it people's worldview" (Kovach, 2009, p. 59), conveying both explicit and underlying meanings. Together, the methodology of NI and theoretical framework of SI aid in capturing beliefs about SUD as a product of, and in relation to the Canadian social context. Carlson (2012) states that the self evolves in relation to the group to which one aspires to be a part. By choosing students in their final year of nursing, beliefs about SUD may have been influenced by the social context of their school of nursing. The result is a narrative inquiry specific to nurses entering the Canadian workforce in Ontario.

CHAPTER TWO: LITERATURE REVIEW

Nurses are likely to encounter substance use (SU), abuse, or dependence in nearly every practice setting. The World Health Organization (WHO, 2018) defines substance abuse as harmful or hazardous use of a psychoactive substance. The WHO (2008) states that globally alcohol claims the lives of 3.3 million people per year, and 3.5% to 5.7% of the world's population use psychoactive substances, costing countries 2% of their gross domestic product. Substance use disorder (SUD), commonly referred to as addiction, is a complex biopsychosocial condition (Campbell-Hider et al., 2009). The labyrinthine physiological and emotional components of SUD are not well understood by the general public, leaving those who suffer this condition subject to stigma and judgement (CAMH, 2012). To support and care for those who suffer SUD, trauma-informed care is recommended (RNAO, 2015). Early trauma is a significant risk factor for SUD (Betinardi-Angres & Angres, 2011), highlighting the vulnerability of this population.

The CAMH (2012) states that SUD indiscriminately affects people of all ages, education, income, race, and religion in Canada. One in seven adults over the age of 15 have alcohol related problems, and one in 20 have concerns with other illicit drug(s) (CAMH, 2007). In part due to the pervasiveness and in part due to the potentially disastrous effects of SUD, nurses will inevitably care for clients with SUD or persons who are impacted by SU. For instance, alcohol use is associated with short term risks such as acute illness or injury and long term risk of liver disease and some cancers (Butt, Beirness, Gliksman, Paradis, & Stockwell, 2011; Johnson, 2016). By-products of alcohol abuse include verbal abuse, neglect, feeling threatened, emotional injury, or physical injury (Health Canada, 2012) resulting in health care utilization. Co-morbidities such as

HIV, Hepatitis C, and mental illness are common among those with SUD and increase hospital admission (Fischer et al., 2007 as cited in Chu & Galang, 2013). Tobacco use by 14.6% of Canadians contributes to significant health care costs (Reid, Hammond, Rynard, & Burkhalter, 2015).

Complexities of Substance Use

The American Psychological Association (APA, 2013) definition of SUD is adopted for this study, where a person's recurrent use of one or more classes of substances results in significant behavioral, physical, social, and psychological impairments. The use of the substance continues despite significant substance related problems (APA, 2013). Throughout this work, the term addiction is used to reflect substance use (SU), and is not intended to describe behavioural addictions such as gambling.

SUD is often viewed as a "moral failing" (Monroe & Kenga, 2011), despite the scientific understanding of SUD as a chronic acquired organic brain disease (Russell, Davies, & Hunter, 2011). Repeated use of substances over time causes changes in the structure and function of the brain, which is why it is often understood as a brain disease (Frank & Nagel, 2017). Lewis (2015) describes addiction as a learned behaviour, where the innate tendency to seek pleasure and avoid pain becomes wired into the brain through a process similar to classical conditioning. Repeated exposure to various substances results in structural and functional changes in the brain circuits which regulate reward, motivation, memory, and decision making (Cadet, Bisagno, & Milroy, 2014). SUD specifically affects the emotional centers of the brain (Wilcox & Erickson, 2000). Neurobiological research is rapidly evolving, increasing the knowledge and

understanding of SUDs (Boulton & Nosek, 2014). It is not a mere lack of willpower that prevents people with SUD from abstaining from using substances, but largely the brain's conditioned response to hijacked neurocircuits.

Prior to sophisticated brain imaging, it was thought persons with SUD compulsively *choose* to use their preferred substance despite devastating costs. The neurobiological explanation helps to explain the loss of choice for many persons engaged in addictive behaviours. One study found belief in the choice model of addiction is more common in the United Kingdom when compared to the Unites States of America and is particularly present among young, non-addiction professionals employed in public/not for profit addiction services (Russel, Davies, & Hunter, 2011). It is unknown how Canadian nurses understand SUD or if they subscribe to the choice model.

The complexity of SUD deepens when consideration is given to the past and present hardships in the lives of those with SUD. Homelessness and mental illness are common among persons with severe SUDs (Bard, 2011). A strong link between unresolved grief and substance misuse exists (Coleman, Kaplan, & Downing, 1986; Furr, Johnson, & Goodall, 2015; Zuckoff, Shear, Frank, Daley, Seligman et al., 2006), highlighting the emotive and psychological components of SUD. Histories of physical, emotional, and sexual abuse are common among those with SUD (Furr, Johnson, & Goodall, 2015; Kovalesky & Flager, 1997, Mate, 2009). Active addictions are associated with the loss of relationships, jobs, finances, memory, health, time, and friends (Furr, Johnson, & Goodall, 2015), further complicating the lives of these individuals. For these mental, emotional, and social reasons, persons with SUDs require understanding, compassion, and hope.

For many, it is difficult to understand how the vicious cycle of perpetual drug use and self medication persists in the face of "adverse psychosocial and medical conditions" (Cadet, Bisagno, & Milroy, 2014, p. 91). SU temporarily provides a sense of pleasure or relief and unfortunately leads to antithetical social stigmatization, damaged self worth, and health disparities (Singer, 2012). Over time, the substance can be required just to feel normal (Mate, 2009). High risk situations and behaviours do little to quell intense cravings caused by brain biochemistry, physical dependence (Buchman, Illes, & Reiner, 2011), behavioural conditioning (Lewis, 2012), emotional pain (Mate, 2009), and/or psychosocial dislocation (Alexander, 2009). Numerous theories and models attempt to explain the complex interplay of factors driving SUDs. Criminalization and drug policy further contribute to the moralizing of SUD (Ben-Ishai, 2012; Earnshaw, Smith, & Copenhaver, 2013; Mate, 2009; RNAO, 2015). Without adequate understanding of the multifarious forces at play in SUDs, it is easy to understand why a tremendous amount of misunderstanding persists in society.

Generational Trauma

Trauma and SUD are inextricably linked (Felitti, Anda, Norenberg, Williamson, Spitz, et al., 1998). The aftermath of the trauma is passed along behaviourally, emotionally, and epigenetically (Yehuda, Daskalakis, Biere, et al., 2016), highlighting the biopsychosocial nature of this condition. In Canada, the presence of generational trauma is one of the complex facets of the health and social issues affecting First Nations people (Firestone, Tyndall, & Fischer, 2015). Generational or historical trauma is the "cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences" (Braveheart, 2003, p. 3).

This kind of wounding occurred in Canada for over a century as Canada attempted to assimilate the Aboriginal people (Truth and Reconciliation Commission of Commission of Canada [TRCCC], 2015). Colonization and its policies of cultural genocide have left deep scars on many of Canada's Aboriginal peoples (TRCCC, 2015). Social conditions, such as residential schools, resulted in traumatic experiences for large numbers of Canada's Aboriginal peoples. North American and Australian Aboriginal peoples display an incontestable example of generational trauma among their peoples, along with the presence of high rates of SUD (Health Canada, 2011; McGrath, Rawson, & Adidi, 2013; Seale, Shellenberger, & Spence, 2006).

In the case of generational trauma, SU serves as a form of self medication to avoid painful feelings (Braveheart, 2003). In Canada, SUD poses serious concerns for Aboriginal peoples. The Canadian Center on Substance Abuse (2016) states SU is the greatest barrier to wellness among First Nations people in Canada. Health Canada (2011) reports rates of opiate addiction are as high as 85% in some Aboriginal communities.

Colonization is an ongoing process, operating as another societal factor which contributes to the development of socially constructed belief systems (Razack, 2015). Beliefs influenced by the process of colonization have the potential to arise in this research. Frank & Nagel (2017) state that "in some contexts the extent to which certain types of addiction are moralized and stigmatized is connected to race" (p. 133). This is true in the United States of America, where drug laws and research were clearly driven by racial stereotypes (Hart, 2014). The generational trauma of colonization and high rates of SU by Aboriginal peoples creates the possibility race may arise as a factor influencing the beliefs of nursing students.

Due to the possibility of race as a factor influencing the beliefs of participants, due diligence was taken. The researcher would "inquire whether culturally appropriate assistance is desired to interpret, or support compliance with, the research project" (Canadian Institutes of Health Research et al., 2014, p. 118) while acknowledging that "Aboriginal identity in data collection may reveal anomalies that warrant further, more targeted research, which, if followed up, would require community engagement" (Canadian Institutes of Health Research et al., 2014, p. 118). Participation of Aboriginal students would have been "incidental", rather than scheduled (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014, p. 118) and did not occur. The Registered Nurses of Ontario (2015) encourages both cultural competence and trauma-informed care for persons affected by SUD. Aboriginal status or race did not arise as themes influencing students' beliefs.

Stigma

The Center for Addiction and Mental Health (CAMH, 2012) defines stigma as negative attitudes and behaviours towards a person which can reduce one's self esteem and limit one's ability to seek treatment, health care, employment, and supportive relationships. Stigma is one of the greatest barriers to treatment, and unfortunately SUDs are consistently ranked one of the most stigmatized conditions worldwide (Smith, Earnshaw, Copenhaver, & Cunningham, 2016). The stigma surrounding SUD worsens clinical outcomes and well-being of persons with SUD (Global Commission on Drug Policy, 2015). Stigmatizing attitudes are present among health care providers (McLaughlin & Long, 1996; Rao, Mahadevappa, Pillay, Sessay, Abraham, & Luty, 2009,

van Boekel, Brouwers, van Weeghel, & Garretsen, 2015) and the public alike (Lovi & Barr, 2009; Mental Health Commission of Canada, 2016; Puskar, Gotham, Terhorst, Hagel, Mitchel et al., 2013; vanBoekel, Brouwers, van Weeghel, & Garretsen, 2013; WHO, 2008). Watson, Maclaren and Kerr (2007) stress the importance of attitude in the therapeutic potential of health care interactions.

Negative attitudes of health care providers are associated with sub-optimal care (Van Boekel, Brouwers, van Weeghel, & Garretsen, 2013; Watson, Maclearen, & Kerr, 2007). Vadlamudi, Adams, Hogan, Wu, and Wahid (2008) name "attitudes, beliefs, and confidence" (p. 292) of nurses to be the most significant barriers to overcome in order to improve care for persons with SUD. Nurses in England working on a medical ward were found to negatively pre-judge clients who were admitted for complications associated with illicit drug use (Monks, Topping, & Newell, 2013). A lack of knowledge to care for this population is associated with these negative presupposed perceptions, leading to distrust and detachment from these clients (Monks, Topping, & Newell, 2013).

Meltzer et al. (2013) surveyed medical residents' attitudes towards SUD using the validated Medical Condition Regard Scale (MCRS). Results indicated these residents had less regard for clients with alcoholism and narcotic dependence than those with pneumonia or heartburn. A subset of these residents were given 10 hours of addiction medication training. This educational intervention had a very small effect on attitude; however it did result in a modest improvement in their regard towards clients with alcohol and opiate dependence. Meltzer et al. (2013) concluded that education alone is not enough to address stigma and poor attitudes, both of which can compromise medical care for persons with SU or dependence.

In Canada, persons suffering mental health concerns may not seek care because of the stigmatizing attitudes expressed by front line health care professionals (Langille, 2014). Limited Canadian studies about nurses and SU exist. In the one study found, nurses were found to have a neutral attitude and low motivation to work with persons with SUD (Chu & Galang, 2013). The College of Nurses of Ontario (CNO, 2006) mandate nurses treat all clients with respect and dignity, recognizing their inherent worth, regardless of disease condition. Ethical principles of truth, fairness, respect for life, collegiality and confidentiality are intended to guide nurses in their role of assisting clients to attain their optimal level of health and functioning (CNO, 2009). Stigma and the vulnerability of persons with SUD increases the urgency for health care providers to be able to provide ethical, recovery focused, and evidence informed care.

Sadly, the lack of interest to care for this population is mirrored internationally (Ford, 2010). Health care providers in Ireland state they "would reject the offer of education and training in this area to prevent contact with illicit drug users" (McLaughlinh, McKenna, Moore, & Robinson, 2006, p. 682). Continual blame of the substance user for their addiction highlights the need for increased understanding of stigma (Oliveira, Martins, Richter, & Ronzani, 2013). Oliveira, Martins, Richter, and Ronzani (2013) found education on screening, brief intervention, and referral to treatment (SBIRT) did not affect primary health care providers' moralized beliefs. The judgements reflected in these studies is in direct opposition to nursing professional and humanistic principles.

SUD is an adversary in need of allies who have been liberated by the most recent scientific evidence. The criminalization of SU is one of the most salient factors which

contributes to the moralization and stigmatization of SU and the persons who use substances in the modern world. In order for nurses to promote healing of this complex biopsychosocial condition they must have beliefs which support healing. Through education and advocacy, nurses can work to extinguish professional and public misconceptions about SUD.

Self-stigma

The stigmatizing views held by the general populous is known as societal stigma or public stigma. Self-stigma and label avoidance are two other manifestations of stigma towards SUD (Corrigan, Schomerus, Shuman, Kraus, Perlick, et al., 2017). Label avoidance is the reluctance to address SU as a means to prevent the disrespect and discrimination associated with the condition (Corrigan et al, 2017). Identification with a stigmatized group that a society rejects and denigrates result in the negative thoughts and feelings known as self-stigma (Kulesza, Ramsey, Brown, Larimer, 2014). Self-stigma manifests as self blame and lack of self worth (Corrigan et al., 2017). In a review of narrative literature, Llyod (2013) found stigma to be a significant barrier to recovery. Treatment is avoided or delayed due to self-stigma (Keyes, Hatzenbuehler, McLaughlin, Link, Olfson, Grant et al., 2010; Livingston & Boyd, 2010).

Self-devaluation resulting from self-stigma limits individuals from pursuing life goals (Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008). Stigma is found to be associated with lower self-esteem, higher rates of depression and anxiety and poorer sleep (Birtel, Wood, & Kempa, 2017). Feelings of anger, frustration, and anxiety resulting from the experience of stigma threaten the emotional well-being of persons in recovery (Earnshaw, Smith, and Copenhaver, 2013) and persons actively substance using.

Avoidance of social relationships and services as a means to avoid judgement exacerbates the psychosocial impact of SU and decreases contact with supportive services (Luoma et al., 2008). Self-stigma can decrease self-efficacy (Schomerus, Corrigan, Klauer, et al., 2011), thus compromising recovery. In order to make a difference in the lives of persons with SU concerns, health care providers need to be aware of the deleterious effects of self-stigma on an individual's sense of self. Awareness of all of the layers of stigma faced by persons with SU challenges is necessary to inform care providers' patient care plans and advocacy efforts. Stigma as a barrier is now to be included in nursing education (CASN, 2015).

Harm Reduction

Harm reduction services are intended to reduce the inauspicious aspects of SU. Additionally, harm reduction strategies are helpful to reduce societal stigma and encourage those with SUD to connect with recovery services (RNAO, 2009). Harm reduction interventions are intended to mediate individuals' vulnerability by minimizing adverse consequences associated with continued drug use while increasing one's capacity to deal with the SU problem (Single, 1995). McNeil, Kerr, Pauly, Wood and Small (2016) conducted semi-structured interviews with people who use drugs to assess their perspectives of harm reduction approaches in hospitals. Participants identified access to care is more important than abstinence, where care is culturally safe and values subjective health needs. McNeil et al. (2016) conclude that harm reduction initiatives in hospitals can improve care retention rates and reduce adverse outcomes while supporting patient centered care.

The Canadian Nurses Association (CNA, 2012) declares harm reduction is a non-judgemental approach which "emphasizes human rights and the importance of treating all people with respect, dignity and compassion, regardless of drug use" (p. 1). Canadian nursing organizations are known to publically promote harm reduction. For instance, in 2011 the Canadian federal government tried to shut down the operation of Vancouver's safe injection site 'In-site' despite a significant amount of notable research highlighting the benefits of this harm reduction intervention (Bard, 2011). Canadian nursing organizations were among those who presented to the Supreme Court of Canada in favor of protecting this evidence based harm reduction initiative (Bard, 2011). Despite the support of the principles, Canada has a long distance to go in terms of turning harm reduction principles into real world actions. Hyshka, Anderson-Baron, Karekezi, Belle-Isle, Elliot et al., (2017) compared Canadian provincial and territorial policy frameworks and conclude that current policies are supportive of harm reduction, but lack substance and do not offer specific interventions. Without societal integration of such principles, harm reduction remains an idea rather than a normalized and accepted approach to action and service delivery.

Drug Policy

Principals of harm reduction juxtapose current drug policy. Drug policies of the criminal justice system view drug use as an immoral or criminal activity (Tammi & Hurme, 2007). Laws around SU create a socially unjust dilemma, making acceptance of harm reduction a challenge for many people. Some people believe people who use substances are breaking the law; therefore they should be punished rather than helped.

This position of superiority and judgement forms the foundation of stigma and unequal division of power. This judgement is constructed from dualistic thinking, where one subscribes to the idea of right/wrong, correct/incorrect, health/diseased, normal/abnormal, and ideal/flawed. In this case, the use of a substance is wrong, and the criminal justice system corroborates this idea. Stigma, also known as social disapproval, begins here.

Bruce Alexander (2008), the Canadian psychology professor and researcher, states the concept of SU as being 'bad' and 'wrong' traces all the way back to the 19th century. Intended to scare the populous into avoiding alcohol, the idea of the 'demon rum' was endlessly proclaimed with "religious and scientific endorsements" (Alexander, 2008, p. 173). The 'demon rum' soon evolved into the 'demon drug' as people began to see that alcohol could be consumed responsibly without long term ill effect. Historical research by Alexander (2008) found that from the late 19th to 21st century, the myth was widely accepted that a person would be possessed by a demonic spirit if they consumed drugs or alcohol. The idea of the demon drug persists today, where official government warnings and the criminal justice system exaggerate the harms of SU, conveying the message that illicit drugs are diabolical in nature.

Laws are designed to protect the public. Drug laws and stigma may have been intended to decrease drug use (Palamar, Halkitis, & Kiang, 2013) and prevent harms. However, over time, the destructive implications of the idea that SU is morally and legally wrong has been discovered. Buchman, Illes, and Reiner (2011) proclaim addiction is one of the most stigmatized human conditions. Drug policy contributes to stigma and poor clinical outcomes for all people who use substances, whether the substances are

abused or not (Global Commission on Drug Policy, 2014). Societal fears about drug use inhibit evidence informed policy.

To appreciate the depth of disagreement and societal resistance towards addiction and SUD, consider the following example. After professor David Nutt published "Drug Harms in the UK: A multicriteria decision analysis" (Nutt, King, & Phillips, 2010), he was fired as the chief drug advisor to the UK government (BBC News, 2009). His research highlighted the harms of various substances, including illicit drugs, alcohol, and tobacco. His research spoke to a gap between scientific facts and government policy, where the sanction of substances is not based on actual risk of harm. Many presume this dismissal means the UK government did not want this evidence to inform policy.

Societal resistance to evidence based facts about SU is long-standing and continues today in many nations, including Canada. The aforementioned example of the governments attempted closure of In-Site, the safe injection site in Vancouver, speaks to this. The US led drug war does not respect the fundamental human right of personal choice and systematically marginalizes those who do not conform to policies based on dogma and lacks scientific and social validity (Tammi & Hurme, 2007).

Leading US researcher and neuroscientist Hart (2014) states "current drug policy is largely based on fiction and misinformation" (p. 326). Hari's (2015) historical examination of the circumstances and key players involved in the creation of the 'War on Drugs' untangles layers of malicious falsehoods at the inception of the drug war. Physicians unsuccessfully attempted to stop policies which prevented them from adequately treating many patients (Hari, 2015). Today, scientists and experts all over the world advocate for drug policy reform, as current prohibitive practices are not based on

evidence and have proven to be ineffective with disastrous effects around the world. The Global Commission on Drug Policy (2016) provides evidenced based policy recommendations for countries with consideration given to violent drug markets, security, public health, and controlled medicines. Since 2011, the Commission has strongly advocated against prohibition of drugs, in hopes of a more humane and evidence informed approach (Global Commission on Drug Policy, 2016).

Beliefs

Beliefs are socially constructed in families, workplaces, and society (Blumer, 1969). Both beliefs and SUDs are biopsychosocial in nature, creating a natural alignment of the two topics. Traditional psychology and medicine separate the mind from the body and the person from the environment (Mate, 2003). These divisions are inherently flawed and incorrect, as the "mind develops at the interface between human relationships and the unfolding structure and function of the brain" (Siegel, 2001, p. 67). Supportive emotional bonds lead to optimal physical and emotional development (Elkins, 2016). Neuroscience, attachment theory, and evolutionary biology all indicate that human beings are biopsychosocial creatures who require a social group to develop, live, survive, and heal (Elkins, 2016). Beliefs are both a cognitive (Beck, 1995) and neurological structure (Alcock, 1995) of the mind. Thus, although beliefs arise in the psyche, they depend on the social environment for their physical creation and neurological structure and functioning. Symbolic interactionism supports this biopsychosocial stance.

To understand beliefs in all their complexity requires a broad frame of reference. Biopsychosocial phenomena, such as SUD and beliefs, require an interdependent and

complexity inspired point of view. To understand interdependence, imagine a spider web. Each string of the web depends on the layers above, below, and in each lateral direction for its creation and stability. In the center of this biopsychosocial web is the individual. The life circumstances influencing the individual are like the strings of the web. Factors nearest the individual, or the center layers of the web, can be seen as family and culture, which are influenced by the next concentric layer, such as the political and economic conditions of the nation and so on. All of these factors influence an individual's biological, psychological, and social development. Both SUDs and beliefs alike are dependent on extensive environmental factors to shape the internal conditions on which the phenomenon (of beliefs and SUD) arises. The internal workings of the nervous system manifest to the individual as thoughts and beliefs.

Beliefs are influenced by individual characteristics and experiences. These are shaped by the social environment, which then lead to behaviour specific cognitions and effects, eventually resulting in behavioural outcomes (Pender, Murdaugh, & Parsons, 2002). Beck (1995) similarly states beliefs underlie cognitions, attitudes, and behaviors. Attitudes impact the quality of nursing care (Goldenberg & Laschinger, 1991). The quality of care can influence the decisions about recovery that a person with SUD may make (Speer, 1991). It stands to reason that a nurse's therapeutic potential is based on beliefs, as beliefs govern and drive thoughts and behavior.

A systematic review of stigma and SUD in Canada found societal misconstructions surrounding SUD exist individually, politically, and organizationally (Livingston, Milne, Fang & Amari, 2011). This means stigma exists within individual people, in laws and policies, and within large social groups, such as health care and

police organizations (Livingson, Milne, Fang, & Amari, 2011). This narrative inquiry will begin to illuminate the beliefs of nurses, beginning with a small group nursing students about to enter the workforce.

Nursing Education and Substance Use

Nursing educational institutions create foundational knowledge, skills, and values upon which all nursing practice is built. In addition, nursing programs provide the social environment which can potentially shape and mold cognitive patterns already in place. Sadly, there is evidence societal stigma exists within nursing. McKenna, Boyle, Brown, Williams, Molly et al. (2012) found nursing students to have less empathy toward persons with SU problems when compared to other disease states. More recently in the United Kingdom, Harling (2017) surveyed the attitudes of students of midwifery, nursing, social work, and psychology. Nursing students were found to have the least tolerant attitudes towards persons who use illicit drugs (Harling, 2017). Descriptions of nursing students' beliefs about SU upon entry into the workforce is a critical first step to ensure high quality nursing care is delivered to persons with SUDs in Canada.

The first step in improving health care is identifying there is a need for improvement. Historically, education of health care providers with regard to SUD has been inadequate. In an environmental scan, the Canadian Federation of Mental Health Nurses (CFMHN) found the mental health and addictions content of Canadian undergraduate programs to be inadequate and highly variable (Tognazzi, Davis, Kean, Osborne, & Wong, 2009). Smith & Khanlou (2013) state nurses are the largest group of health care providers and are key partners in reducing stigma and providing adequate mental health and addiction services in Canada. To address the educational gap, the

Canadian Association of Schools of Nursing (CASN) (2015) released the "Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education in Canada" framework. This document is intended to provide guidance to educational institutions for curricula design. The framework clearly outlines six competencies nurses should attain through their education (see Appendix A). Key perspectives include stigma as a barrier to care, the mental health continuum, mental health promotion, trauma-informed care, and orientation towards recovery (CASN, 2015). This proposed narrative inquiry will obtain a snap shot in time of a small sample of Canadian nursing students' beliefs soon after the release of the 2015 CASN document.

Although the sample size is small, the findings of this study will speak to nursing educators, researchers, and employers. Surveying new nurses' beliefs provides relevant information in these sectors, particularly in education, in light of the new guidelines. The absence of education as a theme influencing beliefs, or conversely, the significance of education on beliefs, can inform educators. Educators can use the beliefs of these new nurses to modify course content as needed, aiming to create beliefs which align with CASN (2015) principles. In addition, findings can inform employers' quality improvement initiatives and staff education. Surveying beliefs ultimately provides an opportunity to enhance and deepen nursing's scholarly discussion regarding SUD. With steps being taken to improve nursing education, quality assurance practices and research can enhance the quality of care provided to persons with SUD.

Insufficient education may contribute to the continuation of societal misconceptions of SUD and perpetuation of stigma. Studies conducted in Brazil, United Kingdom, Australia, and the USA show nursing students are inadequately prepared to

competently and confidently care for persons with SUD (Campell-Heider et al., 2009; Holloway & Webster, 2013; Pillon, Ramos, Villar-Luis, & Rassool, 2004). Currently, there are no studies examining Canadian nursing students' beliefs, attitudes, knowledge, confidence, or experiences related to SUD. Deficient education of health care providers around the globe legitimizes the need for inquiry into Canadian nursing students' beliefs. This inquiry focuses on beliefs alone, as it is understood that beliefs are foundational and persist overtime (Beck, 1995).

The following examples speak to the challenges associated with changing beliefs about SUD. Some research has found education to have a positive effect on therapeutic attitude and health care delivery (Ford & Ryrie, 2000; Munro, Watson, & McFadyn, 2007). Conversely, other studies report contradictory findings (Ford, Bammer & Becker, 2008), indicating that education alone does not change beliefs. Skinner, Roche, Freeman, and Mckinnon (2009) found interventions intended to improve the quality of care for persons with SUD must extend beyond to the organizational level, as education and training of individuals alone is insufficient to improve the attitudes of the staff group. The culmination of the collective attitudes of those employed by an organization is known as organizational culture.

Constructive organizational attitudes have been identified as a salient feature of successful mental health care (Clossey & Rheinheimer, 2014). Nurses spend a significant amount of time within the organizational culture. Symbolic interactionism states beliefs are socially constructed (Blumber, 1969). According to this tenet, nurses' beliefs will be influenced by the social culture in which they work. Thus, organizational culture may have the ability to influence beliefs. In an Australian study, *role support*, defined as the

nurse's "belief that she/he could 'easily find someone' to help formulate a response to personal and clinical issues related to patient care" (Ford, Bammer, & Becker, 2008, p. 2459) was found to be the most important factor to improve therapeutic attitude towards illicit drug users, indicating nurses' attitudes are contingent on their peers.

Once student beliefs are well defined and thoroughly understood, educational interventions which incorporate the CASN (2015) recommendations can have a greater degree of efficacy and specificity. Educators can tailor curricula to address knowledge gaps or opprobrium. Further qualitative or quantitative studies may be designed around findings of this inquiry. Organizations may also allow findings to influence their policy, educational programming, and efficiency of working with clients with SUDs.

Substance Use Among Nurses

Moreover, to add to the importance of this topic, nurses are not immune to the development of SUD within themselves. Duffy, Avalos, and Dowling (2015) found nurses utilize alcohol to alleviate work related stress. Nurses who develop SUD thought it would never happen to them and feel misunderstood and judged (Burton, 2014). Monroe and Kenaga (2010) state SU problems among nurses are often under reported due to stigma and punitive policies. Recent publications emphasize nurses need treatment, rather than discipline (Strobbe & Crowley, 2017; Ross, Berry, Smye, & Goldner, 2018). Findings such as these raise questions about the intrinsic perceptions of nurses about SU. For instance, who is at risk, and what does it means to have a SU problem? A recent literature review concludes nursing overemphasizes personal responsibility, leaving a gap in the literature regarding structural factors which give rise to SU, such as physical, social, economic, and policy environments (Ross, Berry, Smye,

& Goldner, 2018). Additional questions might examine the manifestation of self-stigma and perceptual variations among various groups of nurses. This generalist narrative inquiry can begin to assess the status of Canadian nurses' beliefs about SUD, beginning with nursing students.

Quantitative Research

Much of the literature on nurses' and nursing students' experience of SUD is quantitative in nature and was conducted outside of Canada. Only one Canadian study was found which quantitatively surveyed nurses' attitudes using the Drug and Drug Problems Perception Questionnaire (DDPPQ) (Chu & Galang, 2013). All other attitudinal research has been conducted in countries such as the USA, Brazil, Australia, and the UK. International studies reiterate two messages: nurses lack education about SUD (Baldwin, Bartek, Scott, Davis-Hall, & DeSione, 2009; Pillon, Ramos, Villar-Luis, & Rassool, 2004; Rassool, 2004; Rassool, 2007) and stigma exists on personal, structural, and political levels (Chang & Yang, 2013; Livingston, Milne, Fang & Amari, 2011). Researchers survey personal SU history, attitude about SU, confidence to work with this population, and the efficacy of specific educational interventions (Baldwin, Barteck, Scott, Davis-Hall, & DeSimone, 2009; Coleman, Honeycutt, Ogden, McMillian, O'Sullivan et al.,1997; Gerace, Hughes, & Spunt, 1995; Rassool, Villar-Luis, Carraro, & Lopes, 2006; Reilly, 1998). Studies examining nursing education about SU ask students to approximate the type and amount of substance abuse education received (Pillon, Ramos, Villar-Luis, Rassool, 2004; Rassool, 2008). Collectively, the essence of these inquiries is that nurses receive insufficient education about the complex phenomenon of SU and SUD.

A number of quantitative studies examining nursing students' attitudes do so before and after a specific educational intervention (Puskar et al., 2013; Rassool & Rawf, 2007; Vadlamudi; Adams, Hogan, Wu, & Wahid, 2008). Puskar et al. (2013) used the validated Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ) and the Drug and Drug Problems Perception Questionnaire (DDPPQ) to measure student attitudes toward working with clients who use substances. It was found that Screening, Brief Intervention, and Referral to Treatment (SBIRT) education improved students' attitudes towards working with clients who use alcohol, while a less considerable improvement in attitude was found regarding clients who use drugs (Puskar et al., 2013). Rassool and Rawf (2008) used three different validated tools, each one individually assessing knowledge, attitude, and confidence after an eight session drug and alcohol educational program. Each domain of knowledge, attitude, and confidence was improved as a result of the education (Rassool & Rawf, 2008). Vadlamudi et al. (2008) found four hours of alcohol specific brief negotiated intervention education improved knowledge, attitudes, and confidence. A 100-item questionnaire not previously validated was used before and after the educational intervention in their study (Vadlamudi et al., 2008). To summarize, it has been found education can have a positive influence on knowledge, attitude, and confidence regarding working with persons who use alcohol, and perhaps other substances, when assessed shortly after an educational intervention.

Measurement of knowledge, attitude, and confidence towards working with clients who use drugs is challenging due to the variety of drugs which can be used or abused. Reactions of health care providers vary based on the drug abused (McLaughlin & Long, 1996). Consequently, qualitative research can provide deep insight by allowing

participants to freely address subtle and complex aspects of SUDs. Data obtained from qualitative methods can inform nurses which aspects and components of SUD require the most attention, in practice, research and education.

Qualitative Research

Due to the paucity of Canadian literature, prevailing international qualitative research is examined. There are not any qualitative Canadian studies on nurses' attitudes toward SU or addiction. Critical appraisal of available research informed the design of this study as a means to increase internal validity. Many of the available qualitative studies into nursing students' attitudes lack a specific replicable methodology and trustworthiness. For instance, Harling and Turner's (2012) examination of factors influencing attitudes did not stay true to the principles of grounded theory as a questionnaire was operationalized. As Harling and Turner (2012) aimed to identify factors influencing students' attitudes, it was found that:

> Student nurses enter training with a wide range of personal experiences relating to illicit drug use. The influences of society's negative views and the image of drug use presented in the press appeared to be significant factors in developing their attitudes on the subject. In the absence of effective approaches to education, and given that many professionals in the practice environment appear to view illicit substance users in a negative way, it is likely that interventions with identified drug users will be influenced by negative attitudes. (Harling & Turner, 2012, p. 235)

Vandermause and Townsend (2010) describe a narrative approach to addiction education in nursing. Educators found narrative pedagogy a useful means to cultivate

reflective practice among students (Vandermause & Townsend, 2010). However, a vague use of "autobiographical research using a hermeneutical phenomenological approach" (Vandermause & Townsend, 2010, p. 431) renders this qualitative research disadvantageous due to the lack of description of the methodology. Confusion about the data collection and analysis of teachers' narratives about SUD leaves this study lacking auditability.

Moreover, it is difficult to unravel the validity of the Grafham, Matheson, and Bond (2004) exploratory study due to the lack of information regarding data analysis. This exploratory study with 17 nurses found that nurses entered into addiction medicine because of personal interest. A lack of consistent participation of general practitioners (GPs) left these nurses with undue responsibility in clinical decision making when the model of care in the United Kingdom is supposed to be that of shared and multidisciplinary care (Grafham, Matheson, & Bond, 2004).

In a like manner, Byrne, Happel, Welch and Moxham (2013) conducted in-depth unstructured interviews as a means to assess students' perceptions of mental health education being taught by a person with lived mental health experience. The qualitative exploratory approach to this research lacks a theoretical foundation or specific methodology making it difficult to assess validity. The lack of structure is intended to enhance the revelation of significant phenomena. Similar to narrative inquiry (NI), this mode of investigation is person centered and uses the "voices of participants to guide the quest for information and understanding" (Bryne et al., 2013, p. 197). The four stages of data analysis is methodologically congruent with the research approach enhancing the reliability. Overall this study provides useful information and is replicable. The studied

approach to mental health nursing education was well received and impactful for nursing students (Bryne, Happel, Welch, & Moxham, 2013).

Also, Clancy, Oyefeso, and Ghodse (2007) present a generalist type of qualitative study, not linked with any specific type of qualitative research principle or theory to guide their focus groups regarding recruitment and retention in addiction nursing. Data was analyzed using "Burnard's six content analysis stages" (Clancy et al., 2007, p. 161) contributing to reliability and validity. It was concluded that exposure to addiction nursing, autonomy, the client profile, treatment philosophy, and care approach are all influential factors in recruitment and retention of nurses in addiction nursing practice (Clancy et al., 2007).

Burton (2014) provides an example of a methodologically strong and auditable qualitative study. Insightful accounts of nurses' personal experience of SUD is presented through the use of Husserl's phenomenological ideology (Burton, 2014). Nurses with SUD lacked healthy coping skills and suffered shame, fear, and self judgement (Burtons, 2014). To enhance understanding of SUD and humanize the experience Burton (2014) calls for more qualitative research and recommends nurses in recovery deliver nursing education on the topic. The recovery focused approach to mental health care in Australia also encourages mental health consumers participate in education (Bryne, Happel, Welch & Moxham, 2013). The Mental Health Commission of Canada (2016) states education involving persons with lived experience of mental health is the most effective way to reduce the widespread stigma in Canada. RNAO (2017) also supports this approach.

. Overall, the essence of the qualitative research data parallels the quantitative data. Nurses are found to have negative attitudes (Harling & Turner, 2012) and

inadequate education (Boulton & Nosek, 2014; Vandermause & Townsend, 2010). Recruitment and retention of nurses to work in addictions settings is problematic (Clancy, Oyefeso, & Ghodse, 2007). Understanding the beliefs of nursing students can help to design strategies to address such retention issues and educational interventions. The insights gleaned from this inquiry will come at a key time as Canadian educational institutions integrate the CASN (2015) mental health and addictions recommendations into their curricula. It is hoped nursing education can prepare nurses to provide dignified and loving care to those struggling with SU problems.

Nurses are well suited to attenuate societal misconstructions about SUD, safeguarding the rights and humanity of persons with SUD. Insight into the foundational cognitive and emotional structures cumulatively known as beliefs is beneficial knowledge as nursing educators aspire to create nurses who have the capacity to provide meaningful and effective nursing care to this population. Narratives about SUD will supplement current literature by exposing students' beliefs about SUD. Open ended questions allow participants to address various aspects of SUD, which may include choice, risk, harm reduction, stigma, and recovery. Blumer (1969) ascertains beliefs develop within our social worlds. Latent stigma may be unmasked, as nursing students may hold stigmatizing beliefs, similar to the general Canadian public.

CHAPTER THREE: METHODOLOGY

Research Design: Narrative Inquiry

This inquiry shed light on Canadian nursing students' beliefs about SUD. Narrative inquiry (NI) is eminently well suited to elucidate the unknown status of Canadian nurses' beliefs about SUD because narratives provide meaningful, sequential, and culturally specific information. Researchers in education (Clandinin & Connelly, 2000), the social sciences, human sciences, and indigenous studies (Kovach, 2009; Riessman, 2008) have used NI to understand the way people make sense and meaning out of their lives and experiences (Yow, 2005). Narratives are culturally framed, as the culture influences the values, beliefs, and attitudes of its members (Munhall, 2012; Wells, 2001).

NI supports holistic and chronological appreciation of nursing students' perceptions of SUD throughout their lives. Narratives create a dynamic view of the human experience, providing insight into the identity, lifestyle, culture, and historical context of the narrator (Yow, 2005). A fundamental aspect of narratives is contingency and temporal ordering (Riessman, 2008). NI is designed to chronologically understand people's experiences and the meanings they attribute to them within the context of their lives and social world (Munhall, 2012).

Narrative's chronological organization can reveal development (Yow, 2005). Resultant is the revelation of the development of beliefs about SUD in all of their complexity, throughout time, circumstances, and phases of life. Students' early thoughts about SUD are linked together with current beliefs by examining the evolution of their perspective in response to their life experiences and nursing education. A collection of

narratives on a particular topic from a specified population creates an opportunity for cultural, contextual, and relational understanding.

NI can be viewed as both a phenomenon and a methodology. Narratives are different from stories in that they contain a collection of stories, events, or ideas linked together by the narrator as a means to construct a sense of identity and understanding of the world (Riessman, 2008). NI serves as a means to understand the context, characters, and tensions surrounding a topic or situation, assuming people are always in relation with themselves, others, and the social world (Clandinin & Connelly, 2000). The variables which are perceived by participants to influence their beliefs about SUDs are chosen independently. By giving participants the opportunity to reveal how they perceive their beliefs on SUD to have developed, readers are oriented to the context of Canadian nursing. Participants sequence these salient factors and/or experiences in the way that best expresses their points of view.

Perceptions are based on internal and external factors. Internal factors include the selective and biased nature of memory, past personal experience, family of origin, comfort level, emotional state, education, and perception of the researchers' expectations (Riessman, 2008). External factors such as time, culture, research setting, social norms, and verbal and non-verbal actions of the researcher also influence the narrative (Reissman, 2008; Wells, 2011). NI allows for the emergence of a contextual, psychosocial conception of SUD among the group of nursing students under study. Consideration was given to the dominant societal beliefs (stigma), historical context (personal and family history, colonization, and generational trauma), social relations, personal identity, nursing education, and professional nursing ethics and values.

Narratives are a complex form of storytelling. Storytelling has been used for millennia by human beings as a means to understanding one another. Oral history is a universal, traditional mode of conveying information and personal testimony through storytelling in oral form (Yow, 2005). Clandinin and Connelly (2000) describe NI as a collaborative means of inquiry "over time, in a place or series of places, and in social interaction with milieus" (p. 20). Story telling "is the powerful means by which cultures, families, and communities are formed and maintained, national identities are preserved, problem-solving skills are taught, and moral values are instilled (Mehl-Madrona, 2005, p. 1). Riessman (2008) describes narratives as "social artifacts" which provide information not only about the individual speaker, but of the society, culture, and place in time (Riessman, 2008, p. 105). There is an opportunity to examine both overt and covert aspects of perceptions.

NI provides a medium for stories which are not normally told, thereby uncovering hidden truths (Munhall, 2012). The meaning and significance of SUDs is dissected through the examination of cognitions, emotions, and symbols conveyed in participants' stories. The use of metaphor invites the audience into greater comprehension of what is intended to be expressed by the narrator through the use of commonly accepted meanings for ideas, objects, and/or people. Munhall (2012) states narratives reveal conscious and unconscious truths, meanings, values, conventions, and dominant beliefs. These concealed aspects of perception are important considering the dominant societal discourse of stigma surrounding SU.

Charon (2001) describes narrative knowledge as the understanding of the "meaning and significance of stories through cognitive, symbolic, and affective means"

(p. 1898). It is accepted that NI is a collaborate process between the listener and the story teller. Similar to how participants shape their narrative, the narrative investigator will further mold the description, despite honest efforts to control for bias. Researchers unconsciously and unintentionally filter the data through one's own cultural, educational, professional and personal perspective (Wells, 2011), further contributing to co-creation of the narratives. Expectant awareness and self-disclosure of this research hazard is intended to help the researcher deliver narratives which authentically and accurately convey the experiences and beliefs of nursing students.

Experimental Intervention

Semi-structured interviews were conducted. A general interview guide approach was used (Wells, 2011). A set of pre-determined open ended questions was asked in a structured order (Appendix B). Based on the principals of NI, open questions are intended to have participants create the boundaries of the discussion. Clear questions, observation of the participant's non-verbal behaviours (when possible), and continual judgement of the completeness, validity, and relevance of the participants' responses served to guide the researcher to conduct a successful interview by means of appropriate pacing, probing, and clarifying (Yow, 2005). The first question asks participants to describe how they have come to understand SUD (see Appendix B). Additional questions were aimed to have participants share ideas about the concepts contained in the CASN (2015) mental health and addiction framework, including recovery and stigma.

To begin the interview, caring interpersonal relations typical of a nursing interaction built trust between the researcher and participant. For instance, the researcher was pleasant, warm, and professional, introducing oneself and explaining the research

process. Review of the consent and research process, including how any concerns would be handled, demonstrated accountability, competence, ethics, knowledge, and professional relations (College of Nurses of Ontario, 2009).

Narratives were collected, transcribed, approved by participants and analyzed. Using direct quotations, the final product is a meta-narrative or grand-narrative, re-telling the salient beliefs of the group of participants. There were significant similarities and key themes present among all narratives, therefore the notion of a ‘‘collective story’’ (Richardson, 1990, p. 25) was appropriate to express findings and protect participants' identities. A meta-narrative aids in protecting participants' identities by bringing together many examples and views, decreasing the chance that any one participant can be identified by their narrative. Confidentiality was also protected by assigning each participant a number. Pseudonyms for people and places would have been used, but were not required. Narratives are accurate and meaningful to the participants because truth was honoured. The researcher gave meticulous attention to restrain personal biases to allow for full, truthful, and authentic expression of the data. The use of direct quotations honours a participant's truth.

As an additional means to honour truth, the researcher kept a journal of personal reflections at various stages throughout the research process to create personal awareness of reactions to the research process and data. Self-reflection using the questions outlined in Yow (2005) was used. For instance, the researcher asked herself: "What was I feeling so intensely about during that discussion?" (Yow, 2005, p. 233). This directed the researcher to personal agenda(s). Clear articulation of the researcher's thoughts produced in reflexive journaling assisted in clear identification and restraint of personal biases. The

personal awareness of bias prevented the researcher from deviating from the research questions or making any facial expressions in response to participants' responses.

Data analysis revealed themes present among all nine of the participants' narratives about their beliefs about SUD. NI supported this contextual understanding of dominant world views, also known as the authorial voice, rather than seeking an objective truth (Munhall, 2012). Here, participants' views are accepted as truth. NI honours the "insider perspective" associated with the mental health recovery movement (Rhodes & DeJager, 2014). NI is an established research methodology which allows the synthesis of real life experience to inform clinical practice (Rhodes & DeJager, 2014). Insight into the multifarious factors influencing nursing students' beliefs, knowledge, and attitudes provided by NI parallels the holistic perspective required to understand the complex biopsychosocial condition of SUD.

Considerations

Four commonly accepted concepts within narrative guide the approach. The first relates to meaning. Principally, stories hold meaning (Kleinman, 1988). Narrative meaning is saying something in a way another person can understand (Bauman, 1993). Stories are a way to share our experiences (Charon, 2007; Riessman, 2008), make sense of things, and contribute to our identity (Riessman, 2008). Story telling has been an integral aspect of acquiring and transmitting meaning and knowledge through the ages. The second emphasis is on holism. Kovach (2012) states that personal narratives are the most effective way to capture holistic epistemology. Wilson (2008) states that Indigenous peoples of Canada value the inclusion of a storyteller's own life experience into the story as a way to assist listeners to absorb the knowledge shared. Participants' beliefs are

captured in their complexity by inviting participants' own life experiences into the narrative.

The third underpinning concept and the theoretical framework is symbolic interactionism. Symbolic interactionism is a relational perspective, connecting the individual's beliefs to the social and cultural environment. Narratives are contingent on context and meaning. The stories and the language within a narrative are seen as a complex representation of an individual's reality based on the meaning already attributed to the things within the social and cultural environment (Blumer, 1969). The dynamic interplay of meaning making and the social world influences, shapes, and constructs how individuals makes sense of everyday experience.

The fourth inter-related concept that guided the approach was temporality, placing things in the context of time. The storytellers here are all nearing the end of their formal nursing education. Clandinin and Connelly (2000) state that "any event, or thing, has a past, a present as it appears to us, and an implied future" (p. 29). The participants' beliefs about SUD will undoubtedly impact their future actions as nurses. Guided by these four aforementioned principals, raw data from the participant stories was synthesized to express views on SUD, using participants' own words and recalled experiences.

The creation of a chronological narrative allows the telling of how students' beliefs have evolved throughout their lives and in response to their educational experiences. While keeping the story intact, thematic analysis was used to focus on the content of narratives (Riessman, 2008) to identify themes. Themes were highlighted and supported with direct quotations. Key quotations were chosen to tell a story reflective of

the beliefs of the sample, weaving together experiences from various participants. Readers are engaged in a logical, accurate, and insightfully re-told narrative.

Participant Selection

Participation in this research required nursing students be greater than eighteen years of age and be enrolled in the final year of the BScN program. Faculty members served as key informants, providing the researcher with access to students. Convenience sampling was chosen. The goal was to recruit eight to ten participants. Wells (2001) states a sample of five narratives is sufficient for complex analyses studies. The complexity of narratives as a social phenomenon (Polit & Beck, 2012) requires detailed analysis; therefore, fewer participants are required when compared to projects with less detailed evaluation. A sample slightly larger than the recommended minimum was chosen to support data saturation and to allow for possible attrition. The sample size is small enough to allow the researcher to really 'hear' the essence of students' narratives but large enough to reflect multiple views.

Narrative inquiry is far more than merely telling a story (Clandinin & Connelly, 2000). When a story is told, it carries context. The context for this study was a midsized university in northern Ontario, Canada. The city is located in an urban location which serves as a hub for many rural communities. Although the sample size is small, findings from this study may inform nurses and educators in both rural and urban settings. It is possible study participants may have originated from a large urban center, a small rural town, or remote reservation, reflecting beliefs specific to that context. This site is chosen to reflect the uniquely Canadian population.

This study involved eight Caucasian participants and one Caucasian/Aboriginal participant. There were eight females and one male. Participants were aged 21 to 41 years, with an average of 27 years of age. Five interviews were conducted in person, and four over the telephone. Each participant responded to the circulated e-poster (Appendix E) by faculty which outlined the basics of the study. Prior to the interview, participants were electronically provided with the invitation to participate (Appendix G) and the consent form to review (Appendix D).

Ethics and Recruitment

Ethics approval was obtained from the researcher's academic institution, York University, and from the research ethics board of the university where the data collection took place. Participants were selected from one educational institution to ensure exposure to the same curriculum and social context. In response to a letter (Appendix H), permission to conduct the study was obtained from the director of nursing. To access the student population, the director of nursing, or gatekeeper, initially circulated the invitation to participate. An e-poster (see Appendix D) was sent to all fourth year nursing students. Faculty teaching the fourth year research classes later assisted in electronically re-circulating the e-poster after the first distribution did not yield the ideal sample size.

Participants were offered to meet the researcher at a convenient, comfortable, real world, time and location. The interview did not exceed sixty minutes. If a face to face interview was not possible, a telephone interview was arranged. A small incentive (a ten dollar coffee gift card) was provided to participants at the time of their interview and after they approved the transcribed version of their interview. This incentive was intended to increase participation, as incentives have been found to improve participation

(Edwards et al., 2009, as cited in Polit & Beck, 2012). Ongoing, informed, written and process consent was obtained.

Any inadvertent negative consequences arising as a result of the research would have been documented and followed by the researcher in accordance with nursing ethics. This would include duty to report and safety assessment (CNO, 2015). As appropriate, participants would have been assisted to connect with supportive services such as medical care, counselling, addiction services, 12-step programs, or ALANON should participation in the study causes emotional distress. The researcher and participant would have together decided on an appropriate plan of care. This was not required. The researcher was available to participants after completion of the study (telephone and email) if questions or concerns arose. To date, none of the participants have contacted the researcher for any reason. All participants were happy to participate. No safety concerns arose from completion of this research.

Data Management

All data remained confidential. The consent form is the only documentation containing the participants name. Consent forms are stored in a locked file separate from the remainder of the data. Questionnaires and transcriptions were assigned a corresponding number. Participants told stories with very limited identifying information, requiring very little changes to ensure anonymity. Interviews were transcribed within one week. The transcript was emailed to participants for their review, also known as member-checking. Participants were aware they could remove, change, add or clarify any component of the transcription. Negligible changes were applied to one of the interviews before approved. Otherwise all transcripts were approved by

participants to be accurate reflections of what they said and meant. All recordings and transcription documents have been stored with password protection, only accessible to the researcher. Consent forms are locked in the researcher's office. All data will be securely stored for a minimum of five years following completion of this study and then destroyed.

Trustworthiness

As modern science makes room for qualitative research, researchers are required to take steps to ensure trustworthiness of data. Subjective data seeks to understand participants' truth, rather than one universal truth as defined by a positivist approach. The social construction of beliefs speaks to the credibility of narrative inquiry for attaining truthful and trustworthy data. Lincon & Guba (1985) state transferability, dependability and confirmability contribute to trustworthiness. Participants self selected to participate. This study did not seek to control for different demographics or characteristics other than the requirement to be a fourth year nursing student. This study can easily be repeated in other settings.

As a means to ensure dependable research, the researcher maintained an awareness of personal biases and the influence of the researcher. Journaling personal perception and feelings of the researcher shines light on the influence of one's own past experience, current understandings, and professional expectations. The researcher was pleased participants understood the complexities and challenges associated with SUD. The researcher has a personal bias that stigma exists in nursing. Self-reflection of the researcher aided in keeping biases and personal influence out of the data. Research procedures were followed exactly, without deviation from the semi-structured research

guide. Self reflection reduced the temptation to ask additional questions or make facial expressions or other non-verbal gestures which may indicate the researcher's feelings. Confirmability was supported by having participants approve the transcription of their interview. One participant requested the word "he" be changed to "I" in the sentence "I can see who he was when I was a kid". This was the only correction applied to the transcriptions.

Rigor

To ensure rigor, the following Burns (1989) criteria were used: (a) descriptive vividness; (b) methodological congruence; (c) analytic preciseness; (d) theoretical connectedness; and (e) heuristic relevance. To ensure descriptive vividness, participants validated the accuracy of their stories before analysis began. The researcher clarified understanding during the interview and participants reviewed and approved transcribed data. The authentic nature of narratives may draw on the heart strings of readers, emotionally engaging them in the topic. The goal of research is to raise the consciousness (Munhall, 2012) on a given topic, in this case nursing students' beliefs about SUD. Evocation and expression of truth and emotions will aid in attainment of this objective.

Transparency and methodological congruence are maintained by presenting all research procedures in the final report (Munhall, 2012). Clear documentation of the steps taken throughout the research process ensures auditability. Ongoing informed consent supports ethical rigor. Reflexivity will apprise the researcher of any threats to validity or deviation from narrative methodology. The researcher acknowledges that qualitative data is a co-construction of the researcher, the research process, and the participant. Denzin

(2001) affirms it is not possible to attain an objective truth which guarantees absolute methodological certainty outside of a social, historical, and value laden world. The truth is what is true for the participant. The establishment and acceptance of this truth enables the researcher to critically analyze the research process to identify potential biases or methodological flaws.

Ongoing review and feedback by members of the thesis committee prior to finalization served as a peer review, aiding in analytic preciseness. Polit and Beck (2012) state a peer review may aid in identification of any omissions, obvious errors, coherence, or areas for improvement. Theoretical connectedness is supported by the use of Clandinin and Connelly's (2000) three dimensional space for narrative structure approach. Clandinin and Connelly (2000) popularized NI for educational research, validating its use for this inquiry. Heuristic relevance encompasses three domains: intuitive recognition, relationship to existing knowledge, and applicability (Burns, 1989, p. 51). The researcher denotes intuitive recognition by clearly presenting narratives in an incontrovertible fashion. A comprehensive literature review and the strong rational for the study connects this inquiry to existing knowledge. Recommendations for nursing practice, education, and further research demonstrate the applicability of this NI.

Data Collection

Contact began with all potential participants via email as participants responded to the e-poster (Appendix E) circulated by faculty. Participants were thanked for their willingness to participate in nursing research and were emailed a copy of the invitation to participate research letter (Appendix G) and the participant consent form (Appendix D). Participants were asked to review the information and ask any questions prior to

negotiating a time to conduct the interview. A mutually agreeable time was set to conduct the interview. Participants chose the location most convenient for them. Three of the five face to face interviews were conducted in a coffee shop, and two were conducted in a quiet office space. Narratives were told without any identifying information; therefore, confidentiality was not compromised. Participants did not have any concerns about the semi-privacy of the coffee shop. The remaining four interviews were conducted over the telephone. Each interview was conducted by the researcher. All interviews were completed within 60 minutes.

A semi structured interview approach (Appendix B) was used to individually interview participants on one occasion. Interviews were conducted between October 1, 2017 and January 8, 2018. Interviews were conducted in a friendly professional manner, with minimal discussion prior to data collection other than a brief introduction and review of the consent and research procedures. An opportunity to ask questions was provided at the beginning and end of the interview. The researcher reviewed with all participants the voluntary nature of the research, potential harms, the ability to withdraw from the study at any time without penalty of any kind, and the choice to not answer any question(s) during the course of interview. It was made clear to participants the researcher was an independent entity, unrelated to the participant's university. It was hoped the lack of affiliation to the school would reduce the power differential between researcher and participant by eliminating any academic expectation(s). Confidentiality was maintained by providing students a pseudonym, in this case a number. Any identifying data such as work places, dates, and names (Kelly & Howie, 2007) would have been changed on transcribed data. This was not required.

Demographics and research questions about past personal SU and personal experience with SUD were obtained through an anonymous paper questionnaire (see Appendix C) before the interview began. The presence of societal stigma, shame, fear, or professional accountability may have prevented participants from openly discussing personal experiences of SUD. Thus, this option was given as a part of the paper questionnaire. It is possible personal SU may be a factor in creating beliefs about SUD; however, this information was not intentionally sought out in the interview. Nursing ethics and mandatory reporting standards apply only to licensed nurses (Canadian Nurses Association [CNA], 2008; CNO, 2015), but not nursing students. If a participant disclosed a personal SU problem which could compromise safe delivery of nursing care to members of the public, the participant would have been encouraged to connect with support services. Support in accessing these services would have been provided in accordance with the participant's wishes. Law enforcement would have been contacted if any threat to one's personal safety was present.

The researcher did not want to convey any opinions or biases related to the subject matter; therefore conversation was limited prior to starting the interview. Participants were thanked for their time. After informed consent was obtained, participants completed the demographic questionnaire (Appendix C) and the audio-recorder was set up. Each interview followed the same structure and sequence by following the interview guide (Appendix B). The researcher also referred to the interview guide for gentle probes such as “can you tell me more about that?”, “might you be able to give me an example?”, and “is there anything else you might like to add?” (Munhall,

2012, pp. 150-151). These prompts were seamlessly posed in a conversation-like exchange intended to generate detailed accounts (Riessman, 2008).

Each interview was audio-recorded and transcribed verbatim. Interviews are digitally stored with password protection. Interviews ranged from twelve to 60 minutes. Participants were emailed transcribed data within one week. They were offered a subsequent interview to omit, enrich, or clarify data. Second interviews can support descriptive vividness (Burns, 1989) and expression of truth. All participants declined a second interview and approved the transcript of their interview electronically through email. Individual interviews allowed for conversational depth to unfold, creating a sacred and confidential space. Contrarily, group interviews risk “group think” or dominance of a few narratives.

The researcher aimed to collect and deliver unbiased research. Reflective journaling was used to keep the researcher's perspective separate from participant's perspectives (Polit & Beck, 2012). The researcher kept personal views bridled, careful not to convey any judgement or personal opinion. Reflective journaling aids in identification and recording of biases, feelings, surprising findings, conflicts, methodological steps, and problems (Polit & Beck, 2012). It is recognized that ultimately narratives are a co-construction of the researcher, the participant, and the research process (Wells, 2011). A second journal, in the form of a field text was used to aid the researcher in accurate re-restoring of narratives. For the interviews which took place in person, attention was given to the environment, non-verbal actions, and characteristics of speech delivery (Clandinin & Connelly, 2000; Wells, 2001).

Data Analysis

Data collection and data analysis was performed in a systematic fashion. Demographic data (Appendix C) was compiled into the tables. After each interview was approved, each transcript was read and re-read (Wells, 2001) along with the field notes. Initial impressions and themes from each narrative were noted. Participant responses were then organized specific to each question from the research guide (Appendix B) on coloured pieces of paper. For instance, participants' responses to question one were compiled on purple paper and responses to question two on pink paper. The colour coding of the responses was helpful to keep data organized, creating a tangible way to move back and forth between narrative responses to the research questions. Themes and key points were underlined. Initial impressions were noted in the margins of the coloured paper. The responses of all participants specific to each question was again read and re-read and analyzed for themes specific to each question (Wells, 2001).

Finalized datum was analyzed for both theme and structure. The following five steps outlined by Wells (2011) were operationalized in thematic analysis: 1.) read and re-read; 2.) write initial impressions; 3.) identify themes; 4.) colour code themes, repeatedly reading each theme separately; 5.) make note of conclusions associated with each theme.

Thematic analysis. Review of the data continued until patterns or 'themes' of beliefs were evident to the investigator. Initial impressions ascertained from each narrative was documented. Thematic narrative analysis examined "what" had been said in the narratives (Riessman, 2008, p. 53). Attention was paid to local and societal discourse. Insights attained from reading the transcripts was compared and contrasted to discern between themes that were present among all participants' narratives and among

individual participants' narratives. Themes were memoed and documented in a computer spreadsheet. Data was read and re-read to consistently code the entire data set (Polit & Beck, 2012). Codes were organized under the categories of the emergent themes. Finally, conclusions were drawn from the entire data set and documented.

Structural analysis. Subsequently, structural analysis took place. According to Munhall (2012) evaluation of the use of language and metaphors allows for greater understanding of unconscious meanings, conventions, and societal beliefs. Evaluation of language is a form of structural analysis, evaluating the structural components of the narrative. Structural analysis is a process which can further organize data and increase validity of the narratives (Riessman, 2008). As data was transcribed, prosodic figures of speech such as pauses, changes in tone, or pace signaled line breaks (Riessman, 2008). Participant accounts were broken into stanzas according to topics (Riessman, 2008). Structural analysis brought attention to linguistics, grammar, metaphors and structure of the narrative. Recurrent figurative language was noted. Munhall (2012) recommends attention be paid to patterns in language, inconsistencies, self descriptions, intentionality, and authorial voice. Highly organized data can then be compared and contrasted, identifying common elements across stories, "achieving triangulation" (Riessman, 2008, p 91).

Story telling. To begin re-storying in a logical manner, Clandinin and Connelly's (2000) three dimensional space narrative structure approach was used to create meta-narratives. The three-dimensional narrative inquiry framework allows for logical configuration of the data. Meta-narratives are "webs of meanings that reflect cultural themes and beliefs that give a local story its coherence and legitimacy" (Zilber, Tuval-

Mashiach, & Lieblich, 2008). Through the creation of a meta-narrative, emergent and repeating themes are highlighted while keeping readers engaged in a coherent, meaningful story. Meta-narratives convey the essential aspects of interviews while protecting the identity of participants, along with the people and places contained in the narratives. Data were considered under the following categories: “personal and social (Interaction); past, present, future (Continuity); and place (Situation)” (Clandinin & Connelly, 2000, p. 50) along a timeline.

Founded on the work of John Dewey, Clandinin and Connelly (2000) created the three-dimensional approach as a means for researchers to create narratives which move inward, outward, backward, and forward, while remaining situated in a place and context. Loosely based on Dewey's theory of experience, Clandinin and Connelly (2000) integrate the awareness of continuity, and interaction, and situation into their narrative work. They include past, present, and future thoughts as a part of continuity. Interactions are both personal and social (environmental), intertwined with situation, or place (Clandinin & Connelly, 2000). Thus, the three-dimensional framework helped the researcher to create a chronological structure for the re-storying of narratives, inclusive of personal and social dimensions related to the development of beliefs. As narratives move backward and forward through time, stepping into temporality, the inward world of thoughts, feeling and beliefs to readers is conveyed, while keeping readers oriented to the context (Clandinin & Connelly, 2000).

Structural and thematic analysis of data unearthed themes and patterns. Data in the form of direct participant quotations was organized with assistance from the three-dimensional framework to convey the essence of the narrative and emergent themes

about SUD while moving back and forth through students' lifetimes, while staying oriented in nursing school in Northern Ontario, Canada. Students' beliefs are presented to readers in a logical sequence using direct quotations to reflect language (Munhall, 2012) and perspective.

Lastly, ancillary data from field texts was evaluated to add richness to participants' stories where able. This included description of tone, cadence, and posture. Field texts aid in bringing the researcher back to the interview and setting, in a far more accurate way than memory alone. Field texts support creation of rich, nuanced, and complex narratives (Clandinin & Connelly, 2000). Attention was given to the environment, non-verbal actions, and characteristics of speech delivery (Clandinin & Connelly, 2000; Wells, 2001). Key points were italicized, providing significant information about the non-verbal construction of the narrative. Affective expressions such as laughing, sighing, crying, change of tone, or length of pauses (Wells, 2011) support the re-telling of an engaging, emotionally evocative narrative.

CHAPTER FOUR: RESULTS

Analyzed Demographic Data

Table one outlines the demographic details of participants. Of the nine participants, 90% were female. One person self identified as both Caucasian and Aboriginal, and the remaining 90% identified as Caucasian alone. Two participants had social service work diplomas, and one had a pre-health college diploma. Two participants held other undergraduate degrees in music and psychology respectively. One participant reported taking some non-nursing undergraduate courses but did not hold another degree. Therefore, 67% of participants had education other than the BScN they were currently enrolled in.

Table 1

Participant Demographics

	Age	Gender	Cultural Background	Past Education
# 1	22	Female	Caucasian	None
# 2	27	Female	Caucasian	Social Service Work Diploma
# 3	26	Female	Caucasian	Social Service Work Diploma
# 4	30	Female	Caucasian Aboriginal	HBSc Psychology
# 5	28	Male	Caucasian	Some undergraduate
# 6	21	Female	Caucasian	None
# 7	28	Female	Caucasian	Pre-Health Diploma
# 8	41	Female	Caucasian	Bachelor of Music
# 9	21	Female	Caucasian	None

Table two outlines participant's past experience with SUD. Experience working with person's with SUD was reported by 88% of the participants. Many of the participants had encountered persons with SUD in their clinical placements. Other settings included volunteer work and in non-nursing employment settings, including the university and a psychiatric hospital. All participants had experienced SUD in a friend or family member, and all participants felt comfortable to work with clients with substance use (SU) problems. SUD within oneself was noted by 22% of participants. One participant noted dependency on caffeine and nicotine in the past. The other participant did not make any additional comments on their past personal experience with SUD.

Table 2

Experience with SUD

	Work experience with SUD	SUD within the self	SUD within friends or family	Comfortable to work with SUD
# 1	Yes	No	Yes	Yes
# 2	Yes	No	Yes	Yes
# 3	Yes	Yes	Yes	Yes
# 4	No	No	Yes	Yes
# 5	Yes	Yes	Yes	Yes
# 6	Yes	No	Yes	Yes
# 7	Yes	No	Yes	Yes
# 8	Yes	No	Yes	Yes
# 9	Yes	No	Yes	Yes

Structural Analysis

Participants orient the listener to situations by providing background details which assemble the characters and situations in a way that allows them to express their perceptions and feelings about the topic. Examples from professional and personal lives were used to express certain notions. Experiences where SU was a salient factor in the situation were discussed. Characters are introduced, the situation is described, and finally

the internal reactions of the speaker and characters are expressed. The internal world of other characters is speculated, often supported by evidence from the story. The speaker's own emotions and perceptions are shared after the scene and characters are established.

A change in the tone of voice and facial expression was used to indicate many things. A change in tone was often used to describe the words or perception(s) of others and to highlight one's own internal dialogue. This change in character tone is similar to putting quotation marks around an expressed sentiment. Other variations in tone were used to convey a range of emotions, including but not limited to anger, compassion, doubt, frustration, inspiration, and grief. Words which were heavily emphasized were italicized in the transcripts. Words that were expressed with an increase and volume and emphasis were capitalized.

The consequences of SUD are linked to the internal world of the individual as well as their social relations. SUD is viewed as a complex behaviour. Making changes to substance use (SU) is compared to other complex behaviour change, such as weight loss. Metaphorical expression of weight loss and control over food was used by two participants to explain the intricacies of SUD. Both of these conditions require significant lifestyle changes and control of urges.

Thematic Analysis and Re-Storying

Theme I: Expanding and Deepening Understanding

Early childhood. As a child, the understanding of SUD was limited, and in some instances hidden. Participant 9 was "never really exposed to anything", and SU was "kind of a taboo topic". Other children were exposed to alcohol use, in the immediate and extended family, where at the time, the SU was normalized (Participant 1, 6, and 8).

Other participants were aware of how SU in the immediate and extended family members negatively impacted the entire family unit (Participant 4, Participant 2). Specifically, wives and mothers were noted to be impacted by the husband and/or father's drinking (Participant 1, 3 and 8).

Adolescence. Throughout childhood and into adolescence, the view and understanding of SU continued to evolve. "It grew I think as I got older, maybe in my later teenage years, I started understanding that there was the capacity for abuse or misuse by individuals" (Participant 6). Throughout the teenage years, exposure to SU grew and knowledge increased. School programs such as Drug Abuse Resistance Education (D.A.R.E) provided formal messages while peers and some participants experimented with various substances. A thoughtful reflection on the development of SUD brought one participant back to teenage participation in sports. "Some kids on the team were smoking or using weed and things like that" (Participant 2). Another participant recounted, "I was very rebellious in high school, me and one of my friends. And I got into a lot of trouble, doing a lot of drugs on the weekend" (Participant 3). With the expansion of knowledge through education, participants grew to question, "Oh is that a little much? Like, you are having three beer and a scotch every night. So I worry a little. I am like, are you abusing alcohol?"(Participant 6). In response to formal education, it came as a real shock to realize the extent of some loved one's substance use. With wide eyes, it was exclaimed "WHOA, my dad has a problem" (Participant 1).

As participants learned more about SU, they made deliberate decisions to avoid substances. When recalling old friends from these young years, it was said "back in high school it didn't seem like a big deal, but it kind of progressed. I do not keep close contact

with them anymore" (Participant 2). The SU separated participants from friends who continued to use substances. Expression of the departure from these relationships was accompanied by a facial expression which implied the lives of these old friends have some degree of ruin as a result of SU. Seeing SUD at work in friends and family members served as a deterrent. "I also have an uncle that went downhill with drug use.... I can see who he was when I was a kid, and now how he is. And also the concern my step mom has for him. I don't want to be a contributing factor. I see what she goes though, being upset about my step-uncle. I am glad I am not doing that" (Participant 3). With respect to the presence of SU within the family, "you either do two things when something like that happens, you either become just like them, or become the opposite. And I would say with that, I have definitely become the opposite" (Participant 1).

From the teenage vantage point, SU is viewed as a choice. Socially, "I made a deliberate choice to exit the situation (of SU), but I also had a life that taught me that I could make that choice" (Participant 3). However, it was said that those who choose to use substances have a lot less choices to begin with. For instance, this story was told about a participant's friend from high school:

> The biggest thing that I can see I learned from her, is that, that easily, it could have been me. Nothing except our different histories...but, had I not made the choice after high school, to separate myself from her, I could easily be in the same place she is now. But I had the ability to make the other choice. Watching her, shaped how I think of it. Only because she and I compare, we did a lot of the exact same things in high school, but we took completely different paths, and I can look back on my childhood, compared to her childhood, and it occurred for us

> very, very different...So, I guess, in high school my belief was it was fun. I just wanted to have fun. But I think for my friend, her choices were a lot more escape based. I was just being rebellious having fun, and I think she was escaping from her reality that was not that great. She did not have a very good childhood growing up, her mom was an alcoholic, her parents would smoke pot in the house. Not a good environment to grow up in...I made a deliberate decision after high school to distance myself from her, which I felt really bad about because we were really good friends. But I didn't want to go down that road. (Participant 3)

Seeing the suffering families experience related to SU influenced participants to see the overwhelming and overpowering nature of SUDs (Participant 1, 2, 3, 4, 8). For instance, "my cousin's heavy involvement kind of came out of nowhere. Because she wasn't able to function any more, that was a huge eye opener for me and how dangerous drugs can be" (Participant 2). In another family, witnessing the influence of an uncle's SU and "the impact that has on his relationship with my aunt. And the stress it causes her. I guess I have a belief about SUD is that it impacts everyone around them. It doesn't just impact the person who has the addiction, it also effects all of the people who are in their lives in many different ways" (Participant 4). The following excerpts further corroborate the awareness of the impact SUD has on families. When recounting the comprehension of her father's SU it was said:

> It is very difficult because I watch how it affects my mother. It affects my relationship with him. It has never been...I have always justified it, because it was never verbally or physically abusive. You know... it wasn't like that. It was just kind of like, whoa. Because it wasn't verbally or physically abuse, or any of those

> things I never thought it was problematic. It's hard to watch, because that is your father. That is your mother. Everything should be ...When you are a kid, you just view them in such a romanticized way. And then as you grow up it becomes different, as you become more educated. (Participant 1)

Another participant discusses how she came to appreciate the impact of SUD on family members:

> My father is an alcoholic. My mother got involved in ALANON when I was 14 or 15 years old, and I went with her to a few meetings. I think there I maybe started understanding a bit more. Maybe not understanding more about the people who were suffering from their substance misusing, but more about the family and the individuals who are living with those individuals. So I started understanding more of the external relationships. (Participant 8)

Through these teenage years understanding and personal agency developed with regard to SUD. Participants started to make deliberate choices about their own SU. Foundational beliefs about SU are built upon. It is believed that SU is a choice which impacts loved ones. Post secondary education further evolves and transforms these beliefs to include vulnerability and extraneous social factors.

Post secondary education and nursing. Understanding through post secondary education moved SUD from a "thing", to a problem or "illness process" (Participant 5) which affects real people. "University has been really a growing point for me. I guess I always kind of understood what it was, but I never really knew what to do about it. But going through nursing, now I definitely feel like I have a better understanding of the

population as *people*, rather than the issue" (Participant 9). Another participant entered nursing with the question:

> What is wrong with that person, why can't they just fix it? But now knowing what we learned in school, there is more to that. I can understand all the things that predispose a person to addiction....and how it affects everything around them. It affects your relationships with friends, family, work....how it can negatively impact your life, and you can end up homeless. (Participant 7)

Past enrollment in psychology and social service work programs contributed to some understanding of SUD prior to nursing for three participants. The social determinants of health were noted to increase understanding first attained in other programs (Participant 3,4). Volunteering in organizations which service people with SU problems also fostered deeper understanding (Participant 2, 3). Stories of recovery were revered. Knowing and seeing real life examples of recovery in action is "inspiring" (Participant 2). Specific mention of the nursing curriculum and its impact is mentioned, where learning from people with real life substance use experiences was impactful and helpful (Participant 2, 8). It was said:

> We had a few really great courses, more on...well... we talk about substance use in some broad terms, but we have had some really good guest speakers (such as a residential school survivor, a recovered nurse who has Hep C) who have come in and talked about recovery in their lives. I think I am less judgmental than I was before. I think I was less tolerant before than I am now. If I was nursing 10 years ago, and I had a patient who was sick and they were intoxicated, I don't know if I would be as empathetic as I am now. I just think exposure to people, and I

> understand why. I am more empathetic, and more tolerant. But I think to get there, I had to put my own pre-conceived notions and prejudices in check. And that used to be hard for me, because of my upbringing, but it isn't now. (Participant 8)

The evolution towards a more involved understanding of SUD brings the biopsychosocial nature of the condition into reality. The role of the brain and genetic factors is given honourable mention (Participant 1, 3, 9). The biology is recognized in brain function, genetics, withdrawal, and physical health consequences. Once addiction neurologically has set in, the ability to stop using is much more difficult. The ability to make another choice is constrained biologically. The desire to avoid withdrawal also perpetuates substance use. "I have heard that it is extremely painful and uncomfortable. So withdrawal for sure. People cannot handle that. It is extremely difficult" (Participant 6). In a compassionate way, it is said, "and then there is the whole role of the brain. The drive to continue using is so strong. It is very, very difficult to stop. And that is science based. You get the whole reward, and it is really, really hard to stop. Sometimes it is really, really hard for me not to eat a cookie, so how much harder can it be for a person who has been using drugs for ten years, to just stop?" (Participant 3).

The psychological realm is appreciated by considering the perspectives, feelings, and emotions of persons with SUD. The social realm is understood as all of the relationships which give rise to SUD, as well as the relationships impacted by SUD. It is recognized that a life of SU can be riddled with challenges.

Obstacles range from denial, adverse health consequences, loss of relationships, loss of financial stability, and the loss of the ability to regulate one's behaviour. Insights came from various sources, including interactions with patients,

> who are struggling with substance use and are at different levels of getting help or who are totally oblivious to the fact they are having health problems as a result of their behavior. Or individuals who understand they are having problems, but who just *can't* for whatever reason, make a decision to change their behavior. (Participant 8)

Adverse health consequences can be the result of SU. These consequences can involve both the physical and emotional body of the person with the SUD and their loved ones. The following example comes from an experience volunteering at a homeless shelter. Awareness of the loss of housing, health, and ability to regulate one's behaviour is expressed when sharing this story:

> There were some nights where things got dangerous, with people who were strongly under the influence of something. I am not sure exactly, but we were thinking it was an overdose of something, the paramedics had to come. I remember the staff was saying it had been a pay day, where they get their government money. So sadly, it was actually kind of common, that after they get their money, they tend to overuse. When they get their money, you can kind of tell. There have been other weeks where nothing has happened. I have heard that it is more common (to have adverse events) when they get their funding to supply their desires. (Participant 2)

The person with the SUD is not blamed for their life circumstances. "It's not just a decision that they made. That they want to ruin their life or anything" (Participant 9). To a degree, participants absolved the person with the SUD of wrong doing. "I don't think anyone chooses to become a drug addict or chooses to become an alcoholic. I think that things just happen in people's lives and sometimes the situation is beyond what people can control or manage" (Participant 8). Each dimension of this biopsychosocial condition is considered to contribute to the idea that a person with a SUD has a certain degree of innocence. To summarize:

> It's not that easy, and there is a lot of layers to substance abuse that needs to be addressed before a person can find recovery. It is not just entirely about the person stopping the drugs. There is a reason why they started, and that reason needs to be addressed, and all of the relationships that have been impacted need to be addressed as well. (Participant 4)

Theme II: Ill-fated Fortune

Complex vulnerability. Participants spoke to varied and multiple factors that predispose a person to falling into problematic SU. None of the participants distilled risk for development of SUD to any one factor. "There are factors there that can contribute to it, there is so many possibilities it is hard to narrow it down to "if you do this, this, and this, then you are going to be more likely" (Participant 9). It was learned in nursing that low socioeconomic status contributes to SUD, "but it is not *just that"* (Participant 3), as people from all walks of life people become involved with SU. "Definitely for a rich person who has a happy life can totally become addicted, but it is more common for a

person who is in a shitty spot in life to become addicted to something. A lot of it is to try to escape their own reality" (Participant 3).

A multitude of circumstances and risk factors were mentioned. With discernment and conviction, risk was expressed to include "people who have had particularly stressful lives or situations. Whether it be family, or situational, or both, risk is increased. In both the research and my personal experience, those are the people who tend to be most vulnerable...They kind of get sucked in and what not. It's not really their fault that is for sure" (Participant 5). Risk is embedded in the social environment. "I think that people who have trauma in their life are at greater risk for sure. People that have lower socioeconomic status and don't have the education to navigate the system to find resources are at higher risk" (Participant 4). Although Indigenous status and youth was not a reoccurring theme among participants, they were identified as risk factors by one participant (Participant 8). A lack of resources combined with difficult life experiences is believed to form the basic predisposition for SU problems.

When discussing risk and vulnerability, recurrent and pronounced emphasis was placed on the social determinants of health, along with environmental conditions and social norms (Participant 1, 3, 6, 7, 8, 9). The social circumstances influence what behaviours are considered normal and acceptable, creating the possibility for generational transmission of SU. European culture normalized alcohol intake in one participant's family (Participant 6). To link the social circumstances to vulnerability, one participant told a story of how she had to disassociate herself from her friend in high school due to her friend's SU. The following excerpt sheds light on her understanding of how social and environmental risk factors contribute to SU being used as a form of escape:

> I think there is an element of choice, but there is the bigger aspect about what choices you have. Her life growing up was very, very, very different than the childhood I had. I had a supportive family. Not perfect, but there for me. Her mom would buy her booze on the weekend. My mom just didn't know I was out on the weekend doing these things. A lot of people think that people who use substances are choosing to, but often those people have restricted choices to begin with. She didn't have the same choice to be able to go to university or not. They have less choices to choose from, and when you have trauma, it is easier to just escape into a high, rather than try to get yourself out of the situation. You don't know that there is something that could be better ...I made a deliberate choice to exit the situation, but I also had a life that taught me that I could make that choice, and I don't think she had that. (Participant 3)

Difficult life circumstances were repeatedly recognized (Participant 3, 4, 5, 6, 7, 8, 9) as contributing to SUD. Challenging life circumstances combined with social conditions which normalize SU lay the foundation for problematic SU. The use of substances is one of a limited number of choices. "People have this mind that 'oh well they chose to do it, so...', like it was their decision to do it. But it is a lot more than that. I guess people don't realize that, or don't want to change that way of thinking" (Participant 9). Further discussion on the idea of SU as a choice is as follows:

> I think a lot of people really put a lot of weight into the idea that the user is *making the choices.* They don't realize they have a lot less choices to make to begin with. It's not a lifestyle choice to be a drug addict. They might be choosing to use the drug, but they are not necessarily wanting to be in that position. They

> just cannot see another position to be in. I see it more as, not everyone has the same amount of choices...and it easily could have been me. But I had a life that gave me more choices that I could make, and I was able to act on it. (Participant 3)
>
> I think a lot of my friends, and definitely a lot of my older relatives view SUD as a behaviour. It is a choice. I don't look at it that way. I think you make a choice initially to use a substance, but the intersection of lots of factors compounds the problem, and I think that at some point when someone is suffering from a SUD they have lost the choice. The choice isn't there anymore. So I look at it more as a medical condition that has physical, psychological, and behavioural consequences. And social consequences. (Participant 8)

In order to recover, the person with the SUD has to address multiple areas of their life.

> You know, like losing weight. Well you are not just going to lose weight by eating healthy. You have to work out. You have to change your lifestyle. There are multiple factors that go into it, so to just try to go into it and recovery from a substance use disorder with cold feet without anything else...well that can be very difficult. (Participant 9)

Generational transmission of SUD. To expand upon the environmental influences which increase the risk of developing a SUD, family and generational transmission was described. For instance, "If you are brought up and your parents are drinking and smoking, maybe you are more at risk, or more likely to take risks at a younger age if you see your parents doing it. Thinking, 'well it's ok to experiment'" (Participant 7) and "if

you are around that environment all the time you may be more likely to uptake the same behaviours (Participant 9). In the second year of the nursing program, insight was gained from a talk given by a residential school survivor. The speaker shared how her SU was a coping mechanism. The SU "became generational. How she brought that down to her children, and now they struggle" (Participant 8). Another example of generational transmission of SUDs was observed in the clinical setting:

> when a 16 year old kid comes in intoxicated, instead of being like 'Oh he is here every day', well I know who his parents are. So I'm like, 'this is why he is here every day'. His parents are unemployed, homeless, and are also our regulars. The mom has a few different kids with different fathers. I don't blame this kid. He didn't have a proper upbringing to know any better. If that is what you see every day, that is probably what you think is normal. He's just a kid. (Participant 7)

In a reflection on her own family dynamics, the presence of SUD was passed along generationally. The participant's mother chose to marry a man just like her own alcoholic father, "because of that same kind of similarity" (Participant 1). It was speculated some aspect of her mother's unconscious mind was drawn to a person with a SUD. Thus, alcoholism remained present in the family.

Although trauma was not discussed at length, it was given specific mention by two participants as being involved in the transgenerational transmission of risk for SUD. To illustrate, consider the following sentiment: "in terms of trauma, people who have suffered various types of violence, or intergenerational traumas. And have seen addiction and grew up through addiction and have been exposed to it. I guess they are at greater risk" (Participant 4). Finally, while shaking her head with uncertainly, it was said "maybe

it is trauma, maybe it was passed down through their parents and they don't know any different, maybe, it was...who knows" (Participant 2).

Coping and escape. When discussing the social determinants of health, participants state the stress caused by a lack of adequate resources or supports increases the likelihood of substances being used as a coping mechanism and an escape from the situation at hand. For instance, "they don't want to deal with what is going on, because it *SUCKS* ! So it's like, lets drink, because we don't want to deal with what is going on" (Participant 1). The word "escape" repeated throughout the narratives (Participant 3,8, 9). Although the facets related to the social determinants of health are not the only factors, they have a strong influence on what participants see as contributing to SUD. "Definitely for a rich person who has a happy life can totally become addicted, but it is more common for a person who is in a shitty spot in life to become addicted to something. A lot of it is to try to escape their own reality" (Participant 3).

> "Now I understand that if people are in a situation where they have unstable housing, where they have unstable economic status...people...If they lack coping mechanisms that we would say are 'healthy' in health care, then they will use whatever coping mechanisms they can to feel better. And alcohol and drugs are a way for some people to feel better". (Participant 8)

A merciful understanding of the desire for relief is expressed. "They are looking for comfort. They are looking to be able to sleep. They are just people who are struggling. Things we take for granted" (Participant 8).

In summation, participants believe SUD is the result of a complex convergence of various factors. Often, this perfect storm of circumstances and variables which

necessitate SUDs are beyond one's control. The SU is seen as an attempt to cope with a difficult situation or troublesome feelings. The culmination of circumstances and behaviours which give rise to SUD are believed to be influenced by the social environment, particularly that of the family. It is helpful to understand the unique circumstances which have lead to the SUD, as this can be helpful in setting individualized, appropriate goals with clients (Participant 9). Privileging the complexity of this condition, it was said "instead of patching them up with a Band-Aid solution for their symptoms or cravings, maybe actually trying to tackle the root cause. It would be more work, it would be more digging, but it would help. Help them find a better understanding of why they are the way they are currently" (Participant 2).

Theme III: Stigma

Stigma was discussed on a number of different levels. Stigma exists in health care, in the community at large, and at the dinner table. In the clinical nursing practice setting, participants experienced stigmatizing attitudes of older nurses to compromise care. Stigma towards substance users is seen to prevent them from seeking supportive services. Substance users will avoid seeking care for all health related concerns, not only those directly related to SU. A sense of resignation is expressed with regard to dealing with the stigmatizing beliefs and attitudes of others.

Misguided judgement. Participants noted "people are so quick to blame and judge" (Participant 1) and do not understand the complexity and challenges associated with a SUD. One participant heard a lot of people say, "'why don't they just stop using drugs', or 'why don't they just get clean', or whatever. Some people just don't realize that it's not that easy, and there is a lot of layers to substance abuse that needs to be addressed before a

person can find recovery" (Participant 4). In another instance, the participant expressed frustration with hearing a family member say "'Well if they really wanted to change, they could do it'. And I am like, no! You don't understand. There are factors that play a role in it" (Participant 7).

It was recognized that stigma is a barrier to care. The result of the societal proclivity for judgement of SUD results in negative attitudes and unkind actions. For instance, if a person with SUD decides to seek care, they may "have not been treated very well if they have gone. Maybe judged or hurt" (Participant 2). Persons with SUD "don't want to come forward because they are embarrassed or scared of being judged or looked down on" (Participant 4). Stigma creates a sense of fear within persons with SUD. "Fear of being judged" (Participant 7). "Fear of seeking treatment, fear of lifestyle change, fear of losing friends, depending again on the person of course. Fear of not being able to do it" (Participant 5). This avoidance of pain is instinctual. The avoidance of an original discomfort leads to substance use to "escape". The avoidance of the discomfort of treating the SU leads to its continued use, creating a vicious cycle.

Participants empathize with the challenges faced by persons with substance related problems and disagree with moralized opinions. To demonstrate, consider the following quote:

> I think my feelings are 'It sucks. It sucks what you are going through'. That is no fun. I have a more empathetic approach to it. Where most people are like, they view them in this one way, and they judge them on other things. Even in (nursing) care, if someone is addicted to something, or has a history of pain, opiate addiction, a lot of students and nurses are very quick to, kind of, say that they are

> using it for abuse...It is horrible to see that people write people off because of that. (Participant 1)

Participants were also able to see the person separate from their SU.

> It is not a professional term, but "victim blaming" is common. "Oh that person just does drugs, that is all they care about". "Why don't they just do better or get themselves out of the situation". And that is not how it works at all in my opinion. I separate the person from the issue. (Participant 5)

Regardless of who the person is, what they have done, whether they use drugs, it is important to "show respect for people" because "you don't know what happened to them, or why they are in that situation. So you really shouldn't judge it" (Participant 3). The impact of the judgement on persons with SUD was repeatedly acknowledged.

Stigma among nurses. Stigma is noted to be present in various levels of society's consciousness. Stigma present among the general public, friends and family, and fellow nurses was discussed. Despite the fact that caring is a foundational nursing tenant, "I have seen staff talk about patients, and their addictions, in not a very nice way" (Participant 2). Participants have witnessed nursing care that does not adhere to the ethical guidelines provided by College of Nurses Ontario (CNO). For example, "I had this preceptor who basically said 'All of our patients today are losers'" (Participant 3). Participants did not agree with such judgements. Participants were utterly clear that discriminatory words and actions are not acceptable in nursing practice.

It was stated that client's choices should not be judged, even if the nurse personally disagrees with the choice (Participant 6). Fundamentally, "nurses should provide unbiased care" (Participant 6) to all clients. Inquiry into the individual's life story

aids in understanding where the person is coming from, which is necessary to be able to help them (Participant 2, 4, 8, 9). "People don't want to live in a way that is painful. But there are other factors that lead them to that. And to just blame someone, and not take into account that they are a person...You are not helping them" (Participant 3). Participants recounted clinical experiences where they had seen judgemental words or stigmatizing actions:

> As a generalization, some people do not believe in recovery. Nurses, for example. There is one instance I can think of where we have patients that come in, and the nurses say "they will be back in no time" with the complications from drinking so much. It is just like automatically, they are like 'they will be back, they will be back'. There are a few patients where I have heard that. But I also don't know what supports are put in place when they are discharged. It didn't seem like they (the nurses) had a lot of hope. It wasn't all nurses, but a few I have experienced. (Participant 2)
>
> I think I even notice even a difference in my attitude when I compare it to, sadly, to the older nurses. I had one bad experience on a clinical. We had a young woman come in after an altercation, and she was completely covered in blood. I was helping another nurse, an older nurse, who had been nursing for many decades, probably 40 years, clean her up....And the other nurse had a very bad attitude. It was the first time I had actually encountered that with another staff member. She actually, not in front of the patient of course, but at the nursing station she said to me "I am tired of dealing with junkies". It actually upset me. That is a patient who is there because they are having a problem. We don't have

> the right to judge. They are there because they need medical assistance. What got them there doesn't matter. Giving them care is what matters. So I have seen that a few times now. I have seen that a few times now...I have seen it with physicians too. (Participant 8)
>
> More often they are just treated differently than another person would be treated. Not given the same amount attention. I get that in one aspect a person may not understand it, so it makes them nervous, to try to approach it. But there are other people who literally think that people who use are worthless. Or not worth their time in any way. I think it comes down to a lack of understanding, or some of their beliefs are misguided. (Participant 3).

Participants recognize how the attitude of the care provider can impact the client's health outcome. It was said: "one of the most important roles nurses can play is to decrease the stigma that is there around SU because that stigma stops individuals from accessing treatment" (Participant 8). Persons with a SUD may fear judgement, or may expect they will not receive "adequate" care (Participant 6). The first example outlines a client's reluctance to seek care. In the second example, a participant contemplates why SU concerns are overlooked.

> So if you are participating in activities like this (substance use), and you know you are going to be judged for them, there is very little motivation to seek out help if you think you are just going to be judged or that you will not receive, you know, adequate care. Which even if you are not seeking out care for the drug abuse itself, even if you just are seeking out care for, you know, you have the flu or something and you want to go get medical attention. If you are worried about a

> health care provider judging you on this other decision that has nothing to do with you having the flu, well you may not even seek out help for that. So you are increasing your risk of even more negative health outcomes, not even related to the substance abuse, but...you know, but kind of related in the sense that you may have gotten better faster if you had went and sought out medical help, but you didn't, because you were too afraid to go because you didn't want to be judged. (Participant 6)

> I know I have helped care for some people at the hospital who clearly have addiction issues, but it is not really addressed. Nobody really talked about it. It was more about caring for the reason they are there, not really talking about what happens when they are discharged. I am not sure why it is not addressed. The nurses might not think it is their role. Or they don't know what to do. Or they don't know how to start the conversation. Or they are just too busy. (Participant 4)

It is believed that in order for a person with SUD to make strides toward wellness, non-judgemental, encouraging, and supportive care is required (Participant 1, 3, 4, 5, 8). It is believed that positive life experiences are required to propel a person into recovery and along the journey that is recovery (Participant 1, 7). Interactions with health care providers should be supportive and encouraging. Notably, participants did not discuss how they responded to witnessing stigma in the clinical setting.

Resignation. Weiss, Ramakrishna, and Somma (2006) state health care providers should work to recognize and mitigate the negative health impact of the health-related stigma. Participants recognize the layers of social exclusion which accompany SUD. Participants made sure to provide clients with the dignified care they deserved (Participant 3, 8), even

when their nursing preceptors did not. Participants described the experience of witnessing stigmatizing attitudes of older nurses. A sense of defeat was expressed with respect to dealing with the attitudes of older nurses. For instance, when describing the negative attitude of a preceptor,

> I don't know how to necessarily approach that, because, how do you change someone's beliefs? If that is what they believe...Especially that nurse that I was working with that day. She was close to retirement. It was a pretty engrained thought process. That me, telling her otherwise, is not going to change her belief. If she thinks that, that is what she thinks. (Participant 3)

Meanwhile, another participant doubted she may hold her compassionate attitude through years of practice. "I have dealt with 5-6 people with SU problems, and they have dealt with 5000. Maybe you become despondent sometimes as you practice" (Participant 8).

Moreover, a sense of resignation was expressed when dealing with family members who hold differing beliefs about SUD. After an unsuccessful attempt at discussing SUD with a family member a feeling of defeat was described as "So, I was just sort of like... shoulder shrug after that. Well, I tried" (Participant 6). Another said in her family,

> I wouldn't even bring it up because I know it would start a heated discussion. I just kind of let it lie. If there is an important piece of information that I think they need to know, to sort of broaden their knowledge on it then I will definitely try to speak up and share that, but I definitely try to just let the sleeping dog lie for the most part with my family. (Participant 9)

Sympathetic feelings have been the result of education for one participant, but she is unable to convince her family members to view it the same (Participant 7). Consequently, one participant felt it is important to "take a role in motivating myself to learn more about (SUD) and share that with others (who are not receptive to this population)" (Participant 9).

In another family situation, the harm reduction practice of a needle exchange program was the topic of discussion. A number of family members were not supportive of this initiative. The following excerpt outlines the challenges with helping to educate loved ones on the principles of harm reduction:

> At the table, someone in the family had said "they just care more about the drug users than everyone else, because they are letting them use all these needles, and leaving them around. They don't care about the public". My response was "No, the program does not want needles, around, but why shouldn't people who are using drugs have access to clean needles"? The only way I was able to reframe it for them was that clean needles don't just protect the user. If we limit the spread of diseases, it also protects the first responders who work closely with drug users. Such as nurses, paramedics, and police officers. Everyone was like, oh that makes sense. The only way I was able to make them see the value in the program was when they could see how it benefited the people who were not the drug users. (Participant 3)

To conclude, friends and family members label one participant as a "bleeding heart" for her differing views on SUD. Additionally, these beliefs "definitely differ" from friends

that are not in health care and a lot of older family members (Participant 8). Friends and family see it as a choice, and this participant does not.

Theme IV: Recovery as a Challenging Process

Recovery takes time. Recovery is described both as being free of the substance (Participant 2, 5, 9) and on the road to freedom from the substance (Participant 6, 7, 8). In all circumstances, recovery was described as a meandering longitudinal process, with many ups and downs. "Recovery is not a straight line. Ever" (Participant 3). To some, recovery is seen as freedom from the chains of addiction. "Recovery means to me, being able to live not depending on that substance, whatever it is" (Participant 2). Conversely, recovery is also described as a process of being on the road to freedom. "To me, recovery is not the individual stopping cold turkey, but the individual cutting down their use and going in the right direction and trying to help their addiction or substance abuse disorder" (Participant 6). Recovery is seen as both a process and a destination. Whether the person has attained sobriety or is in the process of moving towards sobriety, both circumstances are aspects of recovery.

For those whom see recovery as attaining abstinence, it was said "recovery is when the person no longer needs the medication, or whatever they were getting out of it" (Participant 5). Some used to see recovery as abstinence, but through nursing education now view it as an individualized longitudinal process (Participant 8). One participant states recovery for herself would be abstinence, but for her nursing clients, she would define recovery as "whatever the patient deems as what their end goal is" (Participant 9). Some doubt was expressed about the attainment of abstinence. In a definition of recovery

it was said recovery is "being able to live not depending on that substance, whatever it is. I haven't personally seen it yet" (Participant 2).

Those who view recovery as a process state that recovery is "not necessarily getting over your addiction, but you are on the right path towards" (Participant 7). As long as "the individual is cutting down their use and going in the right direction and trying to help their addiction or SUD" (Participant 6). Recovery is never a straight line (Participant 3). Recovery is seen as "a lifelong process. Once people stop using, recovery becomes an everyday thing. They can go back to it at any point. If there is a trigger or a stressor that makes situations hard on them, they might feel the need to go back to using drugs or alcohol" (Participant 4). The maintenance phase is thought to last

> the rest of your life, if you get to that phase. I think that recovery, if I had to give it a clear definition, it is when an individual can return to their regular state of living that is close to where they were before they started using. (Participant 8)

Even then, recovery is an ongoing process.

> I don't think there is a time where you are like, 'Oh I recovered'. I think it is a lengthy process of keeping on track. Whether it is being on methadone forever or the step of going on, and seeking help for your addiction. (Participant 7)

Recovery does not happen all at once, "but if they are making an effort, I consider that recovery. Tapering down, and trying to make positive changes, doing it for themselves and for their family" (Participant 6).

The task of walking the meandering path of recovery has formidable challenges. The challenges encountered in recovery can make it even harder for a person to get into a position where they can see better for themselves and "stay sturdy" (Participant 2). Just

like the SUD itself, recovery is complex. "It is not just entirely about the person stopping the drugs. There is a reason why they started, and that reason needs to be addressed, and all of the relationships that have been impacted need to be addressed as well" (Participant 4). Recovery of any kind is not easy:

> recovery in any sense, whether it be medical condition, from mental health condition, from substance abuse, or from a traumatic life event. Even if you are just trying to recover emotionally, whatever it may be, the recovery is a process, it takes a long time, and it's not something that is any easier when you are alone. (Participant 9)

Having a healthy support network is seen as being paramount (Participant 2, 3, 4, 5, 8, 9). Support may be found in professionals, counsellors, support groups, or family. Safety and stability (Participant 3, 4, 8, 9) provide the foundation, or "stable platform" (Participant 5) upon which recovery is built. Stability means "having resources for reducing stress. Being able to set people up with housing, or if they have supportive families that you can get them in touch with. Getting them in touch with those kind of things. Healthy lifestyle teaching" (Participant 5). It is from this stable platform, people can get in touch with "something they care about, and something you can see better for yourself" (Participant 3).

The motivation to enter into the process of recovery is variable. With much emotion in her voice, one participant said recovery has to be for the self, and come from the self. Despite needing external stability and supports, fundamentally, "the person has to change themselves. You can do whatever you want, you can be the best person in the world, but the change has to stem from themselves (Participant 1). Persons with SUD

have to learn to stay strong within themselves, as they are their own support (Participant 2). Having meaning and purpose in one's life is helpful to find the motivation and drive within (Participant 1,6). "Purposeful things are things that take away from the wanting to drink" (Participant 1). The answer to the question of how to "empower people to be more purposeful in life, and have more..." (Participant 1) remains elusive for one participant.

Family and employment can play a big role (Participant 6) in moving towards recovery. Family is a source of meaning which can increase motivation, "cause you to think, 'Geeze, I need to change, I need to do something about this' vs. if you are single, no kids... you might perceive the situation as 'oh there is no point, I am just going to continue to live like this because you have no one to do it for'" (Participant 6).

When assisting clients in setting recovery goals, it was said they should be tailored to the individual person, not just "the condition they are dealing with" (Participant 9). By and large, there are numerous spokes to the wheel which gives rise to recovery, such as motivation, support, coping with lapses, and developing healthy coping mechanisms. The following excerpt discusses the idea of recovery as an individualized stepwise process, rather than a destination to be reached.

> Realistically not everyone is going to want to cut that out completely, and well obviously that is the ideal goal for a heath care provider, we have to be realistic in understanding that not everyone has the understanding about the effects that that kind of behaviour can have, or have the goals or motivation that we might. So, I think an important thing for nurses to remember is look at where the patient is, and meet them where they are. You know, not set the bar three miles too high, and actually talk to the patient about what their steps are, and take it one at a time.

> Because recovery is not necessarily the end all be all, quitting all behaviours goal. Recovery can be one baby step at a time, depending on what the patient is willing to work towards, and it can come in multiple steps. So it doesn't just have to be the end all be all, and you are not recovered until the end. Recovery is a long process, and as long as you are engaging in trying to stay motivated to whatever your goal may be, then I definitely think you are in a recovery process. (Participant 9)

Throughout the recovery process coping with lapses is expected, and lapses are opportunities for learning.

> You still learn from it. You still have all the skills and strengths that you can draw on from that (time) and you can get back on track... there is always going to be setbacks, but that does not mean everything you have worked for is gone. (Participant 3)

Recovery was compared to weight loss.

> You are not just going to lose weight by eating healthy. You have to work out. You have to change your lifestyle. There are multiple factors that go into it, so to just try to go into it and recovery from a substance use disorder with cold feet without anything else...well that can be very difficult. (Participant 9)

Changes in many areas of one's life and perspective are required, including learning to deal with setbacks. External supports help a person stay the course.

A multitude of barriers. The barriers to recovery are many. Sadly, "I think there is a lot of road blocks. In terms of people getting help" (Participant 4). Persons who enter into recovery may have to cope with withdrawal (Participant 6), fear of change, stigma,

limited supports, and challenges within the health care system. Trepidation to enter recovery may be based on fear of "seeking treatment, fear of lifestyle change, fear of losing friends, depending again on the person of course. Fear of not being able to do it. Not being able to psychologically hold it together while they go through a treatment process" (Participant 5). Getting the mind and heart ready for recovery is a part of the process. "I think that can be a very difficult task for someone to come and speak out and say I am dealing with this and I need help. That is a huge barrier for them to overcome" (Participant 9). Even when a person is mentally and emotionally ready, there are practical hurdles. When recounting lessons learned at a methadone clinic, not having transportation or money to pay for services presented themselves as barriers to compliance with methadone maintenance treatment (Participant 8). The lists of numerous practical barriers are described:

> Financial barrier, language barrier, just not knowing, like health literacy. Or illiteracy. Not knowing what services are available, or where they can go get help. Or it could be cultural barriers. Or they don't feel like they can. Or could be guy who is too embarrassed to go get help. Fear of being judged. Financial. Just getting to wherever your appointment is. Not having a vehicle. Not having transportation. (Participant 7)

> Stigma. Some people don't want to come forward because they are embarrassed or scared of being judged or looked down on. I think there is a lot of road blocks. In terms of people getting help. For instance, detox. I know our detox will only take people who are in active withdrawal. So for those people who are not in active withdrawal, but want help, it is harder for them to find resources that are

> available for them. Financial barriers. Education. People just don't know how to navigate through the health care system. And people who do not have a support system. They don't have anyone who can help them or advocate for them. There are so many barriers. Even transportation. People cannot even get to counselling or support groups that could help them. A lack of support and a lack of resources in terms of people getting into counselling. Long wait lists. Also, social programs. If there is a lack of affordable housing, a person may not be able to maintain their sobriety because they don't have a place to stay, they may end up back on the streets, or back in the place where they were abusing drugs, or just not being able to find a different environment that supports their recovery. In terms of support, if they don't have a plan or goals they can work towards. Then they might not really care that much, and they might go back to using substances. (Participant 4)

With very little effort participants were able to discuss a nearly limitless number of barriers and challenges for persons seeking supportive recovery services.

> Well, I think stigma is huge. We have a methadone clinic here. And my attitude about that has even changed since nursing school. It really, really has. I had a lot of misconceptions about that. I even have health care providers in my family, and we would talk about the methadone clinic before, and I think my view point was affected by what they told me. And even some of them did not support that initiative, and had really negative commentaries about the program, and about giving people who have drug problems drugs. So that is definitely a stigma. And unfortunately, that stigma even exists even in health care, with clinicians. And the same goes for alcohol. Unfortunately, where we live, there are those socio

> environmental or economic factors too. So we have a lot of Indigenous communities in our area, I think there is 13 in our district, or 14 reservations. And a lot of those people don't have vehicles. And some of them don't have driver's licences. So if the programs are not offered in their community, they cannot always get to them. Unfortunately that is a barrier. Even the methadone clinic, I did a week long placement there as a part of my placements here. And there are people who cannot have their carries, who have to come in everyday. Sometimes patients would miss their day because they literally didn't have a way to get there. That is very unfortunate because those are individuals who have made an attempt at recovery now, and there is a barrier there. And even at the methadone clinic, I did not realize that people have to pay for their methadone. That was another misconception I had. I know I watched a client counting nickels and dimes to get their dose for the week. So unfortunately, in Canada, for some people cost is still an issue. Some initiatives might be funded, but not all of them. Say someone wants to go away to a treatment center, a really good rehab program. There may be costs involved that they just cannot come up with the money. So that is a barrier. (Participant 8)

Inadequate support and service. The obstacles to entering recovery are many. The health care system generates some of these challenges. There is a lack of resources, and accessing these resources is challenging. Participants were acutely aware of the lack of integration of treatment and recovery services in Ontario. Numerous obstacles which limit access to these fragmented services is discussed. The following two excerpts explore system level challenges:

I have seen that we don't have enough treatment options for people. And the treatment options are waiting lists of months and months and months. And at the time they go to treatment, they have to be detoxed. You have to go to detox before you go to treatment, but detox is small. I can't remember how many beds there are, but it's not very many, and it is even less if you are female. I worked at the shelter last year on the SOS team, and we tried to bring people to detox all the time. They rarely had beds. And if they did have beds it was one. And they never had female beds. If they did have male beds, it would fill up by the end of our shift, and they would not have any more beds left. In terms of someone who wants treatment, and they have detoxed, and they want treatment right now, they can't get into treatment, for like...six months. Well...what happens in that six month period? They are obviously not going to stay clean, or at least it is very unlikely. If you are living a very transient lifestyle, because you don't have anywhere to stay, and you are a drug addict, and you have nowhere to go, and you living where ever, a lot can happen in those six months. You may not be able to make it detox the day before, or a few days before treatment, and then you lose your treatment spot. That is a huge barrier for people. (Participant 3)

I think that...what else would be a barrier here...the stigma. The lack of service here can be a problem too. In my community we do not have an inpatient treatment center here. They are working on one now. A ten bed in-service treatment. But at this point, if we have individuals who want treatment they have to leave the community. Which for some people that might be a barrier, because maybe they have children and they can't leave. Even though they need treatment,

> maybe they can't take a month or six weeks off their job. Maybe they can't do it. So not having access to the services is a barrier. (Participant 8)

Not only are there challenges to access services, but there are other resources and supports that are required to "get them on their feet with a plan. Something that will work" (Participant 5). Some of these needed services have long waits and sometimes are not paid for without extended benefit coverage. For instance, the financial means to attend counselling or treatment is a barrier for many people or they may not be able to leave their family or job to attend treatment (Participant 4, 9). They may not have the skills or assistance to navigate the system. It is recognized that recovery is not just about the substances. "A lot of people need the psychological support as well" (Participant 5).

Theme V: The Nurses Role

Connection. SUD affect one's relationship to the self and other. Relationships with loved ones often become strained. Sometimes relationships are lost. SUD can lead "to people feeling very alone. And so it is important to help those people. To reach out to those people. For them to know there is a way out" (Participant 4). Connection is an important aspect of healing SUD. Connecting with the client, connecting the client to resources, and connecting clients to "other people. I guess this is the whole concept behind groups like AA" (Participant 8). Participants emphasize it is important to inquire, listen, and understand where the person is coming from. Taking the time to

> actually listen to your patient, and let them tell you their story, so that you understand it from their perspective. Then maybe you can make a difference in their care. And not just in their care, but in understanding populations, or other

> patients you will meet that are similar. Because I think that every experience is an opportunity for us to learn. (Participant 8)

Taking the time to sit and talk with a person with the SUD was found to be a rewarding experience. The client was deeply grateful for the connection, leading to the reflection: "trying to connect with people is, I don't know....maybe that is what people need" (Participant 8).

Another participant suggested that through dialogue, a nurse may have the capacity to "help the person understand why they have the substance use problem to begin with" (Participant 5). As nurses, "we can help with supporting recovery by asking about their story. What brought them to this in the first place? If it is appropriate to ask. So you can get more towards the root of what is causing it" (Participant 2). Creation of a safe, open, stigma-free environment for clients to talk about things, to "share how they feel" (Participant 4) is seen as being helpful. Connection was not only described as verbally communicating with clients, but also by providing quality nursing care. In the following exemplar, the participant created a connection with a client who was not assigned to her direct care, as senior staff appeared to ignore this individual on the basis of her SUD.

> I definitely think that people who are users are often dehumanized, and treated like they are not worthy, or are less than, you see it in just not taking five minutes to ensure a person is getting washed up, not spending time doing things you would do for another patient. It is sometimes subtle. And maybe people don't realize they are doing that. On the other end of it, being just rude...I don't see a lot of that. Just kind of ignoring them, not giving them the same amount of

> service...One of our patients was an aboriginal girl, about 20. An IV drug user. She was there with a kidney infection. She was there, in her room for 3 days, and I swear she had not had a bath or been washed up in any way. I felt like everyone was kind of ignoring her. I had been on shift those three days, but she wasn't my patient. So I noticed things. You notice things when you are on a floor that isn't that big. I noticed she wasn't getting that much attention. So I made a point to get her a basin with some warm water and a new gown. And let her get washed up. (Participant 3)

Beyond the personal connection, nurses can connect clients with other supports and services. "Nurses can offer resources. If nurses are caring for someone who is still an addict, then they can offer resources to try to help them" (Participant 4). This might mean connecting them with community resources, specialized interventions, counselling, rehab centers or whatever else the person might need (Participant 5). This may also include social work, or doing some health teaching (Participant 7). Not only should nurses attempt to connect their clients to the appropriate supports, but nurses can assist with system navigation and advocacy work. "Nurses should advocate for their patient. With the social determinants of health, sometimes individuals who are using are not even aware of the help that they could receive. So pointing them in the right direction, making sure they are aware of resources that are available to them" (Participant 6). Working to reduce stigma is also a form of advocacy. "Stigma stops individuals from accessing treatment. Sometimes I think that it can alter the course of treatment or recovery. We need to work to address that, to break those barriers down. Not just with the individual,

but with the community at large (Participant 8). In summation, nurses can connect with clients, and connect clients. Connection was perceived as an antidote to SUD.

Encouragement. The choice model of addiction, the media, and social conditioning have labeled SU as "bad" (Participant 1, 5). The idea that someone is choosing SUD perpetuates stigma and negative attitudes towards persons with SUD. For instance, with the choice model, it is assumed that SU "is a poor decision that someone made, and they deserve the consequences or whatever. And I think that is absolutely ridiculous (Participant 9). The idea SU is a choice is noted among friends and family.

> I think a lot of my friends, and definitely a lot of my older relatives view SUD as a behaviour. It is a choice. I don't look at it that way. I think you make a choice initially to use a substance, but the intersection of lots of factors compounds the problem, and I think that at some point when someone is suffering from a SUD they have lost the choice. The choice isn't there anymore. So I look at it more as a medical condition that has physical, psychological, and behavioural consequences. And social consequences. (Participant 8)

This complex understanding informs how participants believe SU problems should be treated. Similar negative beliefs may be internalized by the person with the SUD. As such, it is believed to be important to encourage people to want more for themselves. Clients with SUD should be empowered, encouraged, and supported. Clients should be treated with a "positive attitude" and "positive re-enforcement" (Participant 7). Nurses can be "that shoulder they can lean on, an extra little motivator, remind them of what their goals are, check in on them, make sure they are doing ok. Support them in

whatever way they need" (Participant 9). Nurses can remind clients about their self agency and capacity to make choices. For instance,

> you don't have to go down this path, you are able to make a decision and make a change. You are your own person, you are your own support, your own body. You are in control, even if you might not feel you are in control". (Participant 2)

With a small degree of excitement and a large amount of conviction, it was said:

> I think nurses for so long, come from a role of "no you shouldn't", authoritarian. That is horrible. I think we more so need to come from the angle of a friend. We care about you. We want you to succeed. Not we are going to condemn you for being bad, or because you had a falling down. We need to empower them. We need to lift them up. Even if you just got someone...(Participant 1).

Within this supportive and encouraging stance is the recognition that everyone will be in slightly different place on the trajectory of SUD. Some may not recognize the problem, others may want help but struggle to accept it, while others may be actively seeking assistance. In all circumstances, the client needs to be seen as who they are, independent of their SU, and offered support.

> There will be some people who won't be willing to accept help, and you either have to try to motivate them to accept help or ask them what they need. If maybe what you were offering before isn't what they are interested in, there might be something else. Some other way that you can support them. (Participant 9)

In some instances, helping a person with a SUD might be assisting them to find a meaningful distraction, as "a lot of drinking comes from that sense of not having anything

meaningful, not having a sense of empowerment, or they are in a depressed, low point in their life" (Participant 1).

All nursing interactions should come from a non-judgemental place, because it is impossible to fully understand the persons' experience (Participant 8, 9). Each person with a SUD is

> someone's mom or somebody's sister, or somebody's daughter or somebody's son. They don't want to be there. I am sure they don't want to be there. They are just people that need to help themselves. And they need other people to facilitate that. (Participant 8)

Nurses are well positioned to be able to help person's with SUD. The recognition of the complexity and challenges associated with SUD aids in successfully providing ethical, compassionate, and supportive care. "It is difficult for individuals dealing with substance abuse and addictions, right? And once you are so far in, it is hard to quit" (Participant 6).

The multiple areas nurses can be of service are described in the following excerpt. Also, it is noted the actions and attitudes of health care providers impact clinical outcomes.

> I think that nurses can play a huge role in recovery on so many levels. On the physical level, from the biomedical perspective nurses can help individuals who are having physical symptoms of withdrawal or physical symptoms that are coming from substance misuse. We can help mitigate the effects of co-morbidities like hepatitis. On a behaviour level we can make an impact to. *Because we know that how clinicians interact with their patients has the capacity*

> *to change their behaviour*. So, if nurses can be educators, and can help people see facilitating factors to recovery, then we can help them toward their recovery (Participant 8).

Under this premise, it is important that health care providers believe in recovery. If a health care provider doubts a person can recover, this will be conveyed in their actions. A belief in recovery is important in a population who often have fears or doubts about recovery. This is especially true when the system poses challenges that make recovery seem elusive. Support and encouragement can increase commitment to change. It is clear to participants that nurses should provide much more than biomedical care. The societal, social, familial, mental, and emotional aspects of SUD should be considered as much as the biological needs of the person.

Narrative Conclusions

Each of the participants in this study shared their unique perspective on SUD and recovery. Each story wove together characters, experiences, and knowledge to present their understanding of SUD and how SUD affects people. Through the cultivation of a more complex understanding, the capacity for compassion and empathy grew within these participants.

Overall, five core themes and fourteen subthemes were identified. Based upon these themes, several key summations can be made about fourth year nursing students' beliefs about SUD:

(1) All participants' beliefs evolved through time. An explosion of understanding was the result of their nursing education.

(2) People do not choose to have SUDs, but rather engage in SU as a form of coping and escape from difficult feelings or life circumstances. The factors which necessitate SUD are complex, generational, and often beyond one's control.

(3) Stigma towards persons with SUD is rooted in ignorance and misunderstanding. This lack of knowledge is present among nurses, negatively impacts persons with SUD, and is difficult to address.

(4) Recovery from SUD is a challenging, longitudinal process through which people need to be supported.

(5) It is the nurse's role to connect with and encourage persons with SUD to set recovery oriented goals for themselves. Nurses can also aid in reducing the barriers to recovery.

These findings are discussed further in the following chapter, where they are integrated with the theoretical framework of this study.

CHAPTER V: DISCUSSION

The Science of Belief

It could be argued that much of what was expressed in participants' narratives was professional knowledge rather than deep seated personal beliefs about substance use (SU). It was clearly expressed that knowledge gained in the nursing program influenced current perspectives on SUD. The following discussion will further define and discuss the nature of beliefs, distinct from knowledge. A leader in the field of cognitive therapy, Beck (1995) describes the most central and fundamental layer of belief as the core belief. Core beliefs develop in childhood, forming the basis of ideas about the self, other, and the world. Core beliefs are so deep that it is difficult to articulate them. Global, rigid, and over generalizing, these beliefs are often incorrect and dysfunctional.

Core beliefs lay the foundation for intermediate beliefs, which are known as attitudes, rules, and assumptions (Beck, 1995). Intermediate beliefs lead to perceptions experienced by individuals as automatic thoughts. The automatic thoughts which arise in situations lead us to our emotional, behavioural, and physiological reactions. Intermediate beliefs are not as static as core beliefs, and can evolve or change with the right self awareness and stimulus (Beck, 1995). The aim of this study was to gain an understanding of intermediate beliefs about SUD, as intermediate beliefs contribute to attitudes, rules, and assumptions (Beck, 1995).

"Beliefs are, in essence, our expectations about the world around us" (Alcock, 2001, para 22). Our interactions with the world around us shapes these beliefs (Siegal, 2001). Our beliefs, or expectations, act as a compass for our thoughts to follow. The process by which beliefs contribute to automatic thoughts is largely unconscious. Thoughts then give rise to behaviours. This basic idea is well accepted in psychology,

and forms the basis of cognitive-behavioural therapy. Without awareness, many behavioural responses to thoughts are automatic. For instance, conditioned every day behaviours like brushing the teeth or riding a bike. Beliefs tend to recede into the background of awareness when the practices they make possible become habitual (Bencivenga, 1999).

Due to the proclivity of beliefs to lead to behaviours, it is beliefs which are of interest, as these invariably effect clinical practice. Beliefs lead to subtle physical actions and reactions, even if we 'know' better. We may 'know' something intellectually, but 'feel' something else (Alcock, 2001). The physiological and emotional reaction associated with 'feeling' leads to the expression of non-verbal behaviours by means of the autonomic nervous system, particularly mediated by the facial muscles of the social engagement system (Porges, 2011). As social creatures, human beings are wired to interpret and sense the reaction of those we interact with (Porges, 2011). Therefore, beliefs will lead to subtle behaviours which can be sensed by others, even in the absence of outright actions. It is well established that the attitudes and behaviours of health care providers contribute to clinical outcomes (Corrigan, Druss, & Perlick, 2014).

Thus, the focus on attitudes and assumptions rather than assessing professional knowledge is desired, as beliefs (unconsciously) contribute to our thoughts and behaviours (Beck, 1995). To summarize, thoughts and behaviours stem from beliefs which lie below one's conscious awareness. Beliefs form the basis of thought and action, and although beliefs tend to be static in nature, they can change over time. Intermediate beliefs, as assessed here, are easier to shift than deeper, more entrenched core beliefs (Beck, 1995). Any automatic *reaction* to a thought can be re-patterned. With conscious

control we can learn to *respond* in a different way (Dasgupta & Rivera, 2006) to automatic thoughts. Beliefs can change, supporting new thoughts and behaviours.

Through this narrative inquiry, it was observed that beliefs about SUD evolved through the passage of time. Much of what was expressed by these fourth year nursing students was influenced by what they had learned in school. Oxford University Press (2018) defines knowledge as "facts, information, and skills acquired through experience or education; the theoretical or practical understanding of a subject" (para1). It could be questioned if this inquiry assessed beliefs or professional knowledge. Knowledge contributes to beliefs, but is more cerebral in nature. Beliefs are a much more sophisticated behavioural structure than knowledge (Bencivenga, 1999). In this inquiry, most participants were able to link their new knowledge gained through the nursing program with personal experiences, and reported a greater understanding of a concept which did not previously entirely make sense. This progress is characteristic of the growth of a new belief. The principles of symbolic interactionism aid in further explanation of why findings are reflective of beliefs, rather than knowledge.

Symbolic Interactionism and Beliefs

The main tenants of the sociological perspective of symbolic interactionism (SI) popularized by Blumer (1969) are that through social interactions, we ascribe meaning to symbols such as objects, body language, and language. This meaning evolves out of our social interactions and is subject to change over time depending on future interactions. Therefore, people have slightly different subjective meanings for phenomenon based on their social interactions. This rings true for participants in this study. The meaning participants had for persons with SUD was influenced by and evolved through

interactions with their families, social circles, the media, and formal educators. Their understanding of SUD as a choice evolved to have a greater degree of complexity where SUD is seen as a biopsychosocial condition.

Alcock (2001) states that beliefs are formed through direct experience, by observing others, through logical, analytical thought, and/or they are passed onto us through sources of authority, such as parents, teachers, or the media. Initially, it was not clear to participants who develops SUD, or why they could not stop substance using. Upon entering into post-secondary education, where participants learned from authorities, many puzzling aspects of SUD began to make sense. A more global understanding of SUD was attained. With understanding of the biological, psychological, and social components of SUD, it no longer made sense to see SUD as a choice.

In order to change a belief, Beck (2004) states the change needs to be of free choice, the individual has to perceive consequences, and the individual must believe the change will affect someone. From this sample, education had a significant influence on participants' beliefs. Understanding the negative implications of stigma helped participants see the impact negative beliefs can have on persons with SUD. Stigma has consequences which will impact substance users, creating a compelling reason to change past negative beliefs about SUD. Participants were not forced into a new understanding of SUD, but views changed in response to professional nursing knowledge. Participants were able to take into consideration the multiple factors giving rise to SUD. From this vantage point it no longer made sense to blame the substance user, or ascribe to the idea that SUD is a choice someone is making. Awareness of the barriers to recovery contributed to more empathic feelings about persons with SUD.

In response to the experiences associated with nursing education, the meaning ascribed to the symbol of an "addict" shifted notably. Initially it was difficult to understand why someone would choose such a life. The "addict" was viewed with confusion and some judgement. The knowledge delivered through the caring and holistic principles of nursing created the understanding of the factors which contribute to SUD. Participants were then able to see the "addict" as a vulnerable person with many challenging life circumstances. SU was understood to be an attempted coping strategy. Guest speakers and clinical interactions with persons with past or present SU problems offered opportunities to further break down preconceived notions about SUD.

Continuing on with the principals of SI, it can be assumed that beliefs may change again as participants enter into the workforce. Some participants discussed their experience of stigma among more experienced health care professionals. Other health care providers attribute negative, "dehumanizing" (Participant 3) ideals to persons with SUD and are cynical about recovery. Despite the understanding of stigma and SUD as a biospychosocial condition, it remains possible beliefs may change over time in response to social interactions with senior staff and persons with SUD. Senior staff may have received different education than participants of this study. The possibility to "become despondent" (Participant 8) after years of practice was recognized by one participant.

Limitations and Errors

Limitations are generally factors which limit the transferability of findings (Creswell, 2009). Tension exists in narrative inquiry to create a product which can provide generalizable theories while still honouring participants' personal and particular experience (Clandinin & Connelly, 2000). This study was limited to fourth year students

from one university. Beliefs and experiences are therefore specific to this geographic location, educational institution, and sample. Participants' beliefs were influenced by their education, both in nursing and other programs of study. Therefore, to increase transferability, repetition of this study with fourth year students from other baccalaureate programs should be completed. Furthermore, self-selection for participation is another limitation of this study. Despite providing a small incentive aimed to reduce bias, participants whom were interested in the topic of SUD may have self-selected to participate. Therefore, this study does not reflect beliefs of the entire class.

A logistical error is also present in this study. The participants may have been exposed to two different curriculums. All participants were fourth year nursing students, however it was later disclosed to the researcher that participants would have been from one of two different cohorts in the nursing program. This particular nursing program has two streams of study. A three-year compressed stream and a four-year stream. As the researcher was not aware of the two streams initially, this information was not captured as part of the demographics for this study. This may have been an important consideration because the two cohorts experienced similar, but different, curriculums in the specific year of this study. In response to the CASN (2015) recommendations, the mental health and addictions content was updated, and the mental health course was modified for the three-year compressed program students. Therefore, if participants were in the four year arm of the program, they experienced an older version of the mental health course and perhaps different content across the curriculum in general. Research participants in the three-year compressed program would have had a mental health course created with the CASN (2015) framework in mind. It is unknown what version of the

mental health course participants in this study received. Some participants had other education from different disciplines. Therefore, findings from this sample cannot be linked conclusively to the CASN (2015) framework.

Changing Context

This research has been conducted at a unique time in Canadian history. Schools of nursing now have formal guidance from CASN's (2015) recommendations on what should be taught about mental health and addictions. Moving forward in time, curriculum content for Canadian nurses is going to be far more consistent than it has been in the past. In addition to Best Practice Guidelines, RNAO (2017) created an additional resource for educators. In this document, reflective practice is encouraged for both students and faculty (RNAO, 2017). At this time, we know what beliefs are held by a sample of nursing students near the beginning of this more standardized messaging across nursing education in Canada.

Within the larger Canadian social milieu, drug policy is beginning to change. Cannabis is soon to be legalized across the country (Government of Ontario, 2018). An examination of attitudes of students at three Canadian universities found non-users of cannabis to see cannabis use as a deviant behaviour (Hathaway, Mostighim, Kolar, Erickson, & Osborne, 2016). Hathaway et al. (2016) recommended further investigation on the topic to assess the cultural transformation as it unfolds over the coming years. Medical providers, law enforcement officers, human services workers, and the public alike will together adjust to this national change. The beliefs, attitudes, and knowledge of health care professionals will be of great importance to help educate the public about "the real costs of drug policies and how they impact lives, communities and the economy"

(Global Commission on Drug Policy, 2017, p. 6) and the potential harms of drug use. The Canadian government has a clear public health mandate, with the Department of Health leading the cannabis reform (Rolles, 2018). The task force is comprised predominantly of health care professionals, utilizing lessons learned from alcohol and tobacco control (Rolles, 2018).

Despite the fact that health care professionals are leading the Canadian task force in charge of making evidence informed decisions about cannabis reform, it will take time for social attitudes to change. For instance, physician groups in Canada agree legalization of cannabis will help protect young brains from the adverse effects of the drug (Rankin 2017). However, the Canadian Medical Association states the age for use should be twenty one, not eighteen, whereas the Canadian Pediatric Society states that eighteen years of age is reasonable based on current brain research (Rankin, 2017). As the public debate on drug policy and drug use in Canada moves into the spotlight, citizens will look to their health care providers for information. Nurses are trusted professionals (CNA, 2018), who can provide education regarding stigma and the use and control of drugs in society. As public opinion shifts, how will the beliefs and attitudes of health care providers evolve? As drug policy changes there will be many more questions to be answered about attitudes, stigma, drug use, drug abuse, and recovery. Nursing researchers can choose to contribute to professional knowledge through this transitory time in history.

Recommendations for Education

According to the Mental Health Commission of Canada (MHCC) (2013) "some of the most deeply felt stigma comes from front-line health care professionals" (p 5). Stigma

is one of the key factors which prevents people from seeking help (MHCC, 2013). Pessimism regarding recovery is one of the numerous faucets of negative attitudes and stereotypes which are a consequence of inadequate education and training (Thornicroft, Rose, & Kassaman, 2007). To mitigate stigma the MHCC (2013) suggests having a person with lived experience of mental illness share their story of recovery in an engaging and hopeful way. Thus, students whom may be skeptical of recovery can see the manifestation of success in a real person with a real story. Participants in this inquiry corroborate this recommendation. Participants said that interactions with persons who have a successful recovery narrative helped shape their belief in recovery. For instance, "in my social work program there were people in year 3 of recovery, and I was only 18 when I met them. I do notice that the societal view is that it is hard to get out of that (substance use), but I have seen a few people out of that, and on the other side, so I believe it is possible" (Participant 2). Therefore, it is recommended to have persons who are successfully living in recovery speak to students as a part of their learning (Byrne, Happell, Welch, & Moxham, 2013). RNAO (2017) corroborates this teaching style.

Secondly, from this sample it is recommended to equip students with the knowledge and skills to address societal level stigma. Participants expressed a reluctance to address stigma in nursing practice and in their families. Anti-stigma programming for nurses in training should be two tiered. First, personal stigma, and then system level stigma. Initially, nurses should be equipped with the knowledge, skills, and judgement to self-regulate their own beliefs. As a part of this, self-reflection and self-examination of beliefs about SUD is required (RNAO, 2017). Personal awareness of past or present stigmatizing perceptions help the nurse to evolve into a practitioner who can deliver

caring, ethical, and evidence informed nursing care. Comprehension of the impact of stigma on health care consumption and wellness outcomes provides motivation to change beliefs. Addressing stigma within the self is the first layer for further education.

After an individual is aware of their own thoughts and actions, the second layer of addressing stigma can be actualized. Amelioration of stigma will occur when stigma reduction extends beyond the boundaries of the self to influence other members of society, including other health care providers. New nurses should be prepared to address stigma within the workforce. Nurses can model evidence informed, caring attitudes towards persons with SUD and encourage colleagues to do the same. Efforts can be made to ensure adequate staff education, resources, and support (Ford, Bammer, Becker, 2009). Nursing educators can take an upstream approach to stigma by preparing students with the knowledge, skills, and confidence to address stigma among colleagues, within institutions, and in the community. By preparing new nurses to recognize and respond to stigma where and when they find it, it is hypothesized that a greater impact on stigma can be made. If it is known stigma exists in health care (MHCC, 2013), new health care providers should be prepared to address organizational and individual stigma.

Recommendations for Future Research

Presuming SI is correct in that beliefs change in relation to social interactions, it would be of future interest to interview the same participants in five years time to assess how their beliefs may have evolved. It is known that stigma of health care providers can be reduced through pre-licensure education (Mental Health Commission of Canada, 2013). In the short term, education can improve attitudes (Brener, Cama, Hull & Treloar, 2017). However, to date, there is no evidence to suggest that short-term interventions to

reduce stigma are sustained in the long term (Gronholm, Henderson, Deb, & Thornicroft, 2017). It would be of interest to assess the impact of the workforce on the knowledge and attitudes over the long term. Following participants with either qualitative or quantitative means would be beneficial. Quantitative measurement of attitudes using a tool such as Substance Abuse Attitude Survey would allow for a larger sample size, producing more robust data. Such a scale could be administered at graduation, and again five years later, helping to answer the question: Are beliefs sustained in a working environment where stigma is present?

Repeating this investigation at other sites may produce new perspectives or validate these findings. Ideally, this narrative inquiry would be conducted once the CASN recommendations have been integrated throughout curricula, therefore reflecting to educators the impact of their curricula on students. Based on the principal of SI, actions are dependent on the meaning ascribed to the symbol (Blumer, 1969). In this case the symbols are the addict and SUD. The actions of the new nurse will depend on the meaning ascribed to SUD and persons who use substances.

Another consideration is to take such investigations into the workforce. What does SUD mean to nurses of various ages and years of practice? How do practicing nurses describe the development of their beliefs? What do veteran nurses believe about SUD and recovery? Professional organizations and workplaces may benefit from knowing what ideas more senior staff have about SUD. This information can guide ongoing professional development initiatives.

To develop this concept further, one might consider eventually looking at the nursing care delivered to persons with SUD. How do beliefs about SUD correlate with

clinical outcomes for persons with SUD? What beliefs are associated with the best clinical outcome? What beliefs are associated with the best care as defined by the substance user? Attaining input from persons with SUD about how their care is perceived could be correlated with the beliefs and attitudes of the care provider. All of these suggestions are possible areas of investigation.

Based upon this sample, fourth year nursing students in Ontario appear to be ready to enter the workforce with professional responsibility, accountability, ethics, and knowledge (CASN, 2015). When referencing the RNAO's (2015) Best Practice Guideline for Clients Who Use Substances, it appears that principles from the social determinants of health, the public health model, stages of change model, harm reduction, and recovery perspective were integrated into beliefs of this sample. Participants expressed that nursing care should be individualized and person-centered, and that nurses should help people at all stages of SUD. It was said nursing interventions should also extend to advocacy, working to reduce stigma within society. Recognition of the many barriers to recovery and the importance of nursing advocacy indicates these aspiring nurses are aware of the "service to the public" (CASN, 2015, p.7) they are called to. With respect to "self regulation" (CASN, 2015, p.7), one participant explicitly expressed her need to remain motivated to learn more on this topic. Therefore, this sample of nursing students appear to have internalized much of the recommended CASN (2015) principals.

However, there may be two key factors which warrant further investigation: trauma and culture. Trauma, trauma-informed care, and how it relates to SU was not clearly outlined by all participants in this narrative inquiry. Participants described aspects of trauma-informed care (RNAO, 2015), such as creating a safe environment, connection,

choice, and skill building. Participants described poverty, lack of housing, and difficult upbringing as stressors, not necessarily as factors associated with trauma. Investigating the knowledge and understanding of trauma may be an area for further exploration. In this inquiry, it is not clear how participants differentiate trauma and stress. CASN (2015) states a trauma-informed approach "recognizes the negative effects of violence, abuse, racism, discrimination, colonialization, poverty, homelessness, and early childhood maltreatment (such as neglect) on mental health" (p 13). Poverty, homelessness, and difficult life circumstances were discussed as stressors which relate to SUD. Further investigation into nursing students' understanding of trauma may be helpful information for educators.

Culture is the second factor which may be of interest for further investigation. Interestingly, only one of the nine participants mentioned colonization as it relates to SUD. RNAO (2015) advocates for "cultural competence and cultural safety" (p. 27) as key factors when caring for persons with SUD. Among most participants, there was limited mention of the term "culture". Race was not discussed. Participants discussed how behavioural norms are created in the home environment. Although it was not clearly articulated, the family environment may be considered as "culture" without specifying this. For instance, Participant 6 gave examples of how her culture normalizes alcohol use at family events, and after work. Families all have their unique culture, and the family environment was noted to have an influence on choices about SU.

Further to this, participants repeatedly referred to the social determinants of health. Racialized status and aboriginal status are both factors included under the social determinants of health umbrella. Participants may be linking these factors without

specifying it. Due to the lack of clarity, the role of cultural safety may be another area for further investigation. Participants endorse individualized nursing care. Race, culture, colonization, and aboriginal health status may be considered when providing individualized care. Specific inquiry around these factors may provide more clear information.

Final Conclusion

Using narrative inquiry, nine fourth year nursing students were interviewed on one occasion about their beliefs about SUD(s). As with all forms of qualitative research, the focus was on the "human realities rather than the concrete realities of objects" (Boyd, 2001, p 76). This inquiry reveals the emic view of nursing students about to enter the workforce. Data were analyzed for themes and then re-written to express key points of view. Overall, participants perspectives were eclectic, while deeply rooted in the social determinants of health. Narratives drew from personal experience and education. The barriers to recovery were discussed at length, while the role of the nurse in caring for persons with SUD was unearthed.

The narratives of aspiring nurses express meaning, tensions, and the evolution of beliefs about SUD. These beliefs arose in a complex social and cultural world wrought with stigma. Each of the fourth year nursing students whose story is told here felt comfortable to work with persons with SUD. The stories draw attention to how novice nurses' beliefs about SUD expanded from the choice model of addiction towards a more compassionate and evidence informed biopsychosocial understanding. The integration of personal experience and professional knowledge created a stance of non-judgement. It was believed nurses should provide ethical nursing care irrespective of the persons place

on the long, winding road to recovery and throughout the lifespan. The criminalization of many substances was not indicated as a reason to harshly judge persons who use substances. These stories offer a way to begin to examine how dominant and negative beliefs about SUD are created, and can be changed. Understanding the escape-based intention behind SU and the challenging life circumstances contributing to this condition allows for these nurses to enter the workforce unburdened by stereotypical and stigmatizing beliefs about SUD. Participants may be more willing to examine and reflect on their beliefs and how their beliefs influence the care they provide. An opportunity is presented here to continue to engage and support nursing students as they transition into the workforce, where not everyone will hold the same empathic professional and personal beliefs.

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Appendix A

Entry-to-Practice Mental Health and Addiction

Competencies for Undergraduate Nursing Education in Canada

Domain 1: Professional responsibility and accountability.

Competency 1**:** The nurse provides care in accordance with professional and regulatory standards when promoting mental health and preventing or managing mental health conditions and/ or addiction.

Domain 2: Knowledge based practice.

Competency 2: The nurse uses relational practice to conduct a person focused mental health assessment, and develops a plan of care in collaboration with the person, family, and health team to promote recovery.

Competency 3: Provides and evaluates person-centered nursing care in partnership with persons experiencing a mental health condition and/or addiction, along the continuum of care and across the lifespan.

Domain 3: Ethical practice.

Competency 4: Acts in accordance with the CNA Code of Ethics when working with persons experiencing a mental health condition and/or addiction.

Domain 4: Service to the public.

Competency 5: The nurse works collaboratively with partners to promote mental health and advocate for improvements in health services for persons experiencing a mental health condition and/or addiction.

Domain 5: Self-Regulation.

Competence 6: Develops and maintains competencies through self reflection and new opportunities working with persons experiencing a mental health condition and/or addiction. (CASN, 2015).

Appendix B

Interview Guide

1.) Describe for me how you have come to understand SUD or addiction, throughout your life. You may wish to start with childhood, then move into adolescence, and adulthood. Alternatively, you may wish to discuss how your understanding of SUD has evolved throughout your education.

2.) What important events or people in your life have contributed to your beliefs about substance use disorders ?

3.) Do you think some are more at risk for SUD than others?

4.) Describe what recovery means to you and what role nurses could or should play.

5.) Are there circumstances in people's lives that increase the likelihood they will recover ?

6.) What barriers prevent people with substance use problems from seeking or maintaining recovery?

7.) If your feelings about SUD differ from other peoples, can you describe for me those differences?

Questions: neutral and non-directional language will be utilized to deliver open ended questions from this semi structured interview guide. Prompts to elicit further information will be provided as needed, by nodding, paraphrasing, allowing time for silence, “hmm”, “I see”. Statements such as “can you tell me more about that”, “might you be able to give me an example”, “how did that make you feel”, “Is there anything else you might like to add” (Munhall, 2012, p. 150-151) will utilized as required. Attention will be given to use the following interviewing skills outlined by Yow (2005): "indicate empathy when appropriate, show appreciation, listen carefully, follow the narrator's pacing, explain the reason for change in topic, use a two sentence format when introducing a line of questions which may be problematic for the narrator, probe when appropriate, use a follow up question when more information needed, and request clarification when needed" (p. 115). These open ended questions are designed with the following core tenants of the CASN (2015) recommendation in mind, these include mental health promotion, recovery orientation, trauma informed approach, stigma as a barrier, and the mental health continuum.

Appendix C

Demographic Questionnaire

Please answer the following questions by checking the most appropriate box:

1. How old are you? _____
2. Sex: Male: ☐ Female: ☐ Other: ☐
3. What population group best describes your cultural background? _____
4. Past education other than the BscN program which you are currently enrolled in:

   None: ☐ Some college: ☐ College diploma: ☐ Some undergraduate studies: ☐

   Other undergraduate degree: ☐ Master's degree: ☐ Doctorate: ☐
5. If another diploma or degree is held, please specify:_____
6. Past work and/or experience with substance abuse disorders: Yes: ☐ No: ☐
7. Past personal experience with substance abuse disorder within yourself: Yes: ☐ No: ☐
8. Personal experience with substance use disorder within friends or loved ones: Yes: ☐ No: ☐
9. Would you be comfortable to work with persons with substance use disorder: Yes☐ No:☐

Additional comments:

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*If telephone interview conducted, questions will be asked by the researcher at the start of the interview.

Appendix D
Research Consent Form

Nursing Students Beliefs about Substance Use Disorder(s)

Investigator: Stephanie Elchuk, RN, MscN student.

Supervisor: Dr. Elsabeth Jensen, York University.

Purpose: The purpose of this investigation is to assess fourth year nursing students beliefs about substance use disorder (SUD). Any fourth year nursing student over the age of 18 is invited to participate. The Canadian Association of Schools of Nursing (2015) recently published "Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education in Canada". Findings from this study may provide educators with valuable insights as to how they may best design educational interventions about SUD and addiction. This will be the first Canadian study examining nursing students beliefs about SUD.

Description of the Research: Participation will require you to meet the researcher at a public location mutually convenient on one occasion for sixty minutes to discuss your beliefs about addiction. Alternatively, a telephone interview can be arranged if an in-person interview is not possible. You are free to choose not to answer any or some of the researchers questions. The meeting(s) will not exceed sixty minutes and will be audio recorded. The recording of the meeting will be transcribed (written). This written version of the interview will be emailed to you within two months. You will be asked to review the written version of your interview to ensure accurate depiction of your experience. Any misconceptions can then be clarified by email, telephone, or in person. Additions can be added if desired by the participant. The total time commitment is 1.5 to 2 hours. All identifying information contained in the data will be removed. Pseudonyms will maintain confidentiality of participants and places. Direct participant quotes will be used in the final report. You will be asked to complete a short (5 min) demographic questionnaire. Again, you have the choice not to complete any question if you do not feel comfortable answering. There are no tests, exams, or assignments. Findings from this study will take the form of a thesis.

Potential Harms: There is a small risk of emotional distress. The content may be upsetting, as substance abuse can have a significant impact individuals, families, and communities. Support and resources will be provided as required.

Potential Benefits: Benefits from participating in this study include exposure to qualitative research and contributing to nursing knowledge.

Confidentiality: Your privacy will be respected. Data produced from this study will be securely stored electronically, with password protection for 5 years. Only the researcher, Stephanie Elchuk, and thesis supervisor, Dr. Elsabeth Jensen, will have access to the data which contains your identifying information. Consent form will be stored separately from research data. Following completion of the research study the data will be kept for 5 years then destroyed. Published study results will not reveal your identity. Confidentiality will be provided to the fullest extent possible by law.

Reimbursement: To recognize your time and effort you will be given a $10 dollar coffee gift certificate at the interview and after approving the transcribed data. This $10 dollar incentive will still be offered if you decide to withdraw from the study. This incentive is offered to reduce the chance of having participants who have a personal interest in SUD.

Participation: It is your choice to take part in this study. You can stop at any time. If you decide to discontinue your participation, all of the data generated from your participation will be destroyed. This will not affect your relationship with the researcher or your university. Your continued consent is required throughout the data collection. You can request a copy of the final report if you wish.

Consent : By signing this form, I agree that:

1) This study has been explained to me and I have had the opportunity to ask questions.

2) I understand and accept the possible harms and benefits of this study. The researcher will assist me to connect with supportive services such as medical care, counselling, addiction services, 12-step programs, or ALANON if required and I am agreeable. I understand that law enforcement will be contacted if the researcher feels there is a threat to the personal safety of myself or someone else. An example of such a concern would be imminent driving under the influence.

3) I understand that I have the right not to take part in the study and the right to stop at any time without any kind of penalty. My decision about taking part in the study will not affect my education at my university.

4) You may stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating or to refuse to answer any particular questions will not affect your relationship with the researchers, York University, your university, or any other group associated with this project. In the event that you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

5) I am free now, and in the future, to ask questions about the study.

6) I have been told that my original responses to the study questions will be kept confidential and all identifying information will be changed.

7) I understand that no information about who I am will be given to anyone or be published.

8) I agree, or consent, to take part in this study.

9) Both myself and the researcher will keep a copy of this signed consent.

_____ _____

Printed Name of Participant & Age | Participant's signature & date

_____ _____

Printed Name of person who explained consent | Signature of Person who explained consent & date

If you have any questions about this study, please contact:

- Graduate Student : Stephanie Elchuk
- Thesis Supervisor: Dr. E. Jensen, Associate Professor York University.
- Office of Research Ethics: Manager. York University. Kaneff Tower, 5th Floor. 4700 Keele Street. Toronto ON.

Appendix E
E-Poster

WANTED

PARTICIPANTS NEEDED FOR RESEARCH ON BELIEFS ABOUT SUBSTANCE USE DISORDERS

We are looking for volunteers to take part in a study of nursing student's beliefs about substance use disorders.

As a participant in this study, you would be asked to participate in a one hour (in-person or telephone) interview, PLUS electronic review and approval of the transcribed version of your interview.

In appreciation for your time, you will receive a $10 coffee gift certificate for both the interview and approval of the transcription of your interview.

For more information about this study, or to volunteer for this study, please contact:
Stephanie Elchuk
York University School of Nursing

This study has been reviewed by, and received ethics clearance through a York University Research Ethics Committee and your University's Research Ethics Committee.

- Office of Research Ethics: Manager. York University. Kaneff Tower- 5th Floor. 4700 Keele Street. Toronto ON.

Appendix F

TCPS 2: CORE Certificate

PANEL ON RESEARCH ETHICS

Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

stephanie elchuk

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **10 March, 2017**

Appendix G

Invitation to Participate in Qualitative Nursing Research

Investigator Name: Stephanie Elchuk
Principal Investigator: Dr. Elsabeth Jensen
Study Name: Nursing Student's Beliefs about Substance Use Disorder

Dear Potential Participant,

I, Stephanie Elchuk, a Master of Science in Nursing Student with York University, invite you to participate in a research study to help understand nursing student's beliefs about substance use disorder(s). As a fourth year nursing student you are in an ideal position to provide valuable information on how substance use disorders are viewed by prospective nurses.

The purpose of this research is to understand the perspectives of nursing students in their final year of nursing education. Any fourth year nursing student over the age of 18 can participate. Findings can inform nursing professionals and nursing educators. This letter is intended to provide you with the information required for you to make an informed decision regarding participation in this research.

Should you decide to participate you will be asked to complete a five minute demographic survey and then verbally answer 7 open-ended questions in an informal, in-person, audio recorded interview. You can decline to answer any question. The interview can take place in a quiet public space or over the telephone. The interview will not exceed sixty minutes. You will also be asked to read and "approve" the written version of the interview. If there is any aspect of your interview you wish to clarify, you can do so when you approve your interview. Participation is completely voluntary and you can stop at any time. Participation will not affect your relationship with your university or any of its employees.

Substance use is a sensitive topic. As appropriate, participants will be assisted to connect with supportive services such as medical care, counselling, addiction services, 12-step programs, or ALANON should participation in the study causes emotional distress. The researcher and participant will together decide on an appropriate plan of care. The researcher will be available to participants after completion of the study (telephone and email) if questions or concerns arise. Should a participant disclose a personal substance use problem which could compromise safe delivery of nursing care to members of the public the participant will be encouraged to connect with support services. Support in accessing these services will be provided in accordance with the participant's wishes. Law enforcement will be contacted if any threat to one's personal safety is evident.

Your responses to all questions will be kept confidential by using pseudonyms. Only myself and my thesis advisor, Dr. Elsabeth Jensen of York University will have access to the data. The interview will not include your name or any other identifying information. Data will be securely stored and destroyed after five years. There is a small risk of emotional distress. Assistance will be provided to connect you with support and/or resources as needed. The benefit of participating in this study is exposure to qualitative research and making a contribution to nursing knowledge. Your participation will be a valuable addition to my research. Findings will lead to greater understanding of nursing student's beliefs about substance use disorder(s).

You will be provided with a ten dollar coffee card for your participation in this study. If you are willing to participate please email to myself and suggest a day and time that suits you. I will do my best to be available. You will be required to sign a consent form. As the researcher, I do not have any current affiliations to your university. I graduated from your university in 2005. If you have any questions please do not hesitate to ask.

I look forward to meeting you. This letter is yours to keep for future reference.

Thesis Supervisor: Dr. E. Jensen, Associate Professor York University.

Research Ethics Board(s):

Office of Research Ethics: Manager. York University. Kaneff Tower, 5th Floor. 4700 Keele Street. Toronto.

Appendix H

Agency Letter

May 1, 2017

To the Director of Nursing,

My name is Stephanie Elchuk, and I am a student in York University's Master of Science in Nursing program. The research I wish to conduct for my Master's thesis involves gaining an understanding of nursing student's beliefs about substance use disorder(s). This project will be conducted under the supervision of Dr. Elsabeth Jensen, associate professor, at York University.

I am hereby seeking your consent to conduct a narrative inquiry with nursing students in their fourth year of study at your university.

I have provided you with a copy of my research proposal which includes copies of the consent form to be used in the research, along with the ethical approval letter I received from the York University Research Ethics committee and your university's Research Ethics committee.

I humbly ask for your assistance to recruit ten participants. Specifically, I ask that you electronically distribute an "e-poster" combined with the invitation to participate letter to all fourth year students. Should the electronic recruitment not yield 10 participants I would like to briefly speak to a class of students. Should an in class presentation be required to increase participation, I will verbally present the "Invitation to participate" letter. I will invite questions and answer any questions about the purpose of the study, time commitment, incentive, confidentiality, and risks and benefits of participation. My presence in the class room will not exceed ten minutes.

Upon completion of the study, I undertake to provide a the School of Nursing with a bound copy of the full research report. If you require any further information, please do not hesitate to contact me. Thank you for your time and consideration in this matter.