# Striving for Connection: A Phenomenological Examination of Nurses' Experience Supervising the Injection of Illicit Drugs

**by**

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B.A., Simon Fraser University, 2012

Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Arts

in the
Counselling Psychology Program
Faculty of Education



**SIMON FRASER UNIVERSITY**

**Summer 2015**

# Approval

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## Ethics Statement


The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

a. human research ethics approval from the Simon Fraser University Office of Research Ethics,

or

b. advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University;

or has conducted the research

c. as a co-investigator, collaborator or research assistant in a research project approved in advance,

or

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# Abstract

The purpose of this study was to explore the experiences of nurses who supervise the injection of illicit drugs at Insite, a safe injection facility (SIF) in Vancouver, BC. The effectiveness of SIFs for clients is strongly supported by evidence, but little research has been done to examine what the experience is like for staff. A hermeneutic phenomenological approach was used to interview 6 nurses who work at Insite. Interview data was transcribed, coded according to van Manen's selective reading approach, and codeweaving was used to determine themes. Four themes emerged: (a) *creating social cohesion through the use of harm reduction*; (b) *opportunities for relationship-building during in-booth supervision*; (c) *balancing relationships and autonomy*; and (d) *working on the edge of trauma.* The essence of participants' experience was *connection.* Clinical implications, study limitations, and future directions for research were explored.



**Keywords**: Nurses; Insite; Supervised Injection; Harm Reduction; Trauma; Phenomenology

## Dedication

I dedicate this research to helpers everywhere who work very hard to support people in their most difficult moments, and to preserve human dignity for everyone. I am deeply moved by the care, compassion, and dedication of the nurses who work at Insite, and I thank you all for allowing me to step into your experience and helping me to understand the very important work that you do.

## Acknowledgements

There are several people I must acknowledge as the completion of this project was contingent on their support. I am very grateful to have had the support of two very intelligent and dedicated supervisors. Thank you to my senior supervisor Dr. Patrice Keats for your guidance, patience, encouragement, and countless hours of editing. Thank you to Dr. Paul Whitehead for sharing in my excitement about this project, and being very grounded when helping me to unravel the jumble of thoughts in my head. I greatly appreciate the time and hard work you have both put in.

A special thank you to my dear friend, colleague, and partner-in-crime, Amanda Mae Hamm. This would not have been possible without your commitment, the endless hours of discussion, editing, and emotional support –I am very grateful.

Thank you to my partner Dean for your support and patience in tolerating the never-ending discussion of this research. I could not have done it without your all cooking, encouragement, and dedication to cracking the whip.

I would like to acknowledge the support of the Joseph-Armand Bombardier Canada Graduate scholarship, and the Travel and Minor Research Awards I received from Simon Fraser University in helping me to complete this project.

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# Chapter 1. Introduction

Harm reduction approaches to drug use are receiving a great deal of attention in the medical and social services communities as a result of their efficacy in reducing harm to those who use drugs, and for communities in which heavy drug use is a problem (Hedrich, 2004; Kerr et al., 2005; Krusi, Small, Wood, Kerr, 2009; Semaan et al., 2011; Stoltz et al., 2007). Safe injection facilities (SIFs) are a prime example of harm reduction approaches to drug use as they provide clients with the means to inject their pre-obtained illicit substances more safely under the supervision of registered nurses. Nurses who work in these settings are often the primary source of contact for clients (Griffiths, 2002), and my exploration of their experiences is important in order to better understand and support them in the challenging work that they do.

## 1.1. What Happens in Safe Injection Facilities?

Safe injection facilities use harm reduction approaches to tackle the problems associated with drug use. SIFs provide clients with a safe place to inject their pre-obtained drugs with sterile materials under the guidance and supervision of registered nurses (Semaan et al., 2011). Most SIFs provide clients with clean syringes, drug preparation materials (e.g., cotton, sterile water, spoon), primary health care, and education about how to reduce the harms associated with injection (e.g., risk of infection, signs of overdose, safely disposing of hazardous litter). If clients are open to further assistance, staff also provide referrals to a variety of social care services such as counselling, legal services, housing and shelter programs, entry into detox, and further treatment for addictions. Although it is not often discussed, a large part of the role of nurses at safe injection sites is also to provide clients with emotional support as clients may share very painful stories while seeking help (Wood, Zettel & Stewart, 2003). It is this support that creates the open communication and relationship building that makes these programs effective in reducing the harms both to individuals and communities.

SIFs typically serve injection drug users who are dealing with problems other than those associated with their drug use. Clients are often dealing with a combination of temporary or chronic homelessness, mental illnesses, criminal histories, a history of work in the sex trade, and serious physical illnesses (Griffiths, 2002; Wood & Kerr, 2006). Perhaps even more challenging for nurses who work with this population is the disproportionately high rate of clients who have a complex trauma history. Rates of childhood sexual abuse, physical abuse, emotional abuse, and neglect in injection drug users have been estimated to be between 33% to 50% (Braitstein et al., 2003; Medrano et al., 2003; Ompad et al., 2005; Plotzker, Metzger, & Holmes, 2007). Because of the high rate of trauma among injection drug users, some of the clients that attend SIFs are likely to demonstrate post-traumatic stress symptoms during their interactions with staff. For example, a client who has experienced sexual trauma may begin dissociating when a nurse touches him/her for the purposes of treating a wound or cleaning repeated injection sites. Another example of post-traumatic stress symptoms may be panic attacks or other severe anxiety symptoms if a client is triggered when a nurse is counselling him/her on safe sex practices. Whether or not nurses are thoroughly trained in psychological health, these types of interactions with drug users may be overwhelming. Even for nurses who are comfortable discussing clients' trauma, they may still experience vicarious traumatization or secondary traumatic stress in response to witnessing a client's suffering and learning of the horrific traumas that they have experienced.

In addition to dealing with complicated client situations, nurses may also face challenges in dealing with ethical dilemmas that arise from working within a harm reduction model. Balancing the needs of staff and clients while trying to work within harm reduction guidelines may be difficult at times.

Nurses fill many roles in safe injection facilities and are often the main source of support for clients (Griffiths, 2002; Lightfoot et al., 2009). For example, nurses may provide clients with emotional support, help them navigate institutional systems like healthcare, or courts, and help them with non-drug related health issues. My own experience volunteering with an organization that provides a safe injection program has shown me that while nurses often find this work very rewarding, it also creates a great

deal of stress that may affect both their professional and private lives. While in my volunteer role, nurses described very intense traumatic stories from clients that left them feeling rattled and shaky. They also shared with me that these stories and intense encounters stick with them long after the interaction. Nurses working in SIFs have also told me about ethical dilemmas that left them feeling torn and anxious as they were unsure of what to do.

An abundance of research has demonstrated that nurses and other health care professionals are at a higher risk of burnout and compassion fatigue than the general population (Burbeck, Coomber, Robsinson & Todd, 2002; Burke & Richardsen, 1990). Additionally, while a great deal of resources have been directed toward learning about the efficacy of safe injection facilities for clients who use these programs (Andresen & Boyd, 2010; Wood et al., 2006), very little research has been conducted on the experiences of the staff who work with these clients. Given this, my goal was to conduct research with nurses who supervise the injection of illicit drugs in order to gain a better understanding of the impact of the work on them, and the unique types of problems they face. A focus on this population will allow nurses to give rich and accurate accounts of their experiences with clients, as well as any ethical challenges they have to face from working within a harm reduction framework. Better understanding of nurses' experience will provide information necessary for enhanced support and resilience. Ultimately, this will have a positive impact on the quality of client-care.

## 1.2. The Current Study

There is a great deal of evidence that nurses who supervise the injection of illicit drugs may experience problematic stress related to their work that could impact their own mental health and quality of work. Despite this, any research looking directly at their experience could not be found in available databases used in this literature review. It is for these reasons I conducted this study to find answers to the question: what is the meaning of the lived experience of nurses who supervise the injection of illicit drugs in Vancouver's safe injection sites? While the nurses' experience is the phenomenon under study, this inquiry focused on two main areas of their experience; first, their experiences with clients and second, their experiences and perceptions of working within a harm

reduction model. I asked participants specific interview questions that focused on obtaining examples of these aspects of the phenomena. Thus, additional research questions were:

- What aspect of nurses' experience, either prior or associated with their current work, draw them to this work?
- How might nurses' perceptions of harm reduction models relate to their work in safe injection facilities?
- How do nurses describe their experiences with clients who use the safe injection sites?
- What types of experiences stay with them (impact them) from this type of work?

I believe that this study will inform the literature on nurses' experiences with drug-related harm reduction programs as well as the literature around types of traumatic stress in nurses. Furthermore, I hope this study will add to the existing literature documenting the importance of healthy relationships between care providers and patients to ensure good patient outcomes and the satisfaction of both parties. While the federal government has halted current progress in the implementation of supervised injection facilities in Canada, new facilities may soon be opened in response to the overwhelming amount of evidence demonstrating their effectiveness in reducing harm to individuals and communities (Wood et al, 2006; Andresen &Boyd, 2010 and Wood et al, 2008). It is my hope that this research will be informative to those who provide help to health care professionals experiencing any type of traumatic stress, and those who seek to understand the very unique experiences of nurses who work in these settings.

In the sections below, I review the literature surrounding nurses' experience supervising the injection of illicit drugs while working at SIFs. In this review the term illicit drug users will refer exclusively to injection drug users. Nurses tend to use the terms *client, patient,* and *participant* interchangeably when referring to people who use their services. To prevent confusion, service users will be referred to as *clients*, and nurses who participated will be referred to as *participants*. This literature review first investigates the meaning of harm reduction and explains the tenets inherent in harm reduction programs. Second, it provides a detailed definition and examination of SIFs to make clear the type of work nurses engage in at these facilities. Last, it reviews the extant

literature on the effects of traumatic stress nurses may experience at work; this is of utmost importance as similar experiences may be found in nurses who supervise the injection of illicit drugs.

The present study used a phenomenological approach to understand and describe the lived experience of nurses who work at SIFs without presuppositions. This study sought to investigate the experiences of nurses who work in these settings to shed light on topics that may help to ensure that they are being effectively supported in doing this very important work.

# Chapter 2. Literature Review

## 2.1. Harm Reduction

Harm reduction is any action that reduces the harm associated with risky behaviours without necessarily insisting that the risky behaviour in question must cease (Lee, Engstrom & Petersen, 2011). Safe injection sites allow injection drug users to inject their pre-obtained drugs with clean materials under the supervision and instruction of nurses. There are four common elements across varying types of harm reduction services. First, harm reduction programs must be low threshold. That is, keeping requirements for enrolment low will ensure that people will actually use the services and not be scared away by a requirement of abstinence from the risky behaviour (Marlatt, 1998). Second, maintaining client autonomy is paramount. This client-centred approach focuses on meeting people where they are at rather than at a place where someone else says that they need to be (Lee et al., 2011). Third, harm reduction takes a holistic stance and seeks to help clients both in relation to their risky behaviours as well as for other issues that influence their physical, emotional, and mental health. By allowing for flexible goals, harm reduction approaches provide a strong platform from which to treat the whole person and not just their drug use. Fourth, harm reduction sees relationship building as being not just a positive outcome, but also a necessary tool to ensure honesty from clients so that effective and personalized treatment can be provided (Griffiths, 2002).The goal of harm reduction approaches for drug use is to educate people and empower them to make their own choices (Wood et al., 2003). This empowerment is created by allowing for client autonomy while providing education and unconditional support for whatever decisions clients make about their own health and well-being.

With these four elements of harm reduction being present in safe injection facilities, nurses have a plethora of ethical issues to deal with in addition to those relating

specifically to illicit drug use. While the *Code of Ethics for Registered Nurses* (2008) has noted that harm reduction approaches to drug abuse are within the practicing ethical guidelines, nurses may still encounter situations in which following a harm reduction model violates their personal values or those in their professional code of ethics. For example, a nurse working at an SIF may learn that a client is abusing prescribed medication, but knows that if the client were to lose that prescription they would then be forced into more dangerous activities to obtain similar drugs that may be less safe to consume. The nurse in this situation may find it difficult to help the client to continue abusing prescription medication and their doctor's trust, but is bound by the mandate of harm reduction to still help this client to use their drug as safely as possible. As a volunteer working with an organization that has experienced ethical dilemmas like this one, I know what it feels like to find myself in a place of uncertainty. My experience of these types of ethical dilemmas often left me feeling anxious, unsure and sometimes betrayed by clients when they knowingly put me in a position in which I had to make a difficult decision.

In considering the main tenets of harm reduction and the potential ethical dilemmas that may emerge, it is clear that working from this paradigm can be very emotionally demanding for staff. Nurses may struggle to remain accepting, open, and non-judgmental while balancing personal values with their professional code of ethics and the mandate of harm reduction programs. Thus, the experience of nurses working within a harm reduction model is an important aspect to consider when examining their roles in SIFs.

## 2.2. The Impact of SIFs on Individuals and Communities

Long before the creation of Canada's first SIF, other countries implemented harm reduction approaches in communities suffering from problems of illicit drug use. After many years of operation and research, it has been demonstrated that SIFs are effective in providing benefits directly to illicit drugs users and also to the communities in which they live (Seeman et al., 2011; Wood et al., 2006).

Research has demonstrated that the use of SIFs has a significant impact on the reduction of harm to individuals who use drugs and has increased their connection to helpful services. Wood et al. (2006) found that consistent weekly use of SIFs in Vancouver was associated with a quicker entry into addiction treatment programs compared to those who did not use such services. Users of SIFs also tend to undergo behavioural changes that help them advocate for their own health and to adopt practices learned at SIFs that increase their safety while using illicit drugs (Petrar et al., 2007). One of the most significant positive impacts of SIFs is the reduction of deaths by overdose due to instruction on how to inject safely, and the presence of nurses who are able to help someone who shows symptoms of overdose (Milloy et al. 2008; Salmon et al., 2010; van Beek, 2003). When considering a number of SIFs across the world, there is no record of any deaths occurring due to overdose while in SIFs (Broadhead et al., 2002; Kerr et al, 2006).

Despite critics' concerns that providing these programs may encourage drug use, there is no evidence that people are more likely to start, or continue using drugs because they are provided with education and materials on how to do so (Pinkerton, 2011; Semaan et al., 2011). Instead, evidence supports that the opposite is likely to occur as clients are more likely to enter treatment as a result of the strong helping relationships they build with staff that facilitate their entry into treatment (Wood, 2005).

SIFs have also had an impact on the reduction and cessation of many risky activities that cause harm to the communities in which drug users reside. Because the use of SIFs is related to a decrease in deaths by overdose, those benefits are passed onto the community by reducing the need for ambulance and emergency services (Salmon et al., 2010; van Beek, 2003). Further, the education provided by SIFs leads those who use the services to be more knowledgeable and responsible about how their actions affect their community. Use of SIFs has led to clients being more likely to safely dispose of dangerous injection litter, to not share needles with others which may spread disease, and to not inject in public (Hedrich, 2004;Kerr et al., 2005; Stoltz et al., 2007). Because of these changes, the spread of HIV, Hepatitis C, and other dangerous diseases is also impacted when those who use drugs are educated about the dangers of sharing needles and creating dangerous drug litter. Along with the potential for harm to

individual community members, drug use is also a financial liability on societies. Illicit drug use contributes to the burden on the health care system and the criminal justice system, because both systems attempt to lessen its impact on society (Andresen & Boyd, 2010). SIFs have a positive impact on the cost to society as they help to remove some of the burden on other community services by giving those who use drugs autonomy, education, and alternatives they find effective and are willing to use.

Based on the accumulation of the above evidence, researchers and health care professionals in other countries are now beginning to lobby for the creation of SIFs in areas where illicit injection drug use is high (Semaan et al., 2011). It is likely more SIFs will be implemented around the world, thus, it is important to consider the well-being of staff who work in these facilities to ensure clients continue to receive the best care possible.

## 2.3. Traumatic Stress in Nursing

According to Wilkins (2007), registered nurses report some of the highest levels of stress at work when compared with other types of health care providers. Nurses fill many roles in SIFs and are often the primary source of support for clients (Griffiths, 2002; Lightfoot et al., 2009). This sets the stage for nurses who work in SIFs to be heavily impacted by the complicated issues clients bring into their workplace. It is now well-established in the literature that one of the main strengths of the harm reduction approach involves building close relationships with clients. This is beneficial for several reasons, one being so that staff can use that strong sense of rapport to facilitate honest disclosure of activities that affect health, and more frequent entry into treatment (Griffiths, 2002; Wood et al., 2003). Because nurses are making efforts to establish strong relationships with clients, they may be putting themselves in a more vulnerable position when they are exposed to a client's trauma.

Apart from the vulnerability that comes with working with difficult clients who often have histories of trauma, nurses who work in SIFs also face many experiences that may cause high levels of stress with the potential for traumatisation. According to Kerr (2006), nurses who work in SIFs will likely have to deal with client overdoses at some

point, and the experience can be very stressful whether or not the client goes into respiratory arrest. While most overdoses are caused by the use of opiates, some overdoses are caused by other classes of drugs which have different overdose treatments. When a client is using an opiate and then goes into respiratory arrest, nurses are able to administer naloxone hydrochloride (Narcan) to counteract the effects of the drug. The use of Narcan effectively stops the overdose symptoms and clients will usually begin breathing and regain consciousness immediately. Being able to use Narcan may give nurses a sense of relief as they have a very effective tool to revive someone. In cases where clients are using drugs such as cocaine or methamphetamine, Narcan is not an option to resolve respiratory arrest and nurses will have to attempt to revive clients in other ways (typically with oxygen and artificial respiration or CPR). The number of overdoses varies greatly in a given time period, so nurses are always operating in the unknown (Kerr, 2006).

## 2.4. Types of Traumatic Stress

Keeping in line with the philosophy of phenomenology, this study seeks to describe the lived experience of nurses who work in SIFs without assumptions about what type of traumatic stress they may experience, if any at all. A review of types of traumatic stress is included here because there is a great deal of research that nurses working in other fields have experienced one or more types. Nurses who work in SIFs have different experiences than those who work in other fields, but there are enough similarities between the positions that the same types of traumatic stress may emerge from experience working in SIFs. Nurses who work in a variety of settings, such as oncology wards, emergency services and as sexual assault examiners, report a high rate of traumatic symptoms as a result of working with traumatized people (Dominiquez-Gomez &Rutledge, 2009; Quinal, Harford & Rutledge, 2009; Townsend & Campbell, 2009). Because the clients that nurses interact with at SIFs have such significant trauma histories (Braitstein et al., 2003; Medrano et al., 2003; Ompad, Ikeda et al., 2005; Plotzker, Metzger & Holmes, 2007), nurses who work in these settings are also at a great risk of experiencing some type of traumatic stress in response to these interactions.

The types of traumatic stress experienced by other nurses who work with potentially traumatized populations are secondary traumatic stress or vicarious traumatic stress. According to Figley (1995), secondary traumatic stress (STS) involves normal consequential behaviours and emotions that are a response to knowing about traumatic events experienced by someone else, and the stress that comes from trying to help someone who has experienced trauma. STS is primarily characterized by a change in a helper's immediate behaviours and feelings after witnessing another person's trauma and suffering. The helper may present with symptoms very much like what would be expected with a diagnosis of post-traumatic stress disorder (American Psychiatric Association, 2013). Researchers have found evidence of secondary traumatic stress in nurses who work in emergency rooms and oncology wards (Dominiquez-Gomez & Rutledge, 2009; Quinal, Harford & Rutledge, 2009). These environments are similar to Insite as they share the potential for chaos in treating acute issues, as well as the potential for heightened emotions in responding to the dire health needs of clients.

Vicarious trauma is "a process of [cognitive] change resulting from [chronic] empathic engagement with trauma survivors" (Perlman, 1999, p. 52). Vicarious trauma is characterized by a change in how a one sees oneself in the world after such engagement with trauma survivors. This may involve changes in one's sense of self, one's worldviews, or spiritual beliefs. According to Perlman, (1999) those experiencing vicarious trauma often report a changed sense of safety or level of trust and control about being in the world. Maier (2011) found vicarious trauma as well as other types of traumatic stress in nurses who work with sexual assault survivors. Many clients who inject drugs have also experienced sexual assault as well as a myriad of other traumas (Braitstein et al., 2003; Medrano et al., 2003; Ompad et al., 2005; Plotzker, Metzger & Holmes, 2007). Through their relationships with clients, nurses at SIFs may also be impacted by hearing about client's traumatic experiences.

# Chapter 3. Methodological Approach

I used a qualitative approach for this study because I am interested in the subjective experience and meaning-making processes of nurses who supervise the injection of illicit drugs. Qualitative methods are more concerned with subjective experiences than quantitative approaches, and are thus more effective in determining the internal experiences and implications these experiences have on participants. With a qualitative approach I was able to gather rich data that provides insight into the nature of what nurses who supervise injections actually experience in their daily work environment.

I used a phenomenological approach to look at the lived experience of nurses who supervise the injection of illicit drugs in order to understand the common themes that emerged from this experience. According to van Manen (1990), phenomenology can be used to study anything that may enter consciousness as it is in the lifeworld. This means researchers can study real or imagined phenomena, but cannot do so without taking into consideration the setting in which it is lived. Phenomenology is also a good fit for this study because I am interested in the meaning of participants' experiences as they pertain to the shared human experience of being a nurse at an SIF, rather than one individuals' subjective experience alone. Van Manen (1990) argues that this is a key difference between phenomenology and some other qualitative approaches. This topic also fits well with a phenomenological approach, as there is a clearly defined phenomenon (Creswell, 2013). The phenomenon under investigation in this study was nurse's experience of supervising the injection of illicit drugs in Vancouver's SIFs.

The use of the phenomenological approaches in nursing research has been well-established as an effective means of investigating many aspects of lived experience in nursing (Beck 1994; Dowling, 2005). According to Beck (1994), nursing and phenomenology are well-suited to each other because they both involve, "observing,

interviewing and interacting with clients so that a deeper understanding of client's experience can be grasped" (1994, p. 501). Given this appropriate pairing, there are large arrays of studies in the nursing literature that have used phenomenology to investigate nurses' experience (Clarke & Wheeler, 1992; Kornhaber & Wilson, 2011; Wolf, 1991). I applied the phenomenological method in a way that is consistent both with the guidelines of phenomenology and with how it has been conducted in other nursing studies.

Phenomenology is concerned with identifying the underlying essence of the experience of participants. I did not take a positivistic stance that sees aspects of nurses' experience as standing on their own outside of the individual, but instead investigated how these aspects of nurses' experience operated within the unique context of safe injection sites. It is for this reason that I adopted van Manen's approach to phenomenology, which applies a perspective that is a balance between descriptive phenomenology and Heidegger's interpretive phenomenology (Dowling, 2005).Van Manen's (1990) hermeneutic phenomenology is deeply concerned with universal structures of experience that are constructed from the shared experience of individuals. According to van Manen (1990), these shared experiences are still found within individual human experiences. Therefore, examining individual experience can still inform what is common in specific human experiences. In order to identify the positive aspects of nurses' experiences, and help them with the challenging aspects of their experience, I had to first tease out the common elements of their experience. According to van Manen (1990), phenomenology itself is presuppositionless in that it tries to consciously counteract the tendency toward creating predetermined procedures and techniques. Thus, the methods I used to determine the common elements of experience were somewhat flexible and open to change, while still maintaining a focused orientation toward the phenomenon being investigated. This flexibility allows the researcher to adapt the procedure to best fit with the current developments of the interview. I conducted interviews with a set of predetermined questions, but this approach allowed me the flexibility to stray from using *only* my predetermined questions when I heard something in a participant's narrative than emerged as an unexpected aspect of the shared experience.

According to the guidelines of hermeneutic phenomenology, shared experience can only be considered universal to the point at which nurses share the same socio-cultural context. In this case, that means the shared socio-cultural context involves having nursing/medical training, having supervised the injection of illicit drugs, and having worked within a harm reduction model or framework. Because my understanding of the socio-cultural context of the phenomenon is extremely important in hermeneutic phenomenology (van Manen, 1990), I immersed myself as much as possible into the socio-cultural context in which nurses supervise the injection of illicit drugs. It is through this immersion that I was able to embrace the phenomenological idea that I must be aware of any judgments I hold about the phenomenon and set them aside in order to understand the subjective reality of my participants (Creswell, 2013). My own background as a graduate student in counselling psychology provides me with a very humanistic outlook that is consistent with the harm reduction ideology in which nurses at SIFs operate. While I was not educated in the same medical environment that my participants experienced, I am familiar with the organizations in which they currently work and the procedures they typically employ. Part of my familiarity with SIFs comes from the four years I volunteered at the Dr. Peter Centre. This foundation embraces a harm reduction model and provides a safe injection room as a part of its larger program to help individuals living with HIV/AIDS in Vancouver, B.C.. Despite my attempts at immersion, my role as an outsider likely still places limitations on my understanding of participant's experience from their subjective reality. I lessened this impact through the use of several procedures described in the trustworthy section below. In contrast to the potential limitations, I found my role as an outsider to be beneficial because I was able to see impactful things that my participants did not notice when describing their experiences. It was at these moments that the flexibility of the procedure used was most helpful, as I was able to ask questions about specific things participants had shared rather than only sticking to my pre-determined questions.

## 3.1. Research design

### 3.1.1. Situating the Study

SIFs have been implemented in Vancouver, BC to meet the unique needs of Vancouver's downtown eastside (DTES) population. By 2003, the DTES was in great need of solutions to address the rise of extreme poverty and homelessness, injection drug use, drug injection in public, hazardous drug litter, overdoses, and overburdened hospital emergency rooms in the community (MacPherson, 2001; Wood, et al., 2003). In 1997 the Vancouver health authority had no choice but to declare a public health crisis in response to the increased rate of HIV and hepatitis C infection, as well as the climbing number of deaths by overdose (Fischer, Rehm, &Blitz-Miller, 2000; Palepu, et al., 2001; Patrick et al., 2001). Based on these dangerous increases, it was clear that the present methods of dealing with drug-related harm were not effective. In order to bring about change, the city of Vancouver implemented a four pillar approach to deal with the problems associated with illicit drug use in the DTES: prevention, treatment, enforcement, and harm reduction (MacPherson, 2001). The use of SIFs are a prescribed action under the harm reduction pillar and the SIF, Insite, was opened in 2003. It is for these reasons that Vancouver is an ideal place in which to conduct this research.

### 3.1.2. Recruitment

There are currently two safe injection facilities in Vancouver: Insite and the Dr. Peter Centre. Although both facilities were approached to be involved in the research, the Dr. Peter Centre declined to participate; therefore, all participants in this study were recruited through Insite.

Insite operates within the ethical guidelines outlined by the *Code of Ethics for Registered Nurses* (2008), following clear guidelines about what nurses can and cannot do with regard to supervising injection. Clients register for the use of services, and they have the choice to use an alias. They must tell the nurses what substance they intend to use (a pre-obtained substance that they brought with them to the centre) so nurses can be prepared to treat potential overdose symptoms. Clients then enter the injection room,

which is well-lit and lined with booths containing sterile materials needed for the preparation of injecting drugs. Clients sit in the booth facing a mirror that is angled so nurses sitting at their station behind the booths can observe clients' injecting practices. After injection clients are able to relax in a nearby room or seek advice or medical care from staff.

After obtaining the approval of the Simon Fraser University Office of Research Ethics, the Vancouver Coastal Health Research Ethics Board, and the clinical coordinator at Insite, I was able to begin recruitment at Insite. I sent a recruitment flyer explaining the study to the research coordinator at Insite and it was then distributed to staff so they could contact me if they were interested in participating.

I first established contact with participants via phone or email and asked them several questions to determine eligibility for the study and ensure that they understood the process. I then sent them the initial interview questions (see appendix D for interview protocol), and a small pre-interview (see appendix C) questionnaire that focused on the context in which participants experience the phenomenon. I asked them to bring a completed copy to the interview, or to take a few extra minutes to complete it before the interview. I met with all participants at SFU campuses in Vancouver and Surrey.

### 3.1.3. Participants in this Study

Participants were required to be registered nurses or nurse practitioners that had worked at Insite for a minimum of six months, and had supervised at least twenty injections with at least five different clients to ensure they had an adequate amount of experiences to comment on. Participants were not required to be currently working at Insite, but to have worked there within the last three years. The minimum requirements to ensure adequate experience were determined after several conversations with nurses who supervise the injection of illicit drugs at the Dr. Peter Centre. I chose the shortest amount of experience deemed acceptable by staff to ensure a low-threshold for participating in this study.

There were twelve respondents to the recruitment flyer, but half of those respondents did not participate in the study because of ineligibility or difficulties

scheduling. The six respondents who did participate in the study were all female, aged 25-38, and consisted of white and south-Asian backgrounds.

### 3.1.4. Data Collection

Well-established phenomenological data collection methods were used in this study. Semi-structured interviews were conducted with the aim of eliciting concrete examples of participants' experiences (Creswell, 2013). Interview questions focused on participants' specific experience of the phenomenon, including interactions with clients and the context, as well as the impact these experiences had on them and the meaning they made of the interactions with clients. Because qualitative approaches have often been used in nursing research, participants were familiar with, and open to these data collection techniques.

In planning for the possibility that the interviews may cause distress from eliciting traumatic or stressful information from participants, appropriate supportive and therapeutic resources such as self-care activities, and information about seeing a counsellor, were provided. Participants were provided with a copy of the informed consent to participate form that included, the contact information of my supervisor, and me as well as the contact information of relevant resources (such as counselling) that they could access through their employer. All interviews were 55-80 minutes in length depending how much participants wanted to share. All interviews were audio recorded, and were then transcribed verbatim. Interview data was then entered into the data analysis software program MAXQDA. This program aids the organization of qualitative data by allowing the researcher to select text, and easily create codes with participants' words. The codes are flexible to be organized and reorganized according to the themes that emerge during analysis.

### 3.1.5. Data Analysis

I used van Manen's (1990) selective reading approach to determine the meaning of participants' experience. After transcription, the first step in van Manen's method of analysis is to read through the interview data with an open mind and highlight any

statements that stand out as being “particularly essential or revealing about the phenomenon or experience being described” (1990, p. 93). I transcribed four of the interviews, and a graduate student research assistant transcribed the other two. While transcribing, I highlighted important statements, and for the two interviews that I did not transcribe, I listened to them while reading through the transcript, and also highlighted important statements.

In considering van Manen’s view on the hermeneutic phenomenological approach, I made an effort to be very cognizant of my own socio-historical context when interpreting the data and tried to embrace that of my participants. After seeing the data as a whole, I determined the appropriate levels of analysis, and began coding specific phrases being careful to use participants’ exact words for code names. Because I did not have a pre-determined guide to code the transcripts, I began by grouping codes based on the question that I asked. After coding several interviews I consulted with supervisors on the meaning of individual codes and the categories that they naturally fell into. At this point, I reorganized the code system to fit with what participants were speaking directly to, rather than to the specific questions that I had asked. I coded the remaining interviews, put the codes into clusters based on meaning, and used codeweaving to make sense of the categories of codes. Saldana (2013) describes codeweaving as the integration of major codes that make sense together, much like putting together puzzle pieces that will provide a larger picture. Through the narratives that resulted from codeweaving, I was able to formulate my four main themes. Consistent with van Manen (2014)’s hermeneutic phenomenological method, themes emerged as structures of experience that spoke about the inherent meaning of the lived experience, rather than based on the number of codes that fell into a particular category.

In order to ensure the accuracy of themes, it was necessary to return to the original interview data to validate them. After completing the outline of themes, I returned to the code system to validate these themes and reorganize small parts of the resulting themes. All themes were validated. According to van Manen (1990), for a theme to be essential it must be a necessary aspect of that phenomenon (i.e., without the theme, the phenomenon could not be what it is). This was done by using van Manen’s method of free imaginative variation, which involved asking the question, “Is the phenomenon still

the same if we imaginatively change or delete this theme from the phenomenon?"(1990, p.107).The purpose is to see if the phenomenon loses its fundamental meaning when a particular theme is removed. All themes were determined to be essential aspects of the phenomenon, and were described in a summary to be returned to participants. After hearing back from participants I was confident that the extracted themes were accurate representations of participant's experience, and wrote a description outlining the essence of the experience.

## 3.2. Procedures to Establish Trustworthiness

Establishing all factors of worthiness is of utmost importance when conducting qualitative research. I took a number of steps to ensure the four aspects of trustworthiness, credibility, dependability, confirmability and transferability (Shenton, 2004) are present in this research.

### 3.2.1. Credibility

Credibility is defined as any act a researcher does to ensure their data is of high quality and that they are exploring a truly lived experience (Shenton, 2004). To ensure the credibility of my study I utilized a well-established approach that is appropriate for the topic of my study. I also employed a rigorous data analysis method that has proved effective at analyzing interview data taken from nurses. The phenomenological approach required me to provide a detailed description of the phenomenon under study, and this also helped to address issues of validity.

Triangulation of data is also an effective means of establishing credibility (Shenton, 2004). Interviews are the traditional form of collecting data in phenomenology, and while multiple types of data can be collected, they are not used as frequently as in other approaches (Creswell, 2013). I asked participants to complete a short open-ended questionnaire that asked them what they do in a typical day and how many injections they typically supervised to provide a better context in which the supervision of injections occurs. While I hoped to recruit participants from two sites to assist in the triangulation of my data, this was not possible. In addition to those methods of triangulation, I also

obtained a demographically diverse sample. The sample is made up of participants of different ages and with different backgrounds.

Doyle (2007) argues that member checks are necessary when using interpretive phenomenology because returning to participants helps to complete the hermeneutic circle that van Manen discusses. I ensured this fluid movement between participants and interpretation by doing member checks in two different ways. First, I frequently clarified with participants whether or not some things said during the interviews accurately fit with what they meant. Van Manen (1990) argues that this is an extremely important part of data collection, as data analysis and verification need to begin while in the field rather than being completely reserved for later. I did this by paraphrasing any metaphors or unclear content during the interviews and directly asked participants what they meant from a particular statement. Second, I created a summary of themes and took them back to participants to get their feedback before settling on the final themes. This helped to avoid investigator bias as it gave participants the opportunity to correct any misinterpretations, and provide any additional information that was not collected in the initial interview.

I asked participants three questions about their thoughts on the theme summary: a) Does this summary fit with your experience? b) Is there anything off about it? and c) Is there anything you think needs to be added? Five out of the six participants responded via email with feedback to the theme summary, and all feedback confirmed that the themes fit with their experience. For example, one participant said, “Yes, I feel that the summary articulated my experience very well.” Another participant also directly confirmed how the theme summary was congruent with her experience: “Thanks for sharing this summary with me. I would say that the themes fit with my experience at Insite.” Most participants also indicated that there was nothing missing from the summary I presented them with: “Yes, the summary does fit my experience. It was an excellent summary and nothing jumped out at me as missing.”

Several participants noted that even if a particular part of the summary had spoken to something they had not described in the interview, that they could relate to it, or see how their colleagues could. For example, one participant said:

> It was interesting to read through the summary because there were statements that I feel I was unable to express that either you were able to pull out of my interview or the co-participants were able to articulate. I felt I was able to relate to most of the statements even if I don't think they were my responses in the interview.

Two participants suggested adding items that were not clearly explained in the theme summary, but were coded for. One participant commented on the lack of including humour as she thought that was an important part of her experience. Another participant described the importance of balancing the need to keep Insite low threshold with the need to keep staff safe. While I could not go into depth about every important aspect of the results in the theme summary, I made sure to explain these two items in greater depth in the results section below.

Credibility can also be ensured by taking measures to encourage the honesty of participants. I did this by clearly explaining the confidentiality of their data during consenting, and taking the time to build a strong rapport (Shenton, 2004). A thorough and informative consenting session was extremely important for this study because there was the possibility that emergent themes would make participants think that the findings were a bad reflection of them. I also encouraged participants to be honest, and reminded them that there are no right or wrong answers. Because the participants were generally familiar with qualitative research, they were aware that qualitative studies do not utilize a large number of participants. Thus, they knew others in their workplace may know about their participation in the study, and in some cases, they shared their participation with their colleagues.

Throughout the research process I engaged in critical discussion with my supervisors, my professors, and my peers. Frequent debriefing was an important part of ensuring credibility (Shenton, 2004), as it helped me to refine my procedures. This refinement was particularly true of my subsequent questions during interviews, as I learned how and what to ask in response to what participants shared. In addition to reflecting on the project with others, I made an effort to ensure I have written in a reflective way to fulfill the guidelines of hermeneutic phenomenology, and inform the reader of my own background and values.

### 3.2.2. Dependability

Dependability was ensured through the same procedures that created a high degree of credibility. I ensured the transparency of all steps taken during this process so as to help others to understand how results were reached. While the limitations of a qualitative approach do not lend the findings of this study to being replicable, others should be able to read the processes I underwent with enough clarity to replicate my procedures. In my reflective commentary below, I note the effectiveness of the approach and procedures I used.

### 3.2.3. Confirmability

In qualitative research, confirmability is the researcher's assurance that the findings of their study are directly linked with their data and not overly influenced by the researcher (Shenton, 2004). This is probably the most challenging and most important part of trustworthiness for a study using an interpretive phenomenological approach. Because I had to interpret the data to derive meaning, I relied heavily on the input and feedback of my supervisors and colleagues. I reviewed the organization of the data, my own reflective comments, and analytic memos with two different supervisors. I utilized this process at the steps of initial coding, clustering codes into themes, and writing a theme summary to take back to my participants. Including participant responses to themes (above) also helped to ensure participants had a chance to voice anything that I may have gotten wrong, or that I may have missed in my analysis.

### 3.2.4. Transferability

It is my hope that the findings of this study will be valuable for those who are concerned with the well-being of nurses who work in stressful environments such as SIFs. Further, my aim is that this study will provide information that speaks to the nature and meaning of my participants' experience. This will be helpful when designing interventions for nurses suffering vicarious trauma or burnout, and for those who create practitioner renewal programs.

In addition to contributing to the literature surrounding nurses' experience of workplace stress/vicarious trauma, this study will inform a larger audience about safe injection facilities. Despite the overwhelming amount of evidence that harm reduction approaches to drug use can be very effective in reducing harm both on an individual and community level, as well as increasing entry to treatment, many countries have failed to consider them as a viable option. Even within countries that have implemented SIFs, public opinion is generally not in favour of supporting these facilities or other harm reduction approaches to drug addiction (Blackwell & Alcoba, 2011; Caplehorn et al, 1996; Forman et al, 2001).I hope that this study will not only add to the growing amount of information about SIFs, but also speak to the role of nurses in these settings rather than focusing exclusively on their clients. During my time at the Dr. Peter Centre I have witnessed staff go beyond their medical training, as they often use themselves as instruments to build powerful relationships with challenging clients and help them using a genuine, non-judgmental human-to-human connection. I wanted to not only explore what that experience is like for participants, but also to honour it by sharing the results of this study with my participants and the greater community. I hope that disseminating this knowledge through journal publications, conference posters, and presentations as well as broader media sources will serve to inform people who may have formed opinions about SIFs without having a full understanding of what happens at these facilities.

Just as I have utilized phenomenological studies looking at nurses who work in high-stress environments, I am confident that others will be able to adapt my findings. While the experience I am investigating is very specific and unique, the themes that emergedaresimilar to those for other health care providers in different settings. To ensure the findings of this study are extrapolated in appropriate ways, I have provided a very detailed explanation of the context in which the descriptions of these experiences were collected and analyzed.

# Chapter 4. Results

As qualitative research requires the investigator to make sense of results through their own personal lens, it is important that I inform readers of my own biases, assumptions, and experiences. Readers should have a clear understanding of the lens through which I approached the analysis of this data so they may get a sense of how my lens impacted the final themes.

The biases, assumptions, and experiences I present below are based upon a review of the notes taken during and after each interview, the analytic memos I kept while conducting data analysis, and reflection upon my opinions and direct experiences relating to the phenomenon under study. Many of the things listed below are connected with parts of the themes that emerged from analysis. I am confident in the analysis process I used, and while I believe the evidence I present below will strongly support the themes that emerged, it is important for readers to learn of things that may have influenced the analysis.

One of my personal biases is that I strongly approve of harm reduction approaches to health care, and I held the assumption that my participants would share this view. The empirical evidence supporting the effectiveness of harm reduction services, and my own experiences seeing how it is an empowering and compassionate way to help people is what leads me to approve of these services. I also do not hold moral convictions that lead me to disapprove of the use of illicit drugs, and I view drug addiction as a heath concern, not a moral concern. Part of my interest in conducting this research is that I strongly approve of facilities like Insite, and I am interested in exploring the experiences of staff to understand what helps them to do their job well, and what challenges them most. This bias may have led me to look for experiences that support a harm reduction model and discount any views that do not corroborate this position.

As a counsellor, one of my biases in understanding experience is a tendency to search for emotional experience in the narratives of my participants. Many of the follow-up questions that I asked participants were to gain a vivid understanding of that particular example, and my tendency was to ask for the emotional aspect of their experiences because that is most vivid to me. This may have had an impact on how individual codes were selected and named. In order to remedy this, I tried to stay with the specific words participants used, and not place my own interpreted meanings upon them.

Many of my experiences as a counsellor are very similar to helpers who work in other fields like nursing. My experiences of relationships with clients, and what it feels like to have those relationships, was very similar to what I heard from participants with respect to the rewards of the connection, experiences with boundaries, and the potential for secondary traumatic stress, or vicarious traumatic stress. Because of this similarity I took extra precautions when I noticed myself identifying with my participants' words. In those few instances I wrote notes about what I thought and shared them with both supervisors. In some of those instances my supervisors gave a different perspective than what I saw and suggested that my own experience was taking me away from participant’s words. I revised my analysis to be in line with participants' words when that happened.

Through my experience at the Dr. Peter Centre I have seen the strong connections nurses have built with their clients, and the impact this had on them when a boundary is crossed, or something potentially dangerous happens. As a result, I have witnessed symptoms of different types of traumatic stress in nurses, and this peaked my interest in how nurses respond to these events. Because of this experience, I came to the research with the assumption that nurses at Insite likely have similar experiences. This experience led me to be especially curious about anything traumatic that participants might have experienced.

The experiences and biases I have presented may be viewed as a limitation to the research as it is likely that they have influenced my perspective. However, according to van Manen (1990), true objectivity is impossible in research, and all experience can

be understood as shared human experience. Elements of my own experience are very similar to that of my participants, and my unique view may enable me to understand the data in a way that people outside of helping professions may not be able to. While readers should be aware of my personal biases so they may understand how it may have impacted my analysis of the data, I am confident in the themes I have presented. Below, I present the themes with many text examples of participants' own words. In the trustworthiness section, I also present text of participants' reactions to these themes. Their positive response makes me confident the themes I have presented are an accurate account of what it is like to supervise the injection of illicit drugs at a supervised injection facility in Vancouver, British Columbia.

Codes were categorized into clusters based on what they revealed about the phenomenon, and themes were determined through reflecting on how those clusters made sense together. Combining my personal lens with participants' words and feedback, we were able co-create a description of the meaning of their experience. Four main themes were identified after analysis of participant responses about working in a supervised injection facility: (a) *creating social cohesion through the use of harm reduction;* (b) *opportunities for relationship-building during in-booth supervision;* (c) *balancing relationships and autonomy;* and (d) *working on the edge of trauma.*

## 4.1. Creating Social Cohesion Through the Use of Harm Reduction

Participants expressed a desire and intent to create social change that goes beyond reducing harm. They highlighted the importance of creating social change through inclusion and empowerment rather than through control, segregation, and marginalization. The theme identifies how participants experience their work as creating social cohesion through the use of harm reduction. Social cohesion describes a society that "works towards the well-being of all its members, fights exclusion and marginalization, creates a sense of belonging, promotes trust, and offers its members the opportunity of upward social mobility" (OECD Development Centre, 2012, p. 53). Participant responses were categorized into five major areas that contributed to the creation of social cohesion: (a) elements of social cohesion, (b) education as

empowerment, (c) the rewards of community, (d) the importance of harm reduction as a way of life that facilitates cohesion, and (e) cohesion among staff.

### 4.1.1. Elements of Social Cohesion

The desire for social cohesion was demonstrated through participants' descriptions of wanting to use their position as nurses to advocate for, and engage people who are marginalized. Through these descriptions they also expressed the hope that this way of being with people would have an impact on how people in the larger community interact with one another.

**Personal morals and values in supervising injection.** In reflecting on their descriptions of the broader social impact of their work, participants commented on their values as individuals, expressing a felt sense that their work was the right thing to do, and their responsibility to empower people. One participant spoke about her ability to access health information as a nurse, and that this evidence leads her to think this work is “the right thing to do, it’s right to have harm reduction available to communities.” This strong belief that harm reduction is the right thing to do is a personal value, rather than simply an opinion based on evidence. Participants went on to express strong convictions that people should be respected as worthy, and that they have a responsibility to ensure that everyone has that experience. For example, one participant said:

> I feel it deep down when I see somebody being discriminated against. And I don't like the way that is and I want to fight against that, and I want to show people they are worthy, they are human, and that they deserve to be treated with respect. That's just a value that I've got.

Another participant spoke to her horror when marginalized people are declined care or access to harm reduction materials because society does not approve of their behavior:

> I have seen documentary footage where there are no needle exchanges, where . . . people who are engaging with injection drug use or sex work who don’t have the means to be assessed by a medical staff member, to seek treatment for what’s happening for them, and . . . it horrifies me that communities can leave people to die on the street or prevent harm reduction activities from occurring.

She shared her strong conviction that all human lives are valuable, and that everyone has the right to be cared for.

Participants also spoke of having a professional responsibility to model good behavior and inclusiveness inside and outside of work. One participant explained, “There is a responsibility to live my life ethically as well, and fairly. And to sort of conduct myself in a manner that befits being a mentor, being a role model for somebody.” Using oneself as a tool to create inclusivity (i.e., being a role model), demonstrates a cohesive approach rather than an us-versus-them approach.

**Working with people who are marginalized.** Many participants expressed a desire to work with people who are marginalized in society, and see Insite as a place to do that. Working with marginalized people means nurses are connecting with people in society who are discriminated against, and not generally seen as worthy or deserving of respect. One participant expressed, “I like to go where people are not normally appreciated and I like to help those people.” Another participant explained how connecting with marginalized people, and giving them a positive experience with a health-care provider motivates her to do this work, she said:

> ... working with people that are just struggling all the time and just treating them amazing. I think that’s where I get my motivation, is just having these beautiful interactions with people, and treating people better than they get treated in any other setting.

The above quote demonstrates how participants got something enjoyable out of connecting with people who were marginalized. Intentionally connecting to “rebuild trust,” and give them a different experience demonstrates they are worthy of being acknowledged and included in the community. One nurse spoke to how creating a sense of inclusion by treating marginalized people as worthy and equal benefits the broader community, saying:

> I look at trying to work with the people that are within that group, they get the worst treatment and trying to raise that bar. And then that helps with treatment for everybody in the entire group.

This quote demonstrates how the goal of helping marginalized people is seen as a means working toward the well-being of everyone.

One participant described the importance for people who have experienced a great deal of trauma to feel like they are worthy and seen as individuals saying, “knowing that someone is there to engage with you, someone or a group of people are there to engage with you, with who *you* are.” She explained the importance of feeling connected and known to others as being necessary to reach out and receive help.

**We’re all in this together.** Several participants commented on how the separation of their clients from mainstream society makes it difficult to engage and help those people. Participants explained how their clients are often alienated from mainstream resources like hospitals and the police because they are judged and treated poorly there. Given this, participants described one of their main goals as, “reestablishing that connection between health care and them,” and went on to describe how this is done through building connections. Many participants commented on the nature of that connection as being “person to person,” rather than health care provider to patient. This approach towards somewhat egalitarian relationships came from participants seeing alikeness between themselves and their clients. One participant discussed some of the similarities between staff and clients, explaining that within a larger social context both staff and clients tended to come from the edges of society. She said:

> I mean, just knowing that the population of people who become street involved or who become drug involved are usually the people who have never really been in the centre anyway. So, they wouldn’t have been the quarterback, and they wouldn’t have been the valedictorian, they might have always been on the peripheral edges of social groups anyways, so I think that those people who have that lived experience kind of are attracted to that place, both the participants and our, like my colleagues.

The same participant continued to note similarities between staff and clients when she explained there are only a few factors that “separate one woman who grows up into having a position as a nurse, and then the other women grows up having a position as an intravenous drug user.” This participant described how realizing how small differences have led to very different life courses remind her, “that we’re all in it together,

that there isn't really an us-or-them kind of separation." This view of oneness rather than an us-versus-them belief demonstrates a shift toward social cohesion.

Participants explained how when they are able to connect with the marginalized people in the downtown eastside they learn about what is needed to help those people. Because this population generally does not have much power to influence larger social changes, nurses at Insite have the opportunity to lend some of their power to create change. For example, one participant said: "the community of participants are constantly telling us what they need, and so as individuals those people have voices, but together we have a larger voice." Coming together as a cohesive group and sharing knowledge and power to reach a common goal is social cohesion in action.

Participants spoke to how they can use their unique role as nurses, and the power that comes with it to fight inequality and marginalization. As one participant said: "I think in nursing, we have that opportunity to form those groups and to become advocates for community health and for advancement of public health through advocacy and through need, and through study."

**Recognizing inequality and fighting against it.** Many participants explained that a large part of what motivates them to do this work is to address the inequalities and injustices that they see happening within society. One participant explained how she identifies as a drug user, and there are a whole range of drug users, all of whom are treated very differently. She said:

> There's white kids who smoke marijuana, and have less trouble with the law versus people that are of colour who are injecting drugs or smoking crack, and how many of them are represented in our prison systems? So essentially everybody is kind of doing the same thing, they're just using a different drug.

She went on to explain how the difference in how drug users are treated in society based on ethnicity, socioeconomic status, and the drug they use demonstrates inequality in the system. She expressed that, "If everybody is not getting treated equally, then there's a misrepresentation, there's a problem with the system." She described her goal in doing this work as connecting with the people who are treated poorly within the current system, and trying to increase the quality of care and connection that they get.

She said, “That helps with treatment for everybody in the entire group,” because it removes judgment and stigma so that people are freer to seek help in using drugs more safely which keeps the broader community safer.

Another participant commented on how her motivation to do this work relates to not being part of the current system of inequality and judgment. She explained that “being part of a system that's recognized in a community that really needs access to care” is important for her in fighting the current system where people are judged and dismissed because they are seen as less worthy in society.

**Fighting inequality through cohesion.** While nurses expressed their desire to resist the traditional healthcare model where people are judged or dismissed, they also explained the importance of social cohesion as part of an alternative model. One participant described how she has learned “the health of communities does not improve with increasing isolation, it improves with increasing cohesion and collective energy.” She also spoke to the importance of cohesion in dealing with large social problems: “in terms of like how do we resolve larger social problems, I think it happens when groups are very cohesive and are working towards that aim.”

Several participants described what it is like to be part of a different system of healthcare working towards inclusivity and equality. One participant expressed it, “feels good that I'm able to make that difference.” Participants described the concrete differences they see between a cohesive and relational model of healthcare rather than the traditional model where marginalized people receive poorer treatment. One participant explained, “It’s just really great to represent nursing and healthcare and accessibility and harm reduction strategies, and just reach a lot of people who maybe are getting lost in the shuffle when they try to access healthcare normally.” Other concrete changes nurses shared included better care as a result of connections with marginalized individuals and a marginalized community as a whole.

### 4.1.2. Education as Empowerment.

Participants discussed the importance of education to empower people. This was described as helping clients to make informed decisions and to also feel a sense of

empowerment and control over their own lives. In this context, education served to increase safety, build trust, and potentially even impact a patient's social mobility.

**The experience of teaching and empowering people.** Participants described teaching clients as being rewarding and satisfying. They also explained they feel like they're making a difference even when they teach someone a small new practice that increases their safety. One participant explained her surprise and excitement about a client trusting her, and the knowledge that she possesses: "Wow, I can't believe that person actually trusted me. It's kind of a bit of an Aha moment. Like, I have the knowledge and when I share that knowledge, someone actually respects that and trusts that knowledge….it's cool." She realized the power of having more knowledge than her clients, but recognized how trust was also a necessary component to ensure that knowledge was received.

One participant explained how she enjoyed seeing evidence of client-learning, saying"...the satisfaction of knowing they're understanding how to use certain tools properly and to inject properly and independently. That's really nice and to see them come back and do it independently." Seeing clients come back with new knowledge confirms to nurses that clients are absorbing their teachings, increasing their commitment to the work.

Participants also commented on how teaching clients leads them to think about how they made a difference in those people's lives. One participant described how, "it feels good. It feels rewarding, it feels like…I'm making a difference however small that difference might be." She went on to explain when she first started she imagined the impact she would have on a broad scale, and was surprised to discover that helping someone make small changes to a very entrenched unsafe injection practice is also very satisfying. She also explained how clients express their excitement about learning something new from nurses, and that in turn, that leads her to feel excited about empowering someone. She said:

> They just go, "Wow, that worked!" And you're like "Yeah! Try and do that next time. You can do it on your own, if you have trouble ask for my help again." And they haven't asked for help since. And it's just, being able to have that kind of impact and provide that independence to people.

The excitement she shared is in response to bringing something valuable to her client's life.

One participant commented on the importance of teaching clients about Narcan (Naloxone). Narcan is a drug that has a strong affinity for opioid receptors, so that other opioids (e.g., heroin, fentanyl, oxycodone) that may be present in those receptors are pushed out (Howland, 2010). This means the use of Narcan will effectively and immediately stop the impact of the opioid taken, and revive the person in the case of an overdose. In British Columbia, a take-home naloxone program is being piloted, and nurses, including those at Insite, offer training to drug users, their family, and friends about how to use Narcan should they be in the presence of an overdose. This nurse explained how empowering clients to deal with overdoses when they are not at Insite offers her the opportunity to do a different type of work. She said:

> But the thing that gets me off the floor and away from doing as many supervised injections, but still doing really important work is teaching people about Narcan. I identify people by watching who's taking extra supplies, and I'll be like hey, where are you going with that. And are you using that somewhere else, and if you are do you have Narcan?

She went on to explain how many clients share their overdose stories with her, and it feels good to provide them with a tool to keep themselves and others safe when she knows that they will likely experience an overdose again at some point. She said:

> Like you let people tell you about the overdoses they've witnessed, and the overdoses that they've been involved with and the things that they know, and then you just add to it and you're like Yeah! You totally know this! You're already a pro! And like just kind of giving people that confidence, and giving them the support that they'll need when they actually have to use it in the situation.

Educating clients about Narcan empowers them to help themselves and others. Part of nurses' excitement about this harm reduction tool, is that it has the capacity to directly benefit the broader community by reducing overdoses. Fewer overdoses means there would be a decrease in calls to emergency services, and deaths caused with overdose.

### 4.1.3. Rewards of the Community

Participants discussed the differences between a traditional model of healthcare (i.e., working in a hospital) versus a community model of healthcare (i.e., working at Insite). They commented in particular on the problems the community model addresses within the traditional model as there is an opportunity to connect with clients, a prioritization of non-judgment, and a subsequent improvement in care. They also described how they felt lucky, special, and privileged to be a part of a unique community where it is difficult to earn patient trust. Participants also described how it was pleasant to feel safe, supported and respected as a result of building relationships within this community rather than being an outsider who was only there to provide physical care. Experienced by both themselves and their clients, participants described a reciprocal benefit from building a stronger sense of connection within a community.

**Community nursing versus hospital nursing.** The first major difference that participants commented on between these two models of healthcare is the presence or absence of an opportunity to connect with clients. A lack of opportunity to build strong relationships with clients in hospitals means both nurse and clients miss out on the benefits of having those connections, one nurse explained:

> Therapeutic relationships is actually listed as one of our top five roles as nurses. And that is so important to me. And I value that so much, and that's why I don't want to work in hospitals, because it's all tasks, and it's all, you know, you're going do this, this, and this, and if you have a bit of time, you can talk to them. But you're not going to get that same relationship out of it. And those relationships, I think are what help facilitate change in those people's lives.

Participants also commented on how the hospital model is very busy and task-oriented with no time to connect with the people they are helping. While working at Insite nurses are always very busy, but time to connect is built into their work as a task. One participant described what it is like to work in the hospital model saying:

> You feel like you're just kind of...like running after your tasks all the time. You're not making, you're not having as much of an opportunity to connect with people and get to know them, and get to know their real needs. You're just completing your tasks.

Being so task-oriented in hospital-settings means that nurses sacrifice the ability to build strong relationships with clients.

Participants also spoke to how building connections with clients motivates them to continue doing the work, and to do it well. For example, one participant described seeing clients over and over again, saying, “It's very positive, and it makes you want to stay. Because you get to know these people and you're committed to them.”

Participants reported they struggled with the judgmental attitude of many of the healthcare providers who operate within the hospital system. For example, one nurse explained:

> There’s some judgmental nurses out there especially around injection drug use . . . it’s really frustrating working in an environment where there is that judgment and nurses can be quite explicit about that too. And it’s just really challenging to be around I find – to have colleagues like that because I kind of lose respect for them... well, I do lose respect for them.

Another participant explained how she has also seen other nurses hold judgments about injection drug use, and she describes how these judgments go against her idea of what nursing is:

> I think that non-judgment is a huge part of nursing, and walking with people, and the harm reduction model. I’ve had a lot of negative experiences with colleagues, so I was really happy to find a place where there were like-minded individuals.

One participant spoke to how prejudice from health care providers is a large barrier for clients because they cannot be honest about their drug use. She explained that clients can be honest when they come to Insite because they are not worried about being judged. She said:

> When they come to us they know that it's totally confidential, and that's accepted. Like, it's alright. Like, we know that you do, that you use and that's totally fine. That's not going to affect how we care for you.

According to participants, taking a non-judgmental stance, and accepting client’s drug use enabled them to feel safe to connect with nurses at Insite and receive help.

**How it feels to be part of the community**. Several participants described Insite as being one of the most respected resources in the downtown eastside. They felt privileged to work there, and experienced the respect that comes with working there. Some participants also spoke about how lucky or special they felt to be accepted into a community where it is difficult to earn trust. For example, one participant said, “I think lucky is the best way to put it because it's a hard community to earn trust in.”Another participant commented on the difficulty of earning trust within the isolated drug-using community in the downtown eastside, and how earning this trust feels like a privilege. She explains saying:

> It’s not something that everybody gets to do, and I mean, the community isn't a very, like, they're, they aren't standoffish, but they're wary of newcomers into the community. And so to have finally kind of broken through those barriers and become a trusted part of that group, it is a privilege to be with them in that way.

Because it is so difficult to earn trust and be accepted into that community, participants found the moments of seeing a client’s vulnerability to be especially unique and powerful. One participant explained, “it's a very special thing to get to be a part of that community and a part of some of those moments with people” in response to connecting with a particular client.Several participants spoke to how “it feels really nice to be part of that community because they're very supportive and they know each other and they look out for each other. So I never really felt unsafe in that sense... it's really positive.”

Participants commented on feeling trusted in the community, and able to contribute to the community. For example, one participant stated:

> They just know that I'm an ally. That I'm somebody that they can trust, and it just feels really nice to be a part of that. And to contribute *positivity* to this community and to be one of the foundations that they can rely on. So if, even if they're not IV drug users, often we'll have people outside who maybe fell, or have minor wounds, or whatever, and they're like, go to Insite, go have the nurses look at you. And they'll come in and we'll be like, how'd you hear about us? And they'll say, oh, the bar next door told me to come check you guys out. And it's nice. It's nice to be trusted.

One participant reported feeling safe in the downtown eastside because she is an accepted part of the community there. She explained how her friends and family do not understand why she does this work, or how she could possibly feel safe. She said:

> I'll go on a walk on my break on night shift and they're like, "You're walking alone at night in the Downtown Eastside? Like what are you doing?" And they like freak out. But I'm like, "Well no, I feel safe here. Like, I'm part of this community, and people know me, and I know them, and it's okay." And I think it creates a different sense of safety. I don't think its false safety. It's, I mean, there's obviously going to be random acts of violence, but that's going to happen anywhere you are, no matter whether you're in Kitsilano, or downtown in my opinion.

Participants' report how they feel safe when they are a part of the community in the downtown eastside demonstrating the importance of knowing people in that community.

**Reciprocity-giving and getting support.** A participant explained how many people who are not a part of the community in the downtown eastside are afraid of engaging with the people there, and have trouble understanding why she is not. She said:

> Most people would say, "Hey aren't you afraid when you work there?" And it's like, no I'm not afraid, because these people are people, and they're *nice* people. And they appreciate what I'm doing for them, and I'm contributing something positive, I'm not stealing from them first of all. So no, I'm not afraid, I'm not wronging anybody.

Her comments demonstrate not only her caring for her clients, but also her acceptance of them as being worthy of belonging, and demonstrates a reciprocal relationship of care and respect. Another participant shared a story about how clients in the community were looking out for her well-being. She explained the reciprocal care that was present when she was nearly harmed. She said:

> I had a really funny incident happen where I almost got punched when I was standing out in the street, outside the street. Just wrong place, wrong time, I wasn't being targeted but I managed to dodge and there was a number of participants I knew out there, and they were fuming and rallied up and chased the guy away, like "That's not okay, you almost punched a nurse! What are you doing?" And then I was like, "I'm fine guys" and they were like, "No, it's *not* okay, you're part of our community, and it's *not* okay for someone to treat you that way and to almost harm you."

Another participant described the importance of reciprocity in the community during an incident where there was an offsite overdose. She explained how she left Insite in search of the person on the street, and that she has never had a problem finding a person because, “there’s often like people around you know giving direction, like “they’re over there!” So you really get a good sense of, ok there is community awareness around this person having an overdose.” In this example, the community is working together to help someone in trouble. Nobody is being excluded because they are seen as an ‘other.’

Several participants commented on the importance of living in a strong community both for their own well-being, and the well-being of their clients. They discussed how being in strong community means you can access different types of support from those around you. One participant also commented on the importance of connection with those that you seek help from, saying:

> The sort of idea of like taking a number and ticket and sitting down and waiting to talk to someone who you tell your driver license number to about your problem is like, not real engagement and it’s not healthy, it’s not healthy for people living in communities and it’s not healthy for individuals.

This participant commented on how it’s not healthy for individuals or communities to be disconnected from one another. She sees the value of connecting with her own community through this work, and wants to nurture those connections.

### 4.1.4. The Importance of Harm Reduction as a Way of Life that Facilitates Cohesion

Participants explained the importance of harm reduction in creating social cohesion, particularly the central tenet of prioritizing building and maintaining relationships over the achievement of a particular treatment. Participants commented on how harm reduction is foundational in their work and has become a way of life for both staff and patients. Harm reduction is described as not only a method to reduce harm, but also to create harmony by being non-judgmental and providing support while respecting others' autonomy.

One participant commented on seeing harm reduction creating, "positive changes in the community," and described her goal in working at Insite as being part of those changes. She said:

> I'm an East Van resident and so, a lot of you know, my neighbours from my personal living situation are on board with harm reduction because we see how it's decreased property crime in the neighbourhood and increased social order in our neighbourhood. It also gives us somewhere to tell people to go for help, like oh, you have these needs? I know where to send you!

She explained the direct benefits she has seen come to her community, including bringing her neighbours together to include and help the people in the community who need it most.

**Harm reduction facilitating compassion for clients and connection.** Participants explained how harm reduction provides them with tools to support clients without judgment. The main goal of their work is to support people to live healthier and safer lives rather than requiring they abstain from particular behaviours in order to be worthy of services. This low-threshold approach allows nurses to meet clients where they are at and reserve their personal judgments. One nurse explains how her personal judgments about someone's behaviour are not relevant when she is working to support them. She said:

> You're not judging them, you're being more accepting, and you're having understanding, and maybe you don't exactly agree with what they're doing with their lives, but you don't have to. I mean that's not really what it's about. It's about how to support people doing what they're doing, and having healthier lives.

One participant explained that using the harm reduction model to approach clients without judgment leads her to experience, "just living in harmony with what other people's lives are like." Respecting and supporting clients despite not agreeing with all of their actions or choices allows nurses to be content with only helping people with what they want.

Another participant spoke about how the harm reduction model guides her to support people in whatever stage they may be in, allowing her to continue to have compassion for people who do things she does not always agree with. She explained:

> I think one of the gifts that we have working in the harm reduction model is that we're, we get accustomed to what it's like to work with people who are highly traumatized or who are really street involved, and still care for them.

She explained how the harm reduction model creates a framework of non-judgment and compassion that requires staff to set their own judgements aside.

**How harm reduction supports client autonomy.** Participants reported how harm reduction as a model requires staff to respect the autonomy of clients even if client decisions are not what nurses may want for them. One participant described using the harm reduction approach, "to give them [clients] capacity to make their own decisions."Allowing clients to maintain their autonomy facilitates trust by treating clients as equals rather than as sick people who are not trusted to know what's best for them. By not infringing on client's independence, staff create an environment where clients have more power than they typically have over their own health. Nurses then work to incorporate education about safe practices to ensure that people have important information when they make their own decisions about their health, as one participant reported: "I like the idea of giving that person some control over their life. Like hey, you're going to make a decision, so let's make it as informed as you can and as safe as you can."

Participants spoke about setting aside their own plans for a client, even if those plans would ensure better health and safety for that client. One participant reported having to set aside her plans in order to respect client's right to make their own decisions and to decline advice or treatment. She said:

> You have your agenda, and you're like ok, I want to figure out what's really going on with this person. Sometimes it's really easy because they're really receptive to it. Sometimes they're just really not receptive and you just can't because they're just not in the right place like mentally, physically they're just not ready for that.

This participant described how she used the harm reduction model to guide her away from pushing a client to share information that she wanted to know, or do a treatment they did not want. Having relationships as a priority helped nurses to respect client's right to refuse care.

**Harm reduction as a way of life for staff and clients.** Several participants spoke about their involvement in the use of harm reduction as a practice for everyone, rather than just as a tool for dealing with problematic drug use. One participant explained that harm reduction is "a great way to work and live," and that it plays a large role in how she works with clients as well as how she lives her own life. She reported it, "helps you deal with everything from interpersonal working relationships to client relationships. The harm reduction model can just help you kind of deal with the day, and deal with life." She explained that the non-judgment inherent in the harm reduction model guides her to live her life with care and compassion, "if you can treat yourself with dignity and respect, you can do that for other people. So there's just this really great cycle for everybody."

One participant spoke to how she uses harm reduction as a model to support her clients, and those same principles come into her own life and provide her with a model of how to live and not be judgmental of herself. She said:

> It just helps building healthier ways of being, so you're not only doing that for others, but you can also do it for yourself, and your coworkers. So if you really embody the model, you can just develop yourself and your skills so that people and yourself and working on just being better people in the world.

She explained how she uses the harm reduction model to be a better person and to spread that way of being.

**Applying harm reduction to ethical dilemmas.** Several participants commented on how they use the harm reduction model to resolve ethical dilemmas, as it guides them to make difficult decisions. One participant shared a story in which she made a difficult decision that prioritized a client's safety over the rules of the site. She explained:

> Someone came in and they were drunk and they were kind of, it was clear that they –I think it was a Friday or Saturday night so like, it was like the party crowd. And they were kind of like, like they wanted to inject, hadn't injected before and just kind of wanted to do it recreationally and so I had that conversation with them. Like I didn't really want, I didn't feel comfortable signing them up because they definitely weren't entrenched. And at Insite the mandate is for entrenched drug users, yet at the same time they were intoxicated which increases their overdose risk, they had drugs on them already, and they were intent on using and I think it was like, almost just before we closed, like a minute before closing. And, so I made the call to let them use the site, and there wasn't a consensus on the team with that. But like as the nurse in charge I still have to make that call. So that was tough.

This participant said that despite having to defend her decision to other staff afterwards, that morally and professionally she was satisfied with the decision she made to choose the most ethical path. She reported liking the harm reduction model because it helps her to make difficult decisions like the one in this example.

### 4.1.5. Cohesion among Staff

Participants commented on cohesion among staff as being a vital part of their work. In respect to this, they discussed: (a) the importance of staff cohesion; (b) poor cohesion among staff; and (c) suggestions for improving staff cohesion.

**Importance of staff cohesion.** Participants commented on the importance of cohesion among staff for them to feel satisfied and safe at work.

***Cohesion through values.*** Participants explained how part of their satisfaction at work came from working with like-minded people. Participants said that they liked and respected most of their colleagues, and this was important in trusting them. For example, one participant said:

> So working at somewhere like Insite where I know my colleagues are like me, maybe it's our own values? Yeah, values as nurses, and values as people, non-judgment piece. Yeah it's great, I mean any job if you're working with people who are like-minded and we all have that shared vision and *want* to be there. *Everyone wants* to be there who works there because it's not just somewhere where you take a job to take a job. Like you have to want to work there because it's hard to get a job there.

Commenting on the how it is difficult to get a job at Insite demonstrates the expectation that colleagues want to be there and should embrace the principles of the site.

***The importance of cohesion for safety.*** Participants explained that staff unity is extremely important in order to keep both staff and clients safe. One nurse explained that all the different types of staff need to work well together, saying, “You just have to because it's a lot of crisis management, it's a bit of a chaotic place there at times, right, and safety's always a concern for everyone.” Another participant explained why cohesion among staff is important saying, “the safety of the place is so reliant on the ability of the staff to be professional and to perform as a unit and in concert with each other and to be on the same page and communicate.”

Another participant commented on how staff cannot do their work as well if they are working in isolation. She explained that part of creating safety in teamwork is being able to rely on your team members to help defuse a situation, or use their special knowledge to work most effectively with clients. She said:

> You’re not there all the time and you only have a certain number of resources yourself. Then, if you just talk to your team they have better resources that you might not ever have been aware of then just they might have better rapport with that someone or they might know something that you don’t know. It’s just a way better approach for sure.

Having special knowledge about a client can be an important part of maintaining safety as that special knowledge may relate to knowing if a client is likely to be violent, or to do something that may cause themselves harm.

**Poor cohesion among staff.** Participants described the various challenges they face when cohesion is poor among the staff.

***Division within the team.*** Several participants commented on how a lack of consensus among team members caused poor decision-making, which created dangerous situations. There was a divide between some participants who thought that that the team functioned very well together at Insite, and those who thought teamwork was poor. For example, one participant explained her satisfaction with teamwork at Insite, saying, “The strength of that site and the reason why it runs so well is that we

have a good team environment and it's just... no one does anything in isolation." Another participant said that a lack of staff unity was a, "huge problem," telling a story where a lack of consensus about whether or not a client who had a weapon, and had just admitted to committing a violent crime with it should be let into the injection room. The client was let into the injection room, and nobody communicated the circumstances to the nurse in the injection room. This participant said that the team was "totally dysfunctional," explaining that she's, "just so acutely aware of how badly we deal with those sorts of events and how dangerous it really is."

***Feeling unsafe.*** When there was a lack of consensus between team members or poor communication between them, participants reported feeling unsafe by the outcome. One participant shared a story in which several clients got in a fight. She said:

> And they threw some chairs, and one of them tried to punch one of the mirrors and the other staff, I was working with an all male staff, so it was me and all men. And they decided, they kind of had a chat, I was kind of new working there, and they went and had a chat and they decided. They didn't bar everybody, and I felt unsafe. I felt like ok, if people are throwing things that's it, you're out for the night. And they let them come back in later, and there were no further issues, they just were not allowed to be in the injection room at the same time, but the other staff had thought that they were at higher risk of using. I thought they could have been fine out for the night. They weren't using heroin, they were using stimulants, they probably would have been fine. It probably would have been good boundary setting for them too to know that they can't do that. I didn't get the chance to be part of that conversation.

This participant described being excluded from the decision about how to deal with violence in the injection room. She felt unsafe with the decision that was reached, and did not have the opportunity to voice her difficulty with this until after the shift.

***Angry with colleagues.*** Participants described having conflict with colleagues. One participant explained a frequent conflict about letting clients into the injection room who lie about being an entrenched injection drug user. She said:

> I guess literally, what goes through my mind is was M. [other staff member] crazy letting that person in here, and now I have to figure out how we're going to proceed from here, and what plan do we have for this person. You know, with ten or twelve thousand participants like that . . .

> that's not easy, you know and that instance might happen 2 times in a night.

This participant described how when things go wrong because of colleagues making decisions that she does not agree with that she sometimes blames her coworkers. She also said, "I get angry at my colleagues" in response to regular clients telling her that other nurses do not require them to be so independent when injecting. She knows that clients sometimes lie, and she said that she does not think that her colleagues are actually injecting people themselves, but that they are not doing something right if a regular client does not have basic injection skills.

**Suggestions to improve staff cohesion.** Participants expressed their needs in dealing with the problems associated with staff cohesion and offered one main suggestion to improve it: a formal debrief to discuss what happens at work. Even recognizing the challenges with having a formal debrief, participants expressed that it is extremely important. For example, one participant said:

> You're not able to really debrief and get it off your chest. And we'll have staff meetings and there's no opportunity for that. And if there were, I mean, that staff meeting would last forever. So nobody wants to bring that stuff up.

Participants explained that they try to get some of that debrief experience by talking to people who have been on shift the day before when they are coming on shift, or passing along info as they leave. They also discussed using the communication log as a way to convey information, but still found that avenue inadequate, as one participant said: "you're not able to really debrief and like get it off your chest" when there is not time set aside to do so.

## 4.2. Opportunities for Relationship-Building during In-booth Supervision

With regard to supervising client injections, participants spoke primarily about their experiences of in-booth supervision. They discussed five key aspects of the experience: (a) opinions on the practice of injection, (b) adjustment to supervising

injections, (c) desensitized emotion in supervision, (d) felt intimacy in supervision, and (e) supervision as secondary to building rapport.

### 4.2.1. Opinions on the Practice of Injection.

Participants primarily commented on their personal thoughts and emotions about in-booth supervision of injection. Most participants did not explicitly comment on how they saw supervised injection in comparison to how people who do not approve of such facilities might see it. Participants believed so strongly in the effectiveness of harm reduction as a tool to help people that seeing it as morally distressing, or abnormal, was shocking. For example, one participant said, “I don’t really have a moral feeling, you know, people shouldn’t be using drugs, therefore watching them do it is wrong.” Some participants described viewing supervised injection as a way for their clients to manage their own pain. They explained how they are helping people to safely use the coping tool they have chosen to use, while supporting them to choose safer coping tools if there comes a point when they are ready. In response to people who were shocked by the existence of SIFs, one participant described her perspective on this, saying:

> So many of the people there are there to treat symptoms. And so I don't look at it as, because a lot of people are like, "Oh my god, how do you, like, help someone to inject heroin" and like, I get a lot of that and it's kind of like, well, it's I'm providing medical care. I'm helping people manage symptoms.

The lack of moral objection, combined with an empirically-supported harm reduction approach, fostered an acceptance of supervised injection as a normal way of empowering people to use their chosen coping tool as safely as possible. One participant explained:

> As you teach them the proper way to do things, and you just kind of have an attitude of acceptance. Like this is normal here so it's all good, we're just going to show you how to do this right.

Participants expressed how their views of clients’ drug use also had an impact on their acceptance of the practice. One participant explained how, “A lot of people immediately perceive it as it's like the party, everyone's doing drugs, having a good time. You know,

no responsibilities, but it's really a survival thing." Participants' first-hand experience working with entrenched drug users has shown them that people are using drugs as medicine rather than for enjoyment. The same participant explained she views supervising injections as, "I'm helping this person. They have full body burns, and chronic pain. Their doctor stopped their meds. I'm helping them manage their pain." Participants noted some clients treated physical pain, while others used drugs primarily to treat emotional pain resulting from a severe history of abuse.

### 4.2.2. Adjustment to Supervising Injections

Many participants described how in-booth supervision felt scary or uncomfortable at first, but through experience they reported increased confidence and comfort in this aspect of their work. For example, one participant described this shift through her many experiences, saying "It's kind of sombre; it feels a little uncomfortable at first. Now it's totally normal for me."

Some of the discomfort that participants described related to the pressure of doing a good job, and not doing anything to cause the injection to fail. Participants described the pressure created when clients wanted their shot quickly, and when they knew clients had put a lot of effort into obtaining the drug that they have come in with. For example, one participant recalled what it felt like when she was first supervising injections, saying:

> It's a little, kind of scary with the fact that you don't want to mess it up because you know that people have spent a lot of their day and money and time and effort to get what they're injecting, like their drugs. So you just don't want them to like spill it, or you don't want them to miss their shot, so there's that pressure when you initially start working there.

Participants described the adjustment that takes place when they begin to feel comfortable supervising injections. After that adjustment period they describe being so comfortable and confident that the actions almost become automatic with some clients. For example, one participant said:

> There's some people who are clients where we don't even really talk about what we're doing, it's like second nature, we've done it so many

> times together that we're just talking about life and as we're doing it, we're going through the actions and I'm helping them inject. And it happens, and it's almost just kind of glazed over.

When injection becomes routine, participants described conversations about non-drug-related aspects of clients' lives filling the space of instructions.

### 4.2.3. Desensitized Emotion in Supervising Injection

Some participants reported feeling desensitized or dissociated while supervising illicit drug injection. They described ignoring what clients were injecting, apart from how it may impact their well-being in that moment. They reported being more concerned with the safety of the person, and doing their job effectively. For example, one participant said:

> I think also being really desensitized to it at this point. Like, what you're looking for, like you're not watching and thinking, oh they're injecting illicit drugs. What you're looking for is there a soft tissue reaction around the injection site, or how is that person tolerating that much of it. Like you're really sort of thinking more of your assessment, like oh what is their technique like, was it safe, are they using sterile procedure, like their hands are really dirty, did they touch anything like that's going to be involved in the injection material?

Participants' focus on a client's well-being while they are injecting, rather than thinking about them injecting illicit drugs, demonstrates a non-judgmental approach as their personal judgments are not entering the situation. This experience contributes to the destigmatization of drug use, as participants described operating from a place of caring rather than moral judgments.

### 4.2.4. Felt Intimacy in Supervising Injection.

Several participants described the emotional experience of supervising injection as being intimate because they were both physically and emotionally close with clients. Participants' explained how clients' willingness to be vulnerable with them, and their mutual trust made the experience feel intimate. One participant explained both types of closeness when sitting with clients and helping them find a vein, saying:

> It's really intimate. Like the most intimate experience I think I've had with people. As a nurse you're in so many intimate situations, like people telling you things of all kinds, or just letting you be with their bodies in ways that most people can't be. When people are injecting, they're trying to get well. They're in that state of needing to get well, and it can happen many times a day where they need to do that. And they're asking for help because they need help, and so you're in this really tight intimate space with them, and you're helping them find a way to make themselves feel better. So I'm just, I'm very very conscious of that –how close you are physically to people, and you're just like feeling their body. I call it kind of just like brail, brail on their arms. I'll be like ok, I'm just going to feel their arms, and we're going to do this thing, and people just let me touch them, I'm just allowed to touch them.

This participant described how clients are very vulnerable during injections and a great deal of trust is present in allowing another person to be present with that vulnerability.

### 4.2.5. Supervising Injection as Secondary to Building Rapport.

Participants described the supervision of injection as being secondary to building rapport with patients. For example, one participant expressed her view of supervising injections, "I kind of almost think of that as secondary to what we actually do in a way. Yeah, we're there to watch an injection, but that's not really why we're there." When asked the general question about what it is like to supervise injection, participants spent much more time commenting on their relationships with clients rather than on the act of supervising, or the rare instances of danger. They spoke about how sitting in a booth with someone was "a chance to engage, it's a chance to check in with someone," and building this connection was one of the primary goals of supervising injections. One participant explained how she views supervising injections "as a lot more than just putting the drugs in; it's that facilitating connection."

Participants explained how building this connection made their job easier because they were able to care for the whole person, and not just their issues with addiction. One participant described a story about how her connection with a client in a booth helped her to learn about the client's non-addiction related issues and the kind of help that was needed. She noticed the client sleeping in the booth, and sat with the client to keep the client awake to finish the injection. After the client was more alert she was able to learn more about the client, saying:

> "What's going on here, you've been sleeping in your booth for so long and we're really worried about you and you look really rough." Like they looked –and that's the thing if you've seen someone for a long time you know when they're in bad shape, so I said like, you look pretty rough right now. So they told me that they were homeless and they basically hadn't slept for several days, and their eyes were super bloodshot, so I said ok, you know what I'm just going to get you a shelter bed, so I did that. I called some shelters and like they were still kind of like very fatigued, and not in any condition to go to the shelter by themselves, so I asked one of the staff to escort them there to make sure that they actually got to one of the shelters. Because there was such a huge risk that they could just fall asleep on the street. And then that worked out well and they did, and like the next time I saw them, definitely like a big turnaround, not so bloodshot, more alert, very thankful. So that to me was like a meaningful experience because it wasn't about the injection so much.

Supervising injection served as an opportunity to connect with this client and help the client with problems not related to their injection practices.

## 4.3. Balancing Relationships and Autonomy: Relationship Building in SIFs

This theme encompasses the constant attempt to balance two key tenets of harm reduction: the need to build helping relationships to facilitate client care, and the need for clients to maintain their autonomy. While balancing these two needs for clients, participants described how they were also simultaneously balancing these two needs for themselves. In the section below, categories in this theme consist of: (a) the importance of relationships: nurses and clients; (b) the importance of respecting client autonomy and setting boundaries.

### 4.3.1. The Importance of Relationships: Nurses and Clients

Participants discussed at length the importance of relationships as beneficial to both staff and clients, and described aspects of their relationships that helped them feel connected and helped to improve care: (a) the experience of being trusted; (b) the experience of being appreciated; (c) being respected as nurses; (d) increased commitment through interactions with clients; (e) seeing clients as deserving of care; and (f) trust as a facilitator of client responsibility.

**The experience of being trusted.** Participants described a variety of positive experiences as a result of being trusted by clients. They explained how trust feels exciting both for themselves and for their clients. For example, one client said:

> The best part is having someone walk in, look up and be like, "Oh, D., you're here today! Oh that's fantastic, I haven't seen you in a few days." And just them being excited to see you, you being excited to see them, and just that connection with people.

Participants also described how one of the best parts of relationships with clients is when this trust and familiarity leads them to specifically seek out a particular nurse. As one participant said, “the best part is when someone knows your name and asks to see you.” Participants also described how this familiarity not only felt good for both parties, but also facilitated sharing of extra information that allowed nurses to be more effective in their work, and ensure clients got the help they needed. One nurse described an example of a client who she had come to know over time that came in for wound care, and felt enough trust and safety with her to disclose feeling suicidal. The participant explained how having that previous relationship with him brought him to her, “He came to see me because he knows me! Because of being upstairs and I’ve seen him at other places.”

Participants also explained how it feels good to support clients who are very isolated, and who may not have other connections or supports. One participant illustrated this experience: “They come to us and they trust us, and it just feels nice that you're able to be there for somebody who maybe has nothing.” One participant spoke to her belief that staff at Insite provide a special connection for clients: “You know them on a professional and therapeutic level, but at the same time I think they probably see us as friends and allies because they have nobody else in the community sometimes.”

Some participants spoke of their intent to offer even small comments to make clients feel good and further facilitate trust-building. For example, one participant said:

> Just trying to find something you can connect with people, to just make that moment a little bit better right. The people that are coming in there are in a hard space. A lot of the women are likely doing sex work in the moment, like either before or after I see them. So I think there’s a lot of struggle, like they’re putting themselves out there in a lot of really

> vulnerable ways, and so if I can have a positive interaction or just something lovely like I like to be in a space where I can be giving that way. Like, “hey that eye shadow just looks knockout on you,” or “you’re just looking really great tonight.” And just to be able to share something that makes people feel good. Like one time I had this look from this woman across the room, and she was just kind of like staring at me with this really weird kind of look and I was like oh no, what is this about? And she just came toward me with his crazy stare, and she was just like, do you want to see pictures of my cat? And I was like I’d *love* to see pictures of your cat! And she opened up her phone and started showing me all her cat pictures, and all of the things that her cat did for her. So you can just like share somebody’s sweetness, that’s a good time.

Some participants also commented on how the building of relationships with clients has added significance to their work. They reported feeling valued when clients would intentionally choose a nurse that they have a relationship with. One participant said, “They come to *you*, like they seek you out for emotional support, that makes you feel really, like valued and gives a lot of meaning to your work.” Being sought out by clients was seen as a confirmation that participants are effective in their work. One participant described how having good rapport with clients helped to fulfill her idea of what a nurse should be, she said:

> It makes me feel like I’m a good nurse... this is what I feel like nursing *should* be. We’re not just addressing someone’s wound, we’re addressing the person, so we can think bigger picture and get to really know someone’s story and be like ok, I know this person to a certain degree. When I say things to them, or when I give them advice, it’s not like from a text book, it’s from my knowledge about what I know about *you*, and it’s more genuine and sincere. And I think that’s what your clients will appreciate; it’s not just some stranger giving me a buzz, it’s this person that I know that has been seeing me for so long, and I have rapport with is telling me this, like I’m going to actually take it seriously. That’s the value in it, that’s the value I get, I feel like I’m actually being a good nurse, like a true nurse.

For this participant being a good nurse involved seeing her clients holistically and providing treatment that was tailored to what she knows about them as people. This included having an understanding of parts of their life that were not directly related to their physical health, and using the trust she has with a client to facilitate treatment adherence.

**The experience of being appreciated.** Participants described the various ways clients display their appreciation for staff at Insite: “there’s a lot of regulars that come in and they want to give us gifts, or they bring us little chocolates or something, or they tell us about someone’s day, or a lot of joking will go on sometimes.” Participants listed a variety of appreciative actions and comments, and spoke about when those comments are most impactful. They explained feeling good when clients recognize how their own negative behaviour impacts staff, and express appreciation for staff being there. One participant described how that experience helps her to continue doing the work, saying:

> When you have the person walk up to you at the desk and just say, ‘You know what, you guys take a lot of *shit*. Thank you, thank you for being here, thank you for treating us well." It's kind of amazing that the people who come to our project take the time to be like, "last time I was here I may have sworn at you and gotten angry, but I do appreciate that you're here and you are good people and you're doing good things.” It's amazing. Yeah, it feels good.

In addition to the appreciation that clients communicate to staff, participants also reported finding satisfaction in the positive changes they see within clients. One nurse explained her experience of seeing a change, and noted that she gets satisfaction from helping people in dire need. She said:

> It's the satisfaction you get out of knowing you are *really* helping people that *really* need your help. And sometimes they show you how much they appreciate it, and you see a difference. So that's what I love about it, it's *really* necessary help. And it's a marginalized population... I like to go where people are not normally appreciated and I like to help those people.

Being able to work with people who are in dire need, and have very little support brings satisfaction to this participant’s work.

Participants also expressed how having a relationship with a client felt valuable in itself. One participant said, “To have that mutual caring relationship with someone feels very valuable. I mean, it's why I'm there, I want to have relationships with these people.”This describes how the value she felt in connecting with clients motivated her to do the work.

**Being respected as nurses.** Participants reported feeling surprised, honoured and privileged to be given nearly automatic respect because of their title as nurse. One nurse expressed her surprise that people were so open with her just because she was a nurse, “people just let me touch them, I’m just allowed to touch them, and I’m allowed to explore the space.” She explained the authority and trust inherent to being called a nurse, and reported this was the case even when she was a new nurse and not yet confident in her training.

The automatic authority tied to the title of nurse was described as powerful by another participant. She explained, “It’s really powerful, just being called a nurse. Like, it changes how someone looks at you and how they trust you.” The power that comes with the title is an important factor in maintaining the balance between building trust and maintaining client’s autonomy because it shifts the relationship in one direction. As one participant noted: “It’s quite a powerful situation in terms of they will, some people will blindly kind of just trust you and expose themselves to you because I’m part of that profession.” Some participants commented on the importance of being aware and respecting the amount of power they had in these situations.

Participants described feeling privileged and honoured to be given respect as a nurse, and to be in the presence of someone’s vulnerability. One participant said, “I felt really honored that he trusted me enough to kind of share that story, and to be vulnerable with me.” The same participant described her surprise that a client would blindly trust her and be extremely vulnerable with her even when they did not have a relationship. She said:

> This big tattooed-up, you could tell he was like some kind of enforcer, intimidating, guy. Bringing him into the treatment room, sitting down, and just as soon as we sit down, the door is closed he just bursts into tears, and is so vulnerable in front of me. And I had to check myself because I wasn’t expecting it, and you know, that person who always puts up that front and feeling safe enough in that space to pour your heart out to me and talk to me about you know, the issues they’re having with child custody and their family issues and their partner trying to take their kids away and move. And being able to tell me this and be emotional and vulnerable with me, and in this instance I didn’t have a relationship established with this person at this point, they just trusted me in blind faith.

Again, the amount of vulnerability the client showed and the participant's response to it is an example of an important factor in maintaining the balance between building connection and maintaining autonomy. Here, the participant was able to recognize the power she had in that moment and allow the client to be his own person.

One participant described what it means to have the privilege of being blindly trusted. She explained that it is helpful for facilitating a connection, but also how it is important to be mindful of the power that comes with it, saying:

> It's quite grounding; I see it as a privileged place to be in because if you're opening up to someone, I don't want to be in a position where I put any shame towards that. I want to encourage that –that human connection because they probably don't get it in a lot of places. So you know, it's a complete privilege that I try to be mindful of.

Viewing this power as a privilege helped this participant to be cautious with their differences in terms of power and not use it to dominate the client and harm their relationship.

**Increased commitment through interactions with clients.** Participants spoke to the appreciative comments they received from participants, describing them as validating the work they do, feeling good, and ultimately increasing their commitment to continue doing the work. For example, one participant said:

> When someone, looks at me and is happy to see me and says like "Oh, I'm so glad you're in tonight." I think it just makes me feel valued and that kind of reinforces that I'm working in the right place and that the work I'm doing is the right choice for me.

Participants also described how the reward they received from seeing the positive impact they had on clients increased their commitment to the work. While participants commented on appreciating the general changes they saw in clients over time, the most vivid pieces of experience came from when participants described a particular person that they were aware of having directly benefitted. One of a nurse's main intentions in a safe injection facility is to watch for overdose symptoms and intervene should an overdose happen. All participants had experienced a client overdosing, and this was a

powerful piece of their experience where they had a direct impact on a client's well-being. One nurse described her experience of reviving a client, saying:

> There was a guy who had a really bad overdose. And after he came to, he started sobbing and I could tell, it was a real moment for him. He was really traumatized by it, and for every future visit that he had after that, he would come up to me and he would express his gratitude for that time that I saved his life. And he would always ask me to recount it to him, like, "how long was I out for?" Like, he was kind of almost obsessed with it. Like he knew that that was a moment that maybe meant something to him. And he's actually sober now which is really great. It's been, knock on wood, over, over a year and a half. Maybe two years. And I haven't seen him since. And even since then he's sent a letter to Insite thanking me for that moment, and he's passed on thank yous through our management. Just saying like hey, can you just let Nurse S. know that thanks for that time, and say hi to her and I'm doing great. So that's really nice, it just makes me appreciate that that one moment that I had with him really impacted his life.

This experience and the appreciation that followed seemed to have a large impact on both the nurse and client.

Some participants reported that they were proud of their work. They described a strong sense of purpose in providing any sort of help to clients who are in great need of support. One participant described her satisfaction from helping people at work, saying:

> It just makes me proud; I always told my husband that when I come home from my job, I never feel like I didn't do anything that benefited somebody. Like I never feel useless, or that I didn't do something positive for somebody that day because I always do. No matter if it's just like handing out supplies or showing somebody how to tie off their tourniquet, I feel like I benefited their life somehow. I'm very proud of this job, it's so necessary, and it's so bare bones in helping these people out that it's just so great.

Even providing small gestures of support to clients was seen as impactful and contributed to this participant's sense of purpose in doing the work.

**Seeing clients as deserving of care.** Participants described several things that were involved with seeing clients as deserving of care. The heart of this perspective was seeing clients as people, rather than viewing them as the next patient to serve in a line of people without faces. Included in this perspective were the moments of humour that

participants described. All participants in this study were female, and one participant described the importance of a kinship among women that helped her to connect with clients. This right to care speaks to the respect of human dignity, and the intent to preserve that dignity for people who may not receive that respect elsewhere.

***Seeing clients as people rather than just clients.*** Participants spoke to their compassion for clients and their ability to see them as vulnerable rather than as bad people doing bad things. Seeing the vulnerability that is inherent in living within a culture of addiction and poverty helped participants to see their clients as human. One participant explained, “[staff] are really down to earth and quite open. And recognizing that sense of vulnerability that comes along with drug use and just being in that. I think the staff there see people as people.”Seeing clients as people also helped staff to respect their clients’ choices, and not force their own agenda upon them.

Participants also commented on how it was pleasant to see clients outside of the context of Insite where they are seen as an entrenched injection drug user. Participants described contemplating how clients are with their families, and what they achieve in their lives. Using that connection to enjoy successes in clients' lives also helped to see them as deserving of care. One participant said:

> When I think about certain participants who I do know more about, and I have a connection with... there's one girl I know who is now sober and she's been doing really well. It's nice, because I think back and it's like, "Oh, I haven't seen her in a long time" but that's great because I know that she's in a good place. And I know her mom must be really happy, and she must be really proud that she's going back to school. It's just nice that I know her as more than just an IV drug user, or a sex trade worker. That she's a person, and she has a life outside of that.

Participants reported that having the perspective that a client is more than a drug user shifted the balance of power between them to be more equal rather than care-provider to care-receiver. This shift from the normal role of nurse and patient, to a more equal relationship of person and person, helped nurses to connect with their clients and see them as deserving of care. One participant illustrated this shift, saying:

> When you know someone as a person, they become more than just a client. Like I know this person as a person to person, human to human

> interaction like it's not just nurse-client anymore. You still have all those professional boundaries, but it's like kind of reaching another level of like care I guess.

This new level of care that creates greater equality between nurse and client is a move towards social cohesion as power is distributed more equally.

***Humour.*** The participants who spoke about the importance of humour, commented on its role in creating a sense of ease that helped them to do their job. One participant spoke about this ease, and the similar dark sense of humour that may help staff and clients connect. She said:

> I think for me, what kind of gets me by there day to day, given all the stressors that we have, is the humour. I think, like there's a few that have a bit of a dark sense of humour, and I think a lot of street people kind of have a bit of the same humour. So what I kind of smile about or laugh about is the humorous interactions that occur there, which are numerous! Like surprisingly numerous!

Several of the participants said humour was the best part of their relationships with clients. One participant related how the presence of humour made the environment more inviting, saying:

> There's a lot of laughing and there's a lot of like... people are funny! There's some really funny characters that come in and they try to make us laugh –laughs. There's a lot of humour and I think it's not, I mean there's music playing, like it's a pretty inviting environment even though it looks quite clinical.

One participant spoke to the importance of humour as a tool that clients may use to connect, saying:

> People are really good joke tellers! And I think that's a survival skill actually because people can joke themselves out of a situation. And so, definitely when I think about what are the best interactions that I have with people it's something based in humour, right. Humorous situations, and yeah, that would be a surprising answer for some, for people who are really knowledgeable, but I think it makes a lot of sense.

I observed that the way participants described humorous situations was similar to how many people may describe a funny friend. They laughed and clearly enjoyed recounting times they shared laughter with clients.

***Kinship with women.*** One participant described her experience of connecting with female clients:

> I think one thing that really kind of strikes me about when I engage with women who work in the sex trade, or who have sort of lived in a highly sexualized atmosphere their whole lives is when they say to me, and in particular –one woman has said to me, after this is all done, I wish we could be friends. So, to me that seems like myself and the other nurses of Insite are kind of a lifeline to what is a normal life, or to what *could be* after, you know after. So the *after* is kind of the plan for living without addiction and without sex work and without violence and without chaos and without homelessness.

Noticing the similarities between herself and female clients seems to have played a part in her being able to see clients as people rather than individuals who are drastically different and should be treated differently. This participant went on to explain how many of the female clients at Insite have held a job in health care at some point, and she thinks that female nurses may represent the kind of life that clients may have had one day if they had taken a different path. This identification of nurses as a model of normalcy facilitates a connection between female staff and female clients.

**Trust as a facilitator of client responsibility to treatment.** Participants described how having good rapport with clients helped them to provide effective treatment because: (a) they were able to learn more about the person as a whole versus their addiction; (b) clients were more likely to follow medical advice; (c) they were able to get necessary information and trust its honesty; (d) clients were more likely to return in the future; (e) it was easier to deal with difficult clients. They also reported being able to approach clients in exploring new aspects of their care that tend to be more uncomfortable discussing.

***Seeing the whole person.*** Participants described how both staff and clients benefitted from having strong relationships because it encouraged disclosure about multiple aspects of client's lives. One participant described clients coming to her and

saying, "Ok, I need to catch you up on everything that's been happening in my life because it's important for you to know this to help me out."

Participants described how the act of supervising injections provided an opportunity to connect with clients so they were able to learn about more than just their challenges around addiction. One participant described being in a booth with a distracted client, and engaging her to find out what was wrong. The client shared that she just found out that she was pregnant, and the participant reflected upon how if she hadn't gone into the booth to help this client that she would have left without getting further support. She said:

> So we finished her injection and led in to like an hour long kind of counselling session with her talking about how she's feeling about it. That, I think is something that stands out in my mind because it isn't always about just helping people inject. It's about the act of helping people inject opens the door to so many things and so that stands out in my mind because it really kind of led the way into me kind of growing that relationship with that participant and really being able to support that person and help them work through some of that stuff. And help them talk out what all those emotions they were feeling when they find out they were pregnant.

This participant used the opportunity of being in the booth to connect with this client. She also respected her client's choice to finish her injection as this created a sense of safety and acceptance for the client, making their relationship stronger and increasing the likelihood that this client would reach out to this nurse for help.

***Following medical advice.*** Participants spoke to how having strong rapport with clients made clients more likely to listen to staff and follow medical advice. One participant said, "There's a few participants who I've definitely made connections with, and I know that if I approach them and I'm really concerned about them, they'll listen to what I have to say and take that advice." Another nurse described how clients typically do not like to go to the hospital because they are treated poorly there, and how it can be difficult to convince people to go when they need support, beyond what can be done at Insite. She described a situation where she was able to convince a client to be accompanied to the hospital, and emphasized how that was only possible because of the pre-existing relationship she had with that client.

***Clients more likely to be honest.*** Relationship building also had an impact on clients' honesty. One participant reported knowing each other well “really adds to our nurse-client relationship because they’re like ok, I know this nurse and I trust her, and I’m not going to bullshit her, I’m just going to be more honest and like open.” Participants explained that this honesty and openness made it much easier to care for clients because they had all the information needed to create the most sound care plan.

***Clients return in the future.***Participants also commented on how building rapport improved the chances of clients returning for care in the future. They described how making an initial connection made it more likely that clients would come to them with questions later on, trust the information they were given, and also approach staff with uncomfortable topics. One nurse noted that if she did not make connections with clients then, “nobody's going to come to you and ask you for STI [sexually transmitted infections] testing, it's really hard to do that with a stranger.” She explained that this may be especially difficult for clients who do sex work, or who are pregnant.

***Easier to deal with difficult clients.*** Participants explained how having relationships with clients helped them to deal with those clients when they were being aggressive or breaking the rules of the site. One participant described how the existence of that relationship was beneficial to a difficult situation saying:

> It’s helpful because someone, if that person is being very like aggressive or having a bad day, maybe says something that rubs me or someone else the wrong way, its’ easier for me to be like, I know this person, I know they’re not always like that, I know they are having a *bad* day, I’m not going to resent them for it.

Having a prior relationship helped nurses to have more compassion for a client when they demonstrate unacceptable behaviour.

### 4.3.2. The Importance of Respecting Client Autonomy and Setting Boundaries

Three main categories came up when participants discussed the aspects of their experience involved with respecting autonomy while also connecting with clients: (a)

mutual respect between nurses and clients, (b) challenges of trust and familiarity, and (c) challenges of setting boundaries.

**Mutual respect between nurses and clients.** Participants described a mutual respect where trust was expected to go both ways. This demonstrates how both nurses and clients at Insite attempt to maintain a balance between connection and respecting autonomy. One nurse described how trust is reciprocal; clients trusting nurses allows them to make their own decisions, and reciprocally, nurses then trust clients to follow the rules of the site. One participant explains:

> ...giving them capacity, like respecting their choices. People show respect, like I said, there's no security really, you know there's people that come in with weapons and we don't know, or sometimes they do come in with weapons and it's really based on trust, so we trust participants.

Another participant spoke to the importance of both clients and staff being honest and open with one another as an important part of maintaining a balance between autonomy and closeness. She explained:

> And a real transparency I think too, people can read it, people read your face. People on the street are better at reading people than people in the suburbs are. They can tell when you're bullshitting them, so there's none of that. But you also need to not get taken advantage of, and I think newer staff sometimes don't, you have to be able to read folks right back as well. So yeah, there's a mutual respect or dance that happens.

This mutual respect involves a careful balance of trust and caution.

**Challenges in having trust and familiarity.** Participants reported several challenges in having trust and familiarity with clients: (a) getting too invested; (b) creating dependence; (c) personal judgments and values; (d) respecting clients when they don't want help; and (e) when regular clients disappear. I outline these challenges below.

***Getting too invested.*** One participant described the worst part of having a strong relationship with a client being when she becomes overly invested in that person and their well-being. She described a situation where a client was in an abusive relationship and she would often see this client come in with new bruises and contusions. She expressed that it was "hard not get too overly invested and to feel upset

when that person goes back to the abusive partner." She described the client expressing a desire to leave the relationship and asking for help; however, after staff pooled their resources and helped her make a plan to leave town, the client returned to her abusive partner. She described her response, saying:

> We all get so invested and then, yes, and then it completely falls through, she goes back to him and you kind of go "Oh," and for five minutes it just crushes you and you have to go, 'No, you can't put it all on yourself to help these people. 'Yes, she reached out to us, but we can't, you pour all your resources at people, but at a certain point they have to reach out and grab your hand. They have to do, you can't do everything for them.

This participant recognized that there is a limit to how much she can help this client because a client must have some choice and responsibility in the situation.

***Creating dependency.*** Participants described the challenges in maintaining the delicate balance in helping patients without creating a dependency. One participant explained, "you want people to trust you and you want people to seek you for help and care, but it's a balance in terms of you don't want them to like, solely rely on you, or the site."Participants explained their concerns that having strong relationships with patients sometimes acted as a barrier for patients to move on to seek further treatment because they did not want to lose their current connections to staff. One participant described a client she worked with who was pregnant and wanted to seek treatment for her drug use so she could be a better mother. The participant explained how relationships with staff may play a role in her continued drug use. She said, "She's expressed to us that her biggest barrier to doing it is because she feels like we're her family, and if she doesn't - if she stops injection drug use that she'll lose us." Experiences like this one have led this participant to question the relationships she has formed with clients and consider the balance of building a strong relationship while maintaining autonomy. She explained the difficulty in realizing not all relationships are always beneficial saying, "it's made me kind of reassess some of my relationships with some of the clients. To think about, is this relationship beneficial for the client? Am I doing enough, but not too much?" The questions this participant asked herself are important in examining a healthy balance between building close connections and preserving client autonomy.

Several participants commented on how sometimes a client becomes dependent on a particular staff member because that staff member has created a very strong relationship with the person. One participant described how this dependency does not necessarily always tilt the balance between closeness and autonomy, but it can be difficult for staff. She said:

> The downside of that might be that they trust you so much that they only want *you* to help them. And so they won't go to the other person, the other staff that are on shift with you, because they always want the person that they trust to help them. And it kind of turns on you, it's not a bad thing, but it's also exhausting.

While strong relationships with clients are an important goal for nurses, this demonstrates how these relationships can cause problems for nurses.

Some participants explained that some clients might not actually need the help, but they want a person there for support. Clients may not learn to inject independently when relying this heavily on nurses, as one nurse explained, “We give so much help, too, that I sort of feel like people stop helping themselves. So there’s also that balance between, helping-helping, but helping in an unhealthy way that’s just being like enabling-helping.” The main reason for avoiding client dependence on nurses during injection practices is that it kept clients safer. Participants expressed the importance of education to provide clients with the capability to help themselves so they do not have to rely on others. One participant explained:

> That's our job, is to empower somebody, to teach them how to use things, how to use the harm reduction supplies and to inject *independently*. Because then if you decide to inject off-site, you have that confidence and that knowledge to take care of yourself, and not have somebody have power over you... it's really important for you to learn to do this by yourself, because then nobody will control you outside and do shots for you and stuff like that. And to prep your own drugs and do all those steps *all* by yourself. Like we'll teach you for the first few times but it's important for you to try...

While it is sometimes difficult to facilitate client independence with injection practices nurses work hard to achieve this because it keeps clients safer.

***Personal judgments and values.*** Several participants recalled times when they found their personal judgments coming up when working with clients, which could be a threat to client autonomy if staff were to act on them. Participants explained some of the specific judgments they had about participants, and explained how they use harm reduction principles to calm their inner turmoil and not act on those judgments. The harm reduction principle frequently mentioned by participants was the prioritization of building relationships to ensure clients have a positive experience and return to Insite when they need support. One participant described how she struggles to withhold her judgments about young women who she views as being full of potential yet entering the downtown eastside lifestyle because it is exciting and new. She explained:

> It's just hard to reserve judgement because having worked for many years and knowing what I know, you're just like... Ooh, don't do it! Like ahhhh! But in reality what I have to kind of remember is that it's safer for the girls to know how to inject themselves than it is for them to be injected by their boyfriends, or pimps because if they don't, if they don't have control of their own drug use then it's going to get really bad really fast and everything will get really bad really fast and they might end up, they might not live to the end of the summer that they're spending in the downtown eastside.

This participant described how she shifts from personal judgment to the implementation of a harm reduction framework. She explained:

> Even though I want to tell them to 'run out of there! 'It's important that I give them a really good experience so that they come back and when they have their crisis, which, is inevitable and it happens. And when they have whatever crisis sort of occurs next, that they come to us because that's the job and that's the point of us being there.

She knows she cannot stop these clients from using illicit drugs, so she works to build connection with clients to ensure that harm from the drug use is being reduced, and that those clients will return for support in the future.

***Respecting clients when they do not want help.*** Participants reported times when a client does not want help with something, or does not want help from a particular staff member. Allowing clients to maintain their autonomy and respecting their right to refuse assistance can be frustrating for staff when they see the person struggle. One participant recalls what this felt like, saying:

> It can be challenging, and it can be frustrating because if you know someone is in really bad shape and you see them all the time, but yet you can't quite bridge the gap because they're just not open to it. And you just see them deteriorating then that get's very frustrating.

Participants described how despite this frustration there often comes a time when a client needs help so badly that they take the step to ask for it, or accept it at a later time. Several participants explained that they know that they "are not everyone," but working as a team allows clients to find someone with whom they feel comfortable connecting.

***When regular clients disappear.*** Participants explained that there are limits to what they can do when a regular client disappears. In particular, they described trying to investigate within the limits of confidentiality that Insite uses, asking coworkers and occasionally other clients at Insite if they had a relationship with them. One participant said if "it gets to a point where you're really concerned I would probably talk to a manager and then they can do more." Managers are also limited in what they can do because if they were to call a hospital or shelter they would not be able to identify the person whom they are seeking as being a user of Insite services.

One participant explained she is more concerned when a client who does survival sex work goes missing. She explained that "the risk is that they were abducted, lot of women who work in the survival sex trade will be locked in a room and tortured for days, so is that happening?" When a client who does survival sex work disappears, this participant reported asking many people questions about the client's whereabouts and trying hard to find her.

Many participants said there is not a lot of time to investigate or wonder too much. One participant said, "Oftentimes you just don't have the time to think about where someone is. If you haven't seen them you haven't seen them." Another participant spoke about being too busy with everything she needs to do when she is on shift to think about people that may be missing. She said:

> When you think of that there's also the immediate distress and the acuity of the site to think about, so you're divided. Everything at Insite just – it's a blur of happenstance! Like, there's no time for mourning really because you have an immediate *really* pressing concern.

Many participants said that because there is not a lot that they can do to find the person, they just hope for the best. Several participants described being resigned to the boundaries of the site that prevent them from investigating. One participant said, “Well, if I don’t see someone then I hope that everything is ok, but that’s all I can do. Like you can’t really run a missing person’s thing.” Several other participants described looking towards the positive. For example, one participant said:

> I really just hold in my heart that something really amazing is happening, something super transformative, like for the most part the downtown eastside and the safe injection site is kind of the lowest place to be. So I kind of just hold in my heart that wherever they are its somewhere better than there.

This participant’s message is that having hope is the only thing that she could do when clients disappeared.

**Challenges of setting boundaries.** Participants described several important aspects of setting boundaries: (a) learning to set boundaries; (b) responses to working with difficult clients; (c) Accepting limits to how much you can help; (d) Balancing the desire to help with the need for self-protection; (e) concern that setting boundaries will create help-avoidance; (f) responses to disrupted boundaries; (g) setting boundaries with staff or management; and (h) working within boundaries imposed by the site. Healthy boundaries were an important part of relationships with clients, and many participants reported that they felt challenged in implementing them effectively.

***Learning how to set boundaries.*** Participants described undergoing a process in which they first struggled to set boundaries with clients; for example, “I took a lot home with me when I first started working at Insite. My partner has many stories of me coming home really beaten up at the end of the day.” One participant described some of the things she found herself dwelling on after work related to her feeling responsible for the success or failure of clients' injections. She said she would initially take on all the responsibility, but explained how she has since shifted her perspective, saying:

> Then as you start working there, you’re like you know what? I’m here to support them. Really they should be independently injecting on their own, with some support sure, but I mean they have to ultimately do the putting in the needle, the flagging, the injecting of the drug, that’s *all* them. So it’s

> really, their responsibility in a way, if they miss they miss, if they get it, they get it, and that's all in their control.

This participant demonstrates how she learned to set boundaries by accepting that she is not solely responsible for client's injections.

Participants described the process through which they discovered the need to set boundaries. One participant described how feeling depleted after not setting boundaries in the past was a reason to set boundaries now, saying:

> This time I'm setting many boundaries. Because the first pregnancy I left *really, really*, stressed out. *Really really burnt out*. And now I'm learning like I need to set boundaries for myself, cause as much as I love my job, like I love myself too.

Many of the participants in this study described boundaries as being a firm wall. Part of one participant's realization that she needed to set boundaries was understanding that setting boundaries did not mean she had to end the relationship and not help the person. She explained:

> It's getting easier for me. I'm getting more, more confident and better at it. Recognizing that I need to do it. But I think for the first year and a half or so that I worked there, I didn't even recognize that I needed to do that at all. I just thought that this was my job, I'm dedicated and this, I just have to deal with it. Like I need to maybe communicate a little better or be more swift about directing where we're going with this relationship, but it's not about me cutting it off and being like, I can't help you anymore.

Boundaries were easier to set when participants viewed them as porous and flexible rather than as a solid wall that harms the relationship.

***Responses to working with difficult clients.*** Participants reported different ways they responded to difficult clients. For example, some of challenges involved the absence of a relationship where participants tried to balance setting boundaries for themselves while staying open to the possibility of creating a relationship with clients. Other challenges involved having a strong relationship with clients, and struggling to set boundaries without harming the closeness of the relationship.

*It's not about me.* In response to dealing with difficult clients, some participants described the need to separate themselves from how a client was treating them in a particular moment. One participant described not taking it personally when a client was abusive towards her, saying:

> I've learned the hard way, that abuse is not because of me, it's not because of who I am or what I've done, it's a lot more to do with what's going on with that person. It's a lot more to do with, you know, underlying history, what's going on with them right there, their health, their physical health, their mental health, and you just may end up being a target because you're wrong place, wrong time.

The ability to set a boundary and not take a client's hurtful words personally, but realize that a client's anger and frustration is not about you was an important tactic in dealing with difficult clients.

*Stronger boundaries.* Participants reported that they found it difficult to build strong connections with clients who had strong personalities or a history of violence. One participant explained, "For those return clients that have had those negative experiences, I definitely put up more walls with them. It's hard to engage with them the same way." In her example, she compared these types of clients with other clients whom she has a strong relationship, and found that injections were done automatically while comfortably chatting.

*Choosing to disengage or leave.* Participants discussed many tactics they used to deal with difficult people, and reported how sometimes staff need to leave the situation to resolve it. A participant noted that sometimes staff members reach a point where they cannot salvage the relationship with a particular client in that moment. She said "you have to step out of the room if you're that person's trigger, and have the other staff take care of it." In addition to participants realizing their presence may only make the situation worse, they also described times when they decided to disengage before an interaction became difficult. One participant described her experience pulling away from clients with whom she had difficult interactions, saying:

> As a nurse you're only human and you do have certain people who are just like, I'm going to *not* engage with you because I feel really

> uncomfortable or I feel like every time it's a *bad* interaction consistently. So I'm just going to disengage.

Participants described that while at times it was difficult to disengage from a client, they also felt comfortable doing so because there was still the opportunity for someone else on the team to connect with and help that person. One participant explained her experience of this, saying:

> I would never be able to enter that space with that person again, it just got that bad, but other people have been, which is good. My experience at least let other people be able to understand that this was a really big thing, so I know that even though my interaction with her wasn't the best, like she still trusts the space and she still got what she needed that night in some way. And maybe through the building of support that she gets through Insite, she'll eventually be able to deal with the wound, but that night like, it was completely emotionally exhausting.

Participants described the use of the team as being very important in dealing with clients that they found challenging. Being able to call on team members meant there was a chance someone else may connect with a client if one nurse could not.

***Accepting there are limits to how much you can help.*** Participants explained that while it is sometimes difficult to pull away, they have realized that there is only so much they can help their clients. One participant described that despite wanting to help clients with everything, she needed to respect their responsibility for their own lives. She said:

> You can't do everything for those people and they have to be responsible for themselves and you definitely have to remind yourself that you need to put the onus on them, and that as much as you want to be able to do *everything* for them, you can't.

When working with clients, the more experienced nurses were, the more confidence they had in accepting that they need to set boundaries - including boundaries around how much help they could provide. One participant explained her response to a client who became angry with her, saying:

> Once in a while you'll have a participant that will have missed his shot and they'll be like, "look what you did!" Or "the other nurse always gets it!" Or something, and then you just try to – well actually you're also in this

> too, it's not just me that's helping you. I was here to support you but you can only do the best you can so you just feel, yeah you feel more comfortable because you *know* your skills, so you're just more confident.

Sharing responsibility with clients, helped participants gain confidence in setting boundaries and also set a precedent for client responsibility when injecting.

***Balancing the desire to help with the need for self-protection.*** Many participants described the struggle they have in setting boundaries with clients. One participant called it "a constant inner battle" to find a balance between their desire to help clients while keeping their own physical and emotional safety. One participant described what it felt like to straddle this line, saying, "You feel really crappy about that because yes, you do want to help them, but at the same time it's not safe for you to do that."

Another participant described her tendency put more importance on helping a client than protecting herself. She recalled a situation where a client had been very violent in the past, and staff was meant to keep a distance from him when he was in a booth. She said she sometimes felt inclined to ignore those boundaries because she wanted to ensure the client was safe. She described approaching the person cautiously and thoughtfully, assessing her own safety at each step. In this situation, the participant cautiously balanced her desire to help with her need to protect herself as she engaged a client who had a hostile and violent past.

Several participants described the difficulty of disengaging or setting boundaries even if the client was violating the boundaries. One participant described how she uses her awareness of feeling frustrated as a sign that she needs to set a boundary. She said:

> I'm dedicated to committing, to being committed to my patients and to be positive and to *be* there for them. So it's hard to withdraw, but for her, I was getting so frustrated, I just knew I had to set a boundary. So, I'll give her like maybe 6 attempts and then I'll say, "You know what, I'm going to give you a few minutes to try by yourself." And she's been really good about that thankfully.

Some participants described their fears around setting boundaries; they were worried about abandoning the client. Participants expressed a concern that setting a boundary with either a non-violent or hostile client would be perceived as an undeserved

punishment. One participant explained her experience of this: “Because I don't want to feel like I'm abandoning somebody or I'm just, cutting it off. Especially when they haven't done anything, dangerous, or hostile or really risky towards me, like, she's just being herself.”One participant described how setting boundaries with some clients seemed like “being the bad guy.” She elaborated on what it was like for her, saying:

> It sucks, I'm *not* that person. Like that's not in me, that's not my style. For some that comes really naturally, they can set boundaries really easily, they can be really cold and withdraw easily, and it won't affect them. For me it affects me. Like, it really *hits me* because I feel like I'm abandoning my patients… I'm here to care for you, I'm not just going to leave you because I feel uncomfortable. But I should sometimes, because I also need to feel comfortable enough in my work that then I can care for other people.

Even with experience, some participants explained about how difficult it was to set boundaries with clients because they were concerned about how it may negatively impact their relationships with clients.

Participants explained they immediately set stronger boundaries with certain clients who they found difficult to work with. One participant described how when certain people ask her for help she responded cautiously. She said, “I need to have this wall up, if there’s an opportunity like if they’re opening up, sure I’m going to be receptive to that, but to a degree because some people can be very manipulative too.” Several participants commented on the need to protect themselves emotionally from being manipulated or from over-identifying with a client’s story. Participants spoke about how tiring it was to constantly work at building relationships and setting boundaries, and described it as “push-pull,” “exhausting,” and “emotionally draining.”

***Concern that setting boundaries will create help-avoidance.*** Several participants expressed concerns that clients may not ask for help if boundaries are enforced. Several participants felt concerned that boundary setting interfered with client care. For example, one participant recalled a client who had been violent several times, and whom she thought was labeled by other staff as violent. She explained how boundaries were set with him through an agreement about how he would act at the site. She expressed her views on this agreement, saying:

> [The agreement] is good in terms of staff safety, but I think it's also, I mean it's hard, because he's got a lot of stuff going on in his life, and it's kind of causing staff to disengage with him a bit. And so it kind of, it, I question it, but at the same time I know it's for my safety. Because there are these multiple times that it's happened, but I just worry that when he needs the help, or wants the help, he's not going to feel like he can reach out to us because we're much more regimented about him.

Several participants described the challenge of setting boundaries and their concern that enforcing those boundaries would harm relationships by changing how the client would see them. If staff became more regimented with a client they may be viewed as more of an authority because they are using their power to enforce very firm boundaries.

Another participant spoke about the difficulty of setting boundaries based on the type of relationship she had with clients. She recalled her experience of clients flirting with her, or making inappropriate comments towards her; this left her feeling uncomfortable, especially when she had to set boundaries with them. She described setting this type of boundary as being particularly difficult because she did not want to embarrass the client and risk harming the relationship. She reports, "You have to articulate yourself in a certain way that's not going to offend them, and push them away completely and shut the door. And that's something that I'm still trying to learn how to do."This participant commented on the struggle she feels between her discomfort with how the client is speaking to her, and her anxiety around communicating her boundary as gently as possible so the client will still return to her for help.

***Responses to disrupted boundaries.*** Participants described a variety of responses to having their boundaries crossed. One participant's experience of unsuccessfully trying to help a client leave an abusive relationship, connected with experiences in her own life. She explained how that familiar feeling of having her hope crushed was relived at work, she said:

> You see her coming in with black eyes and, clutching the stomach and you just see the physical abuse and hardship. I had gotten so much hope I think, and it was that crushed hope for me. Everything was building and building and, hope is what I had, and then that hope just got crushed and that's definitely never easy seeing someone go back to being in an abusive relationship. And I think I may have brought some of my outside of work baggage in because I've seen friends go through bad

> relationships. And so I've seen that, and I know it's a hard cycle to break, just like addiction. But it's still hard to have hope crushed.

This participant identified closely with this particular client because of her own life experience making it difficult for her to respect the client's choices.

Several participants commented on an ability to detach from their emotions in situations where their boundaries were being crossed when a client yelled or said cruel things to them. For example one participant said:

> If it's just that they're pissed off and they want to yell at someone about it, it's almost like I can put up a bit of a wall. And it's not that I'm putting a wall between me and them, but it's like I can separate it from my emotions. They may be saying "You're a fucking cunt" but, that's *not* the intention behind it. They're just expressing their anger and I'm here for them to express their anger at. And so, I've been able to almost, yeah, I guess a wall is the best way to describe it. I can kind of like, it's like I just kind of take a breath and go "OK, this isn't about me, this is about them, let them get out what they need to get out, because this might help them get through it." And so, that's helped me a lot as I've become more experienced at Insite to be able to be like, Ok, it's not on me. I don't have to take this home with me, it's I'm able to create a bit more separation that way emotionally.

This emotional detachment serves to protect participants and allows them to understand how it is an unfortunate projection on to them rather than something about them personally.

Another participant described how she dwelled on negative interactions long after they happened. She explained that she has become better at setting boundaries than she used to be because she would dwell on every negative interaction rather than set boundaries because she feared upsetting people. She said:

> Yeah, it was hard because I'm kind of like a pushover kind of person. I really like, I like to please people. I really like to have positive interactions, so any time I would have a negative interaction, it would really plague me. And so I would try to avoid that. Like I said with that woman who rushes you at her booth really ridiculously. I would take that, I would take and take and take and take so many clients that were like that at their booths. And, and I would *never* step away, and I don't know why I did that.

Reflecting back on why it was difficult for her to set boundaries this nurse realized that she tended to avoid setting boundaries because she was afraid that the client would become upset with her and then not want her assistance.

Most participants described reaching out to colleagues for help when their boundaries were crossed. One participant described using a team approach when she was unsure about how to deal with a client who had crossed her boundaries. She approached colleagues and told them she was, "at a loss. So you just bounce it off your coworkers and you're like hey, what do you do? What's working for you? Or what should we do?" She explained that she asked other staff members for their support and feedback to help her to deal with difficult clients.

***Setting boundaries with staff or management.*** Because setting healthy boundaries is an important part of having healthy relationships, participants were able to recognize the importance of setting boundaries with other staff and management. One participant described the importance of staff being able to "show a united front and be consistent," particularly in front of clients. She went on to explain that the staff at Insite has "experienced a lot of staff splitting behaviours" which can cause problems when dealing with difficult or dangerous situations. One participant described a situation where she was able to set a firm boundary with a coworker who insisted that she do HIV testing with two clients who had just been aggressive with her in the treatment room. She said:

> I was able to be like "You know what? No. I'm not going back in the treatment room to give them this testing, I will help you get them out of the building but I'm not going to do that for them." And I just said 'no' basically. And my coworker, you know, tried to talk me into it for a couple of minutes and as I said 'no' over and over again, they kind of like 'Ok, yeah you're serious, let's move on' kind of thing.

This participant had to repeatedly set her boundary with her coworker in order for it to be respected. Setting this boundary allowed her to choose a safe course of action with the clients she was working with.

Despite the problems with staff unity explained above, several participants reported they were satisfied with the boundary-setting conversation they had with other staff or with management. One participant described a situation where she was not

included in the decision-making around solving a situation that was dangerous for her. She approached management and explained why that course of action was not fair to her or respectful of her rights. She described her experience of setting that boundary by stating:

> It was good! I mean, I like working there, but I like my safety more. I'm not going to work in an environment that's not safe and I have no problem saying what my needs were for that, or about not being included yeah. I called them on it and they listened.

This participant described being satisfied with management's response to her complaint about how poor communication during problem solving discussions could put her in danger.

***Working within boundaries imposed by the site.*** All staff at Insite is required to operate within the boundaries of the site. One of the most common frustrations participants shared is being limited in how much they could help clients because of the time and resources that are available to them. Two nurses and some support staff work together to manage the injection room, meet with people in the treatment room, and occasionally assist with offsite overdoses. One participant explained that it was hard to connect deeply with someone in distress because there was not enough staff to take on the other responsibilities in that moment. This participant described how, when she is the only nurse in the injection room, it is difficult to "give that person your whole mind because you still have to think of the safety of the other people in the building."Another participant explained her frustration when she "delves deeper" with a client and learns about something significant and distressing for them, but does not have the time or the resources to help that person cope with it. She stated, "then you're like 'great, I've kind of unearthed this thing they're dealing with and I can't really,' all you can do is pass this onto someone else that can help, or just hope that it gets addressed." Clients' needs are often greater than what staff can provide, so they find themselves hoping they can rely on their team members to address issues they were not able to undertake.

## 4.4. Working on the Edge of Trauma

This theme encompasses two types of participant experiences: working with clients who have often experienced a great deal of trauma and working in situations that are dangerous or have the potential to be dangerous and/or traumatic. Participants commented on three aspects of these experiences: (a) their immediate responses to danger; (b) responses to distressing events; and (c) self care and support.

### 4.4.1. Immediate Responses to Danger

Participants described the potential for danger in the *unpredictability* of interactions with some clients as being the most distressing. Unpredictability was primarily characterized by participants as interactions where a client was either aggressive or not responsive, and where they did not have a strong relationship with the client involved. In this context, participants described their experiences of danger related tooth the unpredictability in client behaviour and their own responses to that unpredictability.

**Unpredictability of client behaviour.** Participants commented directly on how unpredictability was a concern for their safety and for other people in the room. For example, one participant said, “People are on illicit substances and therefore, for no good reason, may snap like that and become very violent.” Some participants spoke about the moment in a particular interaction where they knew something was going to shift and how they were at risk. For example, one participant explained what it was like when a client becomes hostile and expresses anger at her. She said:

> And I know that it's going to go wrong, and they're aggressive and they're hostile. And that they're basically going to talk at me the whole time, and direct this person to get their precious shot into their vein. And if I lost that shot - well not me, but if it doesn't work out - then them not getting that shot in, they're going to blow up at me. That is the worst. To me, that's when I really feel at risk. Like, am I really putting myself in this situation right now? And yet I have to, because I might be the only nurse on the floor or the other nurse might be busy.

This participant described feeling unsure, vulnerable, and at risk of harm because of a client's unpredictable behaviour.

Participants also described the difficulty in dealing with unpredictability relating to the well-being of their clients. If a participant does not know a client, it is more challenging to know if the client's behaviour is normal for them, or a sign of something dangerous. This client unpredictability was primarily characterized by clients' unresponsiveness that could suddenly become aggressive. For example, one participant described a story where she approached a client, "who was face down on the table and he had a needle in his mouth, and the needle was bent. And his arm still had a tie on it, and his arm was totally red." She thought he was overdosing, so she grabbed his shoulder and called for help, and the other nurse yelled, "Don't touch him!" The other nurse on duty informed her that this client was not overdosing, he presented that way normally, and if she touched him he could become very violent and start punching her. This participant spoke about how difficult it was to navigate this uncertainty, saying, "At what point do I know? Is this guy overdosing? Because that is a tricky dance to do."Some participants expressed that they were generally more concerned with clients who were not as responsive because it was more difficult to predict what they might do. For example, one participant explained:

> They sometimes are non-verbally responsive to you, so you're trying to like, give direction but you're not able to kind of gauge what's happening. So it can be quite difficult at times. With that part of the population, I worry a lot more about my safety and their safety when there are scenarios where the person's a little bit less responsive to me.

Clients' lack of responsiveness seemed to increase the amount of unpredictability participants experience leading them to feel insecure and vulnerable with clients who present this way.

***Low threshold versus safety.*** Low threshold is a tenet of the harm reduction framework that requires as few barriers as possible to accessing services. Unpredictability arose as a concern when participants encountered problems in balancing their need to maintain safety while still keeping the site low-threshold. Participants reported that sometimes conflict arose between staff as there was

unpredictability in how different staff members would respond to violent situations. Some staff had a tendency to respond with behavior that kept the site low threshold (e.g., not calling the police even if there is violence or other criminal activity) while some prioritized staff safety (e.g., calling the police to deal with violent or aggressive clients). Due to space and prioritization of information I presented, the theme summary I sent to participants (after data analysis) did not contain this issue, even though it was present in the data. In a response to the theme summary one of the participants explained its importance and said the following:

> I'm not sure if this came up in any of your interviews but something I know many of us Insite nurses have found challenging recently is the idea of low barrier vs. safety. Insite operates on a harm reduction model, which is low barrier (i.e., free to access, no security) in order to engage users that typically wouldn't access a health care facility for fear of being stigmatized. That being said, this low barrier access sometimes means that violent/aggressive individuals that have been barred from other sites for their behaviour, can access Insite. So as a nurse we often struggle to maintain safety of staff and users while keeping the site low barrier. It's a challenge. Maybe this might be something to add? It's an ongoing dialogue that our team is having lately and it's quite complex.

During interviews, other participants also made reference to this struggle to balance keeping the site low-threshold while keeping staff safe. One participant described a story about how a disagreement among staff led to a dangerous situation where they could not agree about whether or not to call the police. She said:

> There was a very distressing event that occurred where somebody came in with a bloody knife and said, 'I just stabbed somebody.'.... So, the participant with the bloody knife put the bloody knife on the table, and then my colleague was like, "I'm not taking your knife! Take it back!" "Get it off my table" kind of thing. And then, somehow that man was let into the injection room where I work with his bloody knife. Which I don't know how that happened, but it did and it shouldn't have because he needed to do an injection, but there's a lot of grey area there with what is criminal activity and what is sanctioned criminal activity. And so, he came up to me and was like, "I have a knife in my pocket, I just stabbed somebody." And I think I just said, "Put it away!" And I told him to put it away and I said to my co-nurse, "ok, this just happened and I don't know what to do." And then she was kind of, she was unsupportive, she was like, "Oh, well.... um" I think nobody really knew what to do, but nobody could admit it. And so eventually he left, but at the very front, my colleague wanted to call the police, and that kind of bully girl just started screaming at him, "don't call the fucking police!" and called the police pigs, and just created

> this huge dramatic scene out front, and then, M. was on the phone with the police and, but I didn't call the police, so maybe I should have called... like we're all just kind of like what even just happened? And it was so dysfunctional; it was so totally dysfunctional that we were all at really high risk for maybe contracting a blood-born pathogen, or maybe that person with the knife directing the violence towards us.

Several participants spoke to the idea that Insite was a dangerous place to work, and that while they understood the need to keep with the harm reduction principle of being a low-threshold service, they did not always feel safe or agree with the low-threshold decisions. One participant recalled a time when a client began throwing needles and her coworker did not want to call the police. She said, "my thought is like, when that guy started throwing needles that wasn't ok, like that's completely unacceptable, I don't care what your thing was, throwing needles, it's time to call the cops. That would have been my call."One particpant spoke about her response to the lack of security. She said:

> I pretty much walk in there thinking that everyone has a weapon. Just to have that in my mind, that probably everybody has a weapon. And I've seen weapons in there and I've seen weapons be used in there, and... it was not long ago that one of my colleagues was punched in the face multiple times with very little provocation. People can be really volatile. I think it's a dangerous workplace.

Witnessing the abuse of colleagues and sometimes being involved in a violent interaction, led this participant to think about her workplace as dangerous for staff. Several participants mentioned that embracing the harm reduction principle of being low-threshold and allowing repeatedly violent clients to return also pushed away clients. One participant explained the struggle of balancing the safety of staff and other participants while keeping the site low-barrier:

> We have people who won't access the site because they don't feel safe because certain people access the site. Like certain enforcers, or drug dealers and so they won't come to the site because they might get harassed or hassled by some of the people. So it's like, by being low barrier we're actually creating barriers to some people.

While being low-threshold is an integral part of the harm reduction model, it clearly brings challenges both for staff and clients.

***Worry about safety.*** Because of the unpredictability and the dangers associated with being low-threshold, several participants described a concern for their safety. Insite will bar clients for 24 hours when they do not follow the rules of the site; after 24 hours, clients who were repeatedly violent are allowed to return. One participant reported, “My family worries about my safety a lot.” Another participant found herself questioning staff safety when attending to clients who are unpredictable. She said:

> . . . finally he wakes up. And he rouses and then less than 10 minutes later he stands up, picks up his chair and just throws it at one of the mirrors like where somebody could have been sitting, and he probably would have killed them. With that kind of intensity that’s completely unprovoked, it’s like how do we do our job safely? How do other people come to us safely when this is allowed to happen?

Working with such unpredictability makes it difficult for nurses to do their jobs effectively and safely. Several participants said they understood why violent clients were allowed to return, but working with this unpredictability made them concerned for their security.

**Personal responses to unpredictability.** Participants described three types of personal responses to unpredictability with immediate danger: (a) emotional responses, (b) doubting self, and (c) critical decision-making.

***Emotional responses.*** Participants highlighted specific emotional reactions such as shock, panic, and fear when they had to deal with client unpredictability and the potential for danger.One participant described what it felt like physically when she was alert to danger due to a client’s behavior. She said, “You can feel it, the adrenaline. The body starting, the heart rate was increasing; I could kind of feel myself tensing up a bit.” She then went on to describe the types of thoughts she had in those moments where danger was imminent. She said:

> I was questioning myself. Like, am I safe? Is this fist pounding going to turn into face pounding soon? Like, those kind of thoughts. So definitely a bit of, I don’t know if I’d say like, not really anxiety or fear but just uncertainty, were coming into play.

Participants also expressed panic and fear in response to the realization that they may be harmed by what was happening with clients. For example, one participant described

that experience as, “a bit of a holy-shit moment of like, ‘I don’t want to get stuck with your bloody rig that’s bouncing off the window,’ it just isn’t worth the risk.” Some participants described moments where it was hard to stay present and deal with the danger. One participant said, “its’ really hard to keep yourself in check, and not just freak out and be like, I’m out of here! Or like, you know, to sort of stay, it’s really hard to stay with it.” Participants also expressed the intensity of emotions they felt when dealing with a high-risk client overdose. One participant recalled her fear in one of those moments; she said, “. . . oxygen sats [saturation] were down to like 17% and it was just terrifying in that moment . . . on the inside I could feel my heart pounding and that adrenaline was going, and that there was that holy shit.”

Participants expressed how, when approaching someone who was agitated, they tended to be nervous and prepare for something dangerous to occur. One participant explained her emotional response to approaching a frustrated client; she said, “Sometimes you'll come to somebody who might be super tense, because they've been trying a bunch of times and they're really frustrated and want to get their shot in. That's uncomfortable, that makes me really anxious and uneasy.” Some participants described their own responses of defensiveness when they tried to help agitated clients. For example, one participant said:

> When I approach somebody and I can see that they're visibly angry, or anxious, or just really stimulated, then I get a little bit defensive because I know it will be harder for me to work with them, and I know it could be a risky situation.

Several participants also spoke about their defense mechanism of not having emotions in dangerous situations. One participant explained how the emotions associated with the danger may not be there in the moment of danger, but can come afterwards. She stated:

> You don’t have time to panic or think about ‘how I’m feeling in this moment?’ And then afterwards, then all those feelings might come and you might be a little shaky and need to take a walk or something, but it’s just like adrenalin in the moment. I think that’s what keeps you really focused it’s this like, crazy like focus that you have.

The need to focus and deal with imminent danger overtakes emotions in a crisis. Participants reported how, after the crisis moment was resolved, they had time to feel

and cope with those emotions. One participant explained how she feels exhausted from intense interactions with clients, but believes that her colleagues feel differently. She said:

> It's really tiring, and it's kind of... like it's stressful for sure, but I think that, like you know, stress is stress, but for me the lived experience of it is exhausting. I think for other people it's stimulating. For other people, they find it really stimulating, is what I've heard from my colleagues. But for me, the sort of manifestation of that stress is exhaustion.

This participant believes that her colleagues find those intense interactions with potential for danger to be stimulating.

***Doubting Self.*** In response to the unpredictability of some clients' behaviours and the possibility of danger, participants sometimes doubted themselves or questioned the situation. One participant described being frustrated with herself when a situation started going poorly. She reported questioning her own abilities, saying "I feel like if I was maybe a little more nurturing, or if I had a little more, more of a softer edge or if I had a little more emotional reserve then it would have gone better." When a situation becomes dangerous some nurses reported not only questioning their actions within the situation, but also if they were a good fit for this type of work. For example, one participant said:

> I've considered many times, like can I do this, do I want to keep doing this? Where else can I go? Where can I find my niche in nursing? Is this good for me? Is this good for them? And, a lot of what we do is relationship building, so am I the best person to build relationships to that community, would someone else in my place do a better job?

Experiencing the difficulty of intense moments led this participant to question her ability to do the work.

***Critical Decision-Making.*** Participants also explained how their ability to respond when critical decision-making was needed, kept them and others as safe as possible in potentially dangerous moments. Many of these examples centred around the participant trying to calm the agitated person, set boundaries, call for help from other staff members, or remove themselves from the situation.

Participants explained how sometimes they were unsure of the risk before a situation became dangerous and their need to make a critical decision. One participant described trusting herself to recognize that a situation was becoming dangerous and moving onto critical decision-making. She said:

> Eventually I kind of kicked into, 'ok no, I need to trust my gut right now.' The fact that I'm questioning being in here means I probably shouldn't be here. So that was kind of like, kind of as those thoughts were cycling. The fact that all this is happening in my head right now means this isn't a good situation.

Based on this participant's description, self-doubt was sometimes used as an indication to take action to avoid danger. One participant recalled a situation when a volatile client was frustrated trying to get his shot in. She described using multiple techniques that other participants described when dealing with hostile clients. She explained that she set a boundary, made multiple attempts to calm the client, and eventually had to leave the situation without continuing to help the client. She said:

> Immediately you take a couple steps back, create that safe distance, and just say to the person: "That's not okay. I want to help you but not if this is how you're going to behave." And usually you have to kind of set that limit, and in that instance it just didn't work. None of us went back in to help him. We left him isolated in his booth. I think he eventually just threw out his shot because it got so clotted he couldn't do it, so he left really pissed off. But sometimes if you use that technique, you know, the person will be like "Okay" and they'll like, sit down, put down the stuff and be like "Okay, yeah, please come help me." And you can go back in and they're able, they kind of understand after that moment of aggression that like, "I understand what you said, yeah. Let's try this again, I really do want your help."

This participant expressed confidence in her tactics to defuse volatile clients, but explained that sometimes staff has to prioritize their safety and completely disengage from the client.

Some participants described a tendency to become very task-oriented, non-emotive, and focused when dealing with potential danger. Participants reported how, in moments of crisis, there was no time or space for them to feel, or be aware of what they may be feeling. One participant described how, "in the moment it doesn't feel like anything. It might be afterwards, maybe afterwards you might be a little fatigued. Like

that was an exhausting interaction." Participants described what felt like mechanical or automated behaviour in dealing with crisis. For example, one participant described being focused on the task at hand: "you don't have a lot of time to kind of emote in that moment. You're more focused on your tasks, so in a crisis you become very task-oriented. You're not even thinking about how you feel."

### 4.4.2. Responses to Distressing Events

Participants reported experiencing burnout as the aftermath of dealing with difficult clients and potentially dangerous situations. While participants used the term burnout to refer to how they were affected by the work that they were doing, their descriptions do not meet the criteria for professional burnout. Instead, the responses participants described as 'burnout' included (a) delayed emotional responses; (b) intrusive and self-doubting thoughts; and (c) a tendency to stop attending to self or self-care. Based on participants' descriptions, their distress was a combination of the traumatic stress experienced both directly by participants, and secondarily from watching patients struggle with illness, marginalization, and trauma. For example, one participant said: "At Insite, the need is so high, and the distress is so high . . . when things go down, the things are really big. And there is sort like a constant, there's an insatiable appetite for help."

**Delayed emotional responses.** Participants described a variety of emotional responses to hearing traumatic things from clients as well as experiencing traumatic events themselves. Some participants described the expression of intense emotions relating to work when they were outside of work. As one participant described:

> I would cry before every shift because I didn't want to go back, but I knew that I had to work, and I didn't want to leave early because I'm dedicated to my job and I love my job. But it was just too much, it takes a lot out of you.

Another participant explained what it felt like to continually experience distressing events. She reported when something had not gone well at work, "it just sticks with you a bit longer," and she found herself thinking back over the situation for lengthier times than she normally would. She explained that because of her experience she now attends to

why her thought processes have changed, and often comes to the conclusion that she is working too much, or has not done enough self-care.

Some participants described feeling “fuzzy” or disengaged in response to distress. One participant explained how this experience negatively impacted her work, because she was less willing to do more to help her colleagues and clients. She said:

> When you get burnt out you can really see the way you work, it changes. It’s kind of a bit more um, abrupt with maybe like disengaging from conversations and like you’re not really so willing to jump in and help out. You’re just kind of like doing the bare minimum of what you can do because you don’t have any more to give, like you’re burnt out! Like I can’t give you any emotional/psychosocial support at this stage, I barely have any for myself, or I don’t have any for myself because I’m burnt out.

Participants explained how it was harder to care about clients when they felt depleted after dealing with other distressing events.

Participants also spoke about a distressful feeling of helplessness in response to being unable to relieve a client’s suffering. For example, one participant said, “It’s so uncomfortable because . . . there’s no way to alleviate that suffering. There’s nothing, like I feel like I have no agency or skill or, like there’s *nothing* that I can do remediate that situation.”The experience of watching people become more ill over time was described as being very difficult. One participant said:

> Seeing the dire situations that people are in. Like when they come in looking so much more worse and haggard than you saw them last, it's just kind of like, there's nothing you can do about it. You just see people waste away sometimes.

One participant commented on how it is most difficult for her to see young women who were not entrenched in drug use, start using drugs and engage in dangerous activities. She said:

> The hardest thing to watch is like the fresh-faced-beautiful-smart-crazy-powerful-but-they-don’t-know-it-in-the-right-way-kind-of-thing 20 year old that comes from somewhere very remote, who wants a different life experience, and watching them get sick over the 2 or 3 months of their sort of progression of illness.

Seeing clients willingly begin injection drug use and enter into the associated lifestyle was very challenging for several participants.

**Intrusive and self-doubting thoughts.** Some participants described experiencing intrusive thoughts about work. For example, one participant said:

> It's hard, because even when I was off, like I would tell people this: I would think about Insite *every* single day. And I probably did for the next four to six months. Like you just think about it. At least once a day I would think about certain participants, or if you're on Facebook and you're seeing your coworkers post about certain things and it triggers that. And I would dream about it - that's common with nursing work. Like you always dream about work.

This participant described ruminating and dreaming about her work when she was on a leave of several months.

Participants also described many instances of doubting themselves and their choice to do this work. One participant said, “I’ve considered many times, like can I do this, do I want to keep doing this?” Several participants noted that, “burnout is really high there,” and remarked about the resulting elevated staff turnover. Participants appear torn between the pull of wanting to help, and the push of the work being highly taxing. One participant recalled a difficult time for her in the past, which led her to question why she was putting herself at risk to do this work. She reflected on being torn between wanting and not wanting to do the work; she said:

> As much as I was helping people and I knew I was still doing good work, when I would walk outside on my breaks, I would just be like, what am I doing here? Like the downtown eastside, like there's drug dealers on every corner waiting for the next person to sell their drugs to. There's people selling themselves, and it's just like, I don't want to be here.

While participants were satisfied with the work they were doing, they sometimes still found themselves doubting when they put themselves in potentially dangerous situations to help clients.

Several participants commented on how being in these dangerous situations causes problems for them outside of work. One participant said, “It’s the ones that I

know I'm in a dangerous situation that causes the sleep disturbances for sure." Experiencing danger at work causes the delayed response of intrusive thoughts and doubts that impact participant's well-being.

**Not attending to self or self-care**. Some participants described how their job took over other aspects of their life, leading them to neglect taking care of themselves, or things outside of work that were important to them. For example, very tearfully, one participant said:

> As much as I wanted to, like I really put my all into my job and, yeah, it just burned me out. So this time it's like, no, I can't do that again because I have a daughter at home, and I can't bring that home.

Participants explained how work intruded into their lives, leading them to neglect taking care of themselves. One participant explained this saying, "I was much more devoted to the job than I was devoted to my pregnancy." This response fits with other participant's comments about an expectation among staff that they should be able to handle job-related distress without taking time for themselves. One participant explained how pride in meeting this expectation may be a factor, saying:

> I was talking about it with a program worker the other night. She said, 'You know, I think a lot of people are burnt out at work, but they're too proud to show it.' People don't like to talk about it because they think you know, you just want to be tough when you work in this area.

Another participant expressed some of this pride saying, "I just don't like quitting. That's the thing. So you don't want to be the person that quits or that says that I have to leave early because I can't take it anymore."When participants were not able to tolerate the distress of the job they reported a sense of shame. For example, one participant said, "You kind of feel ashamed, like you're failing. But at the same time I knew I wasn't because I was like fully pregnant and I needed to take time for myself." This participant described an awareness of how she needed to take time for self-care, but her concern that she might appear as if she were failing to her peers, kept her from doing so.

### 4.4.3. Self-Care and Support

Participants described self-care as a way to cope with their traumatic responses. When asked about coping and taking care of themselves many participants commented on three issues: (a) the importance of self-care in continuing to do this work, (b) the specific self-care activities used, and (c) seeking support from others. Participants listed a variety of activities they did to take care of themselves, highlighting the importance of having people to talk to about their experiences at work, and particularly the importance of debriefing with colleagues who understood the work.

**Importance of self-care and support.** Every participant reported how they had experienced a stressful event at work that left them upset long after they had left work that day. Many participants spoke to the importance of self-care in coping with distressing events. For example, about self-care one participant said:

> Very important. It's crucial. And you can probably see the difference in the nurses that do do that regularly. Or the staff that do that regularly versus the ones that don't. Because their body's just more, like loose and smooth and like rejuvenated than somebody who's really tired and like, ugh, and hasn't done much.

Some participants explained how coping with their responses to distressing events becomes easier with time and practice. One participant said, “The more you do it, the recovery time is a lot faster.” Participants seem to strengthen their resiliency after having the opportunity to practice effective coping strategies.

**Specific self-care activities used.** All participants described specific self-care activities that they did inside and outside of work. At work, participants described taking a break by stepping outside, or distracting themselves for a few minutes with their phone in order to escape the world they were experiencing. Several participants described a routine they used upon leaving work, such as biking home or listening to music on the bus, that helped them to reflect or clear their minds after their shift. Outside of work participants described taking time to do activities like yoga, running, giving themselves treats, having a bath, or resting at home. Several participants said that they had considered seeing a therapist to discuss their experiences at work, but had not yet done so.

**Seeking support from others.** One of the main strategies participants described as being important to their self-care was to debrief with other people, "who are going through the same stuff." While one participant commented on the importance of "having a really strong family base and friend base," others expressed their preference to confide in other nursing staff because they have a belief that people outside of that world just do not understand. For example, one participant said:

> . . . definitely talking to friends and coworkers. I have some coworkers that are close friends but I don't like to share too much with my non-nursing friends just because in some ways like, I'm a vessel for sad stories, like there's so much that comes to me, like I wouldn't want to share these stories because then I might be releasing them to someone who just has no context, or even ability to understand, or just basically it can make people really sad.

This participant commented on her concern that sharing her stressful work events may be a burden to others and make them feel sad.

Participants described the importance of seeking support from colleagues when they are on shift. One participant described how, after particularly intense experiences, her colleagues check on her, and she checks on them to ensure everyone's well-being. She explained:

> I mean you do have that, initially have that edge and that's why we do check in with our coworkers, like hey, do you need a couple of minutes to walk it off? Or like, how was that for you? Like we always check in.

One participant explained that she debriefs with colleagues as a way to dispel what she called vicarious trauma. She described how she uses talking-with-others as a way to help herself cope. She said:

> You have to give it away! You can't keep it all! You have to dilute it into the world. Because having someone understand you and being listened to, like everyone likes being listened to. So just having someone listen to you and validate how you're feeling about something is really the most important thing, and my colleagues know better than anyone what it actually feels like, or how it plays out.

Participants considered relying on colleagues for support an important outlet because they had first-hand knowledge about what each other experiences at Insite.

# Chapter 5. Discussion

I conducted this qualitative phenomenological study to answer the question: What is the meaning of the lived experience of nurses who supervise the injection of illicit drugs in Vancouver's safe injection sites? In order to understand the meaning of study findings, I outline the (a) essence of the findings, (b) the four themes that emerged, (c) clinical implications, (d) limitations, and (e) future directions for research.

## 5.1. The Essence: Connection

The essence of the meaning of the lived experience of nurses who supervise the injection of illicit drugs in Vancouver's safe injection sites was *connection*. Connection was the underlying essential nature of the four themes that emerged from the data. The heart of participants' experiences providing education and treatment to clients was about connecting with those clients on an individual level, and facilitating connection with an isolated and marginalized community of people. The central meaning of these connections for nurses was to satisfy their need to fight against the social injustice of their clients being excluded from society. Nurses expressed a strong belief that there were no "disposable" people, and expressed a passion to show their clients, and the greater community, that everyone is worthy of respect, dignity, and care. Through connection, nurses expressed how they were striving for social cohesion by building trust with individual clients, and between different groups in society to ensure that everyone felt a sense of belonging. Social cohesion describes a society that "works towards the well-being of all its members, fights exclusion and marginalization, creates a sense of belonging, promotes trust, and offers its members the opportunity of upward social mobility" (OECD Development Centre, 2012, p. 53).Participants' prioritization of personally connecting with people who were disconnected from mainstream society reflects their stance to reject stigmatization, segregation, and an us-versus-them perspective.

Nurses viewed harm reduction as integral to their work because it provided a client-centred framework that created the conditions necessary for connection and unity: openness, non-judgment, acceptance, normalization, and respect. Supervising injections was primarily discussed as an opportunity to connect with individual clients, and to connect with an entire marginalized community. Nurses spoke about the benefits they personally experienced through connecting with clients, and explained the meaning those connections gave to their work. The cost of those connections was the main challenge that nurses described in dealing with difficult clients. While they saw connection as the reason they do their work, they described how continual compassion took a toll on their well-being.

### 5.1.1. The Problem of Disconnection

The disconnection of marginalized people from society is not often discussed as being the main issue when looking at a struggling community that has a high prevalence of drug use, trauma, and homelessness (Braine, 2014; Cozzarelli, Wilkinson & Tagler, 2001). There is a strong stigma attached to drug use, and opponents to harm reduction approaches speak about their fear that engaging with people who use certain drugs will lead to an erosion of social goodness by enabling people to use those drugs (Buchanan, Shaw, Ford, et al., 2003; Strike, Myers, & Millson, 2004). While drug use is often seen as the primary concern in these communities, it is viewed by society as a moral issue rather than a health issue; this belief perpetuates the stigmatization of people who use drugs (Macneil & Pauly, 2011).

Canales (2000) explains how people who are stigmatized become labelled as *others* by society. This exclusionary process creates an us-versus-them perspective that leaves both groups seeing the marginalized *others* as less worthy, and less deserving of care, respect, and dignity. Regrettably, they are seen as the cause of society's problems. The disconnection between people in general society and stigmatized people acts as a barrier for the marginalized group to seek help, particularly with respect to health care (Butters & Erickson, 2003). It is this barrier that participants in the present study comment on most when speaking about wanting to engage with marginalized

people, fight exclusion, and show marginalized clients that they are worthy of care while they offer them support.

## 5.2. Themes

Four themes emerged from data analysis: (a) *creating social cohesion through the use of harm reduction,* (b) *opportunities for relationship-building during in-booth supervision,* (c) *balancing relationships and autonomy*, and (d) *working on the edge of trauma.* The meaning of each of these will be explored further, and this discussion will include how these structures of experience relate to the underlying essence of connection.

### 5.2.1. Creating Social Cohesion Through the Use of Harm Reduction

When asked about many aspects of their experience, nurses tended to comment on the nature of connecting with clients individually, as well as their experience connecting with the broader community in the downtown eastside. These connections were facilitated through the use of harm reduction. This theme encompasses how participants described using these relationships to bring different groups in society together. In order to understand the story this theme tells it is necessary to consider (a) what social cohesion is, (b) what motivated participants to strive for cohesion, and (c) how harm reduction served as a means to achieve social cohesion.

**What is social cohesion?** According to the OECD Development Centre (2012), social cohesion describes a society that "works towards the well-being of all its members, fights exclusion and marginalization, creates a sense of belonging, promotes trust, and offers its members the opportunity of upward social mobility" (p. 53). Participants in this study described how they use the harm reduction model to achieve many of these aspects of social cohesion. In order to understand participants' experiences in building relationships with individuals and facilitating connections across communities, it is important to explore two important aspects that make up social cohesion: social inclusion and social capital.

***Social inclusion.*** Social inclusion is defined by researchers as social relations and social structures that are just and enable opportunities for good health and well-being, and society-wide participation (Yanicki, Kushner, & Reutter, 2015). Social inclusion can be measured by a lack of things that exclude one group in society from belonging with the other (OECD Development Centre, 2012). For example, a society is seen to be more inclusive if there is less poverty, income inequality, discrimination, and social polarization. Nurses in this study described creating social inclusion by reaching out to a marginalized group and providing them with healthcare services that meet their specific needs; thus, ensuring that they receive healthcare like other members of society would.

One participant described Insite "as a place of safety" for clients, indicating that staff have created an environment of acceptance and fairness where clients are respected. Participants described using relationships with clients to increase their trust in the institutions of society (e.g., healthcare). Within the context of Insite, a sense of social inclusion was achieved, and an expansion of these equal opportunities is helpful, but not sufficient, in striving for social cohesion. Social inclusion involves engaging marginalized groups, and bringing them towards the rest of society, while social cohesion involves all of society coming together. Social cohesion involves the elements that bring people together such as trust and a sense of belonging, (OECD Development Centre, 2012).

***Social capital.*** According to Putnam (2000), social capital is about the connections between individuals and groups. Putnam argues that because humans are social creatures, we view social connections and the resources they come with as inherently valuable. Putnam's views on social capital support the experiences of nurses in this study, as they both describe how building respectful and trusting relationships facilitate a mutual benefit.

According to Putnam (2000), there are two types of social capital: social bonding and social bridging. Social bonding capital is concerned with strengthening the bonds within a group, which can increase social cohesion within the group, but may actually lead to increased segregation between groups. Social bridging capital involves connecting people who belong to different groups. Increasing connections between

groups is more effective in creating social cohesion because it provides a larger variety of interactions and resources offered. Nurses spoke specifically about using social bridging, as they described the importance of connecting clients, who belong to a marginalized group, with various facets of a healthcare system that accepts them. Through building these relationships with clients, nurses are increasing the social capital of both themselves and their clients.

The strength of social capital is seen through the abundance of relationships with others on an individual level, and the complexity and diversity of those relationships with respect to the age, socioeconomic background and group memberships of both parties. While social capital is a necessary component for the existence of social cohesion, it is not sufficient in creating social cohesion (Koonce, 2011). The nature of those relationships plays an important role in addressing inequality, exclusion, and building relationships that create a sense of trust and belonging that is necessary for social cohesion. Social capital refers to specific groups of individuals, while social cohesion includes all of society (OECD Development Centre, 2012).

Participants described two factors that contributed to the quality of their relationships with clients that had a transformative impact on individual clients and social cohesion. The first factor was the deep empathy participants expressed towards their clients. Canales (2000) argues in order for relationships to be transformative, they must involve nurses being able to take the role of the *other* (clients), so that they can act based on that client's "perceived individual and group attributes, rather than prejudices and stereotypes." ( p.25). Participants demonstrated the empathy they had for their clients through their passion and understanding of the struggles that clients face, and through their observations that there is little that separates their own life trajectories from those they help. The ability of nurses to see similarities between themselves and clients assisted them in empathizing and seeing clients as people who are worthy of the same rights that they have.

The second important factor was the sense of responsibility they expressed in using their power as nurses to fight marginalization through connection. According to Canales (2000), this process of using power within relationships is called *inclusionary*

*othering*. While *exclusionary othering* involves one party in a relationship using their power to control and dominate others, inclusionary othering involves creating "transformative relationships in which the consequences are consciousness raising, sense of community, shared power, and inclusion" (p. 25). Nurses experienced inclusionary othering through applying their power and knowledge as nurses to help and educate clients while respecting their right to maintain control over their own lives.

Both empathy and inclusionary othering are important factors in creating greater social cohesion. While social cohesion is a difficult construct to measure, Chan and Chan. (2006) argue that movement towards social cohesion is evident when people stick together and are able to manage conflict effectively. A sharing of power and a willingness to understand the experience of those who belong to a different social group are necessary components to create a healthier cohesive society. One participant's words demonstrated this clearly when she said: "the health of communities does not improve with increasing isolation; it improves with increasing cohesion and collective energy." Nurses going beyond their role in helping individuals with their physical health is not new, there are many instances of nurses doing human rights and social justice work that has a transformative impact on communities as a whole (Paterson, Duffett-Leger, & Cruttenden, 2009; Pavlish, Ho, & Rounkle, 2012; Ridenour & Trautman, 2009). The Canadian Nurses Association also includes promoting justice as one of their seven values (*Code of Ethics for Registered Nurses,* 2008).

**What motivated a striving for cohesion?** Participants voiced their desire and intent to create social change that went beyond reducing harm. Participants expressed a passion for helping people, and a strong conviction that helping marginalized clients was the right thing to do. When participants commented on the value of human life and human dignity, they spoke about the presence of injustice when they saw people being treated without basic respect. Participants described incidents of these wrongs when they heard about clients being turned away from other services, the judgments of other health care providers, and a healthcare system that was not focused on connecting with people who are very disconnected. Participants commented on the importance of providing harm reduction materials and support, but they clearly expressed the prioritization of *engaging* with marginalized people as the most important factor in

helping them. Participants' experiences are consistent with Alexander (2008), who argues that engaging with people, and building respectful relationships with them is the underlying essence of harm reduction.

Lee and Petersen (2009) explain how demarginalization is an important component of engaging with isolated groups involved in problematic drug use. Demarginalization is a process by which those who are marginalized because of their drug use experience health care in a way that is non-judgmental, normalizing, humanizing, and destigmatizing (Lee, 2006). Participants in this study gave examples of demarginalization when describing the process of engaging and building strong respectful relationships with clients. One participant spoke about, 'raising the bar' with respect to how her clients are treated. Participants described being accepting, non-judgmental, respecting clients' rights, and normalizing their experiences of using drugs.

Seeing the social injustices that marginalized clients faced, nurses felt a strong desire to work with them, and fight against the inequality that they faced. Participants commented directly on how the struggles they saw clients go through were representative of a systemic problem. A great deal of evidence supports nurses' experiences that inequality is perpetuated through discriminatory policies that keep marginalized people from being accepted and included in mainstream society. These systemic impacts are evident in policies around the use of certain drugs; conditions for accessing health care; income and housing assistance; and discrimination based on ethnicity, gender, sexuality and socioeconomic status (Alexander, 2010; Carter & Macpherson, 2013; Palepu et al., 2013). In this study, nurses also explained how they witnessed or heard about judgmental and discriminatory interactions between clients and service providers in non-harm reduction focused healthcare. Participants found these individual interactions between nurses, doctors, or paramedics to be disturbing because clients were dismissed, and not offered help because of the healthcare providers' judgments. These experiences have been reported in other healthcare settings when clients were denied treatment, or given different treatment because of healthcare providers' personal judgments (Mclaughlin, Mckenna, & Leslie, 2000; Ronzani, Higgins-Biddle, & Furtado, 2009; Skinner, Feather, Freeman, & Roche, 2007).

Social cohesion involves reciprocal processes that encompass all of society. In striving for it, both nurses and clients were valued for their intrinsic worth as individuals. Several participants in this study commented on their similarities with clients, indicating how there were not many differences between them despite having taken very different paths in life. One participant explained her belief that both the clients and nurses who work at Insite, “have always been on the peripheral edges of social groups.” Through the reciprocal nature of social cohesion, nurses in this study may have experienced their work as overcoming an internal sense of marginalization. This demonstrates social cohesion at work as both groups move towards a sense of belonging.

Participants witnessed the inequalities and exclusion experienced by their clients. This led them to see the importance of connection with people who are trapped in the marginalized role of *other*. Seeing the impacts of disconnection first-hand, participants described their motivation to help people through inclusiveness, trust, and belonging rather than through segregation.

**Harm reduction as a means to achieve social cohesion.** Participants described being able to fight against inequality and facilitate connection with marginalized clients through the use of harm reduction. The four tenets of harm reduction created the necessary conditions for connection by instilling values that prioritized a respect for human worthiness and dignity. These four tenets related to key aspects of participants’ ability to connect with clients: (a) everyone deserves help and acceptance; (b) everyone deserves to make their own decisions; (c) getting to know the whole person; and (d) a prioritization of relationships.

***Everyone deserves help and acceptance.*** As harm reduction programs must be low threshold (Marlatt, 1998), they create an inclusive framework which considers everyone’s well-being. According to Pauly (2008), harm reduction assistance treats everyone as equal, rather than reserving resources and care for those who are deemed to be more deserving. Participants expressed the importance of this inclusiveness as “the right thing to do.” One participant described how it was horrifying when people were not able to access help because they were labelled as not deserving of it, often because of their drug use. Participants also spoke to the challenges of being inclusive and

allowing everyone to access services at Insite. Participants explained that they often work with people who are rejected from other services because they are difficult to work with. Keane (2003) asserts that harm reduction is value-neutral in that people involved refuse to hold moral views about drug use. Participants described using this essential component of harm reduction to be open to anyone who might walk into Insite.

Another aspect of harm reduction that participants described was a normalization of their client's drug use and associated behaviours. Tammi and Hurme (2007) note that one of the goals of harm reduction is to normalize drug use, and change how society views people who use drugs. Participants reported that their acceptance of drug use allowed clients to feel safe knowing that their actions were confidential and acceptable.

Participants found that they were also included and accepted in Vancouver's downtown eastside community. Participants described feeling privileged, lucky, and special to have earned trust and a place in a community where trust is hard to earn. This sense of belonging to the community demonstrates a perspective of *us* a whole, rather than an us-versus-them perspective. Feeling accepted and being willing to be accepted in a community of marginalized people is a step towards social cohesion.

Participants also described how they felt safe because they were a part of the community, and had witnessed clients looking out for their well-being. When both nurses and clients felt included as part of the same community, reciprocity developed between community members. This reciprocity was evident through both sides taking care of one another by providing knowledge and help for physical well-being, emotional support, and a sharing of resources and power.

***Everyone deserves to make their own decisions.*** A harm reduction framework requires a respect for client autonomy, and allows people to make their own decisions (Lee, Engstrom & Petersen, 2011). Participants in this study described how this was one of their most important values, and was also one of their biggest challenges in working with clients.

Several participants commented on how respecting client autonomy was an integral part of their connection with clients because it created a different balance of

power than if they were telling clients what to do and requiring that they comply in order to receive help. Other researchers also found nurses greatly strengthened their relationships by respecting client autonomy; being open and transparent about care decisions; and allowing clients to contribute to decisions made about their care (Belcher, 2008; De Bal, De Casterle, De Beer, & Gastmans, 2005). Despite reporting some struggles to be accepting of clients even after they made decisions that staff did not think were best, nurses reported working hard to respect clients' wishes. They demonstrated inclusionary othering as they used their professional authority to empower clients through education, rather than by controlling them.

Participants explained how educating clients about safer injection and health practices empowered them by allowing them to make informed decisions. Rather than using their power to take control of client's well-being and behaviours, they provided clients with the knowledge to take control of their own lives. According to Pauly (2008), harm reduction increases the value of personal responsibility to care for oneself. Similar to participants' reports in the present study, Berg and Daneilson (2007) found patients maintained their dignity by taking responsibility for their well-being and being committed to their care.

Participants described how it was rewarding and satisfying to witness clients learning how to take care of themselves. Participants also explained how this process made them think they were making a difference in people's lives. Trust was promoted as result of this shift in power, as clients felt safe being honest and open with staff because they knew that they would not be controlled or denied services if they made decisions that were not consistent with what staff wanted. Participants also reported a mutual respect that developed between them and clients demonstrating a sense of harmony and acceptance between the two different groups.

***Getting to know the whole person.*** Harm reduction takes a holistic stance and seeks to provide a strong platform from which to treat the whole person and not just their drug use (Lee, et al., 2011). Seeing clients holistically allowed nurses to help them in other areas of their lives such as with problems related to: housing, untreated wounds, violent relationships, legal problems, pregnancies, and emotional distress. Researchers

who looked at the various challenges injection drug users face found that assistance with nutrition, housing, intimate partner violence, and social isolation were all factors that contributed to their health and well-being (Anema, et al., 2010; Corneil, et al., 2006; Farris & Fenaughty, 2002). If nurses learn about these aspects of clients' lives, they have the opportunity to do more to help them. As participants described in this study, they took the time to get to know clients so that clients felt comfortable sharing other aspects of their lives that were not related to their drug use. Belcher (2008) received similar reports from nurses about taking the time to build relationships with clients and how it led to better healthcare because nurses were able to provide more holistic care.

Participants described how harm reduction had become a way of life both for them and their clients. Nurses described how harm reduction served as a framework so that both staff and clients knew and operated in accordance with it. One participant said: "it's a good model to be under because not only are you aware as a professional, but your clients are aware of it too, so you're on the same page." A harm reduction framework served as a guide for how nurses and clients could interact with one another, and participants spoke about how they followed the same principles in their own lives. Viewing harm reduction as a way of life enabled participants to create acceptance for themselves and for others. The ability for nurses to operate according to the same rules as their clients demonstrates an egalitarian approach that facilitated cohesion.

***Relationships as a priority.*** Harm reduction prioritizes building relationships as a necessary part of providing effective care (Griffiths, 2002). Participants spoke at length about how strong relationships made their job easier and improved care. Quality relationships helped participants to see their clients as people who deserved care, allowed them to be nonjudgmental, and greatly enhanced their enjoyment of the work. Trusting relationships improved the quality of care provided by helping nurses, ensure honesty from clients, increase the likelihood that clients would listen to medical advice, and help resolve crises.

On a broader scale, the presence of quality relationships promoted trust between healthcare providers and the larger marginalized community of drug users. Macneil and Pauly (2011) found that the stigma associated with being a barrier to accessing drug-

related services was reduced when trusted helpers provided those services. Participants spoke to their belief that there is great value in showing people they cared about them in addition to providing them with medical support. By caring for this marginalized group, participants described how clients felt good being included, and also how their caring served as a model for the rest of society how the clients were worthy of care and respect. Sherman and Purchase (2001), confirm this through their assertion that the value in having harm reduction services is that they serve as evidence that people care about injection drug users and recognize them as worthy. The findings of this study, and others (Macneil and Pauly, 2011; O'Brien, 2000) support the use of quality relationships in changing stigmatizing perspectives that promote marginalization and segregation within society. Nurses in this study reported how their use of relationships helped clients to feel normal and accepted while modelling an approach of *us*, rather than *us-versus-them*.

### 5.2.2. Opportunities for Relationship-Building during in-Booth-Supervision

Supervising injection at Insite provides nurses with the platform to strive for social cohesion through the use of harm reduction. Insite was seen as a place to achieve the goals of fighting disconnection, marginalization, and inequality by participants. One participant explained how this goal motivated her to pursue work at Insite. She said:

> I knew through my volunteer work I wanted to work with marginalized populations, people who are discriminated against, to kind of rebuild trust and that. Insite is a great model to be able to provide that kind of care, and so I, shortly after that went to nursing school, and then very aggressively pursued Insite, and here I am.

Participants described supervising injection as a means to an end that had little to do with drug use. Offering this service provided the opportunity to connect and build trust with people who lived in the margins of society so they would be included and the rest of society would accept them.

***An opportunity to connect.*** Supervising injections was viewed as being secondary to building rapport and connecting with clients. Participants described how

supervising injections was the means to achieving the goal of connection. They explained how offering this service was an opportunity to connect with individuals, as well as to connect with the marginalized community as a whole. Staff in a needle exchange program were able to build trust and connect with a community of injection drug users by building trusting relationships (Macneil & Pauly, 2011). Participants reported that they thought they were making a difference because they connected this marginalized community with healthcare.

Participants' personal views of supervising injection helped them feel connected to their clients. Participants did not express any negative moral judgements about using illicit drugs or supervising injection that may have impacted client's injection experience. Participants felt connected to their clients by viewing the injections as a way for people to manage their physical and emotional pain. They expressed the importance of teaching clients to safely use their coping tool of choice, and not pushing their own personal agendas on clients.

Participants described how supervising injection was an intimate experience as they were very physically close with clients, and clients were very vulnerable in those moments. As nurses held this vulnerability and respected it, they felt more connected to clients. Because of this intimate feeling, supervising injection may serve as a special avenue for nurses to connect with clients because it calls for clients to be vulnerable, leading to a very quick context of trust with the nurses.

Participants expressed being scared or uncomfortable when they first began supervision. For some participants, this fear related to the pressure to do a good job because any particular injection was extremely important for a client, and they wanted to avoid being responsible for it going poorly. Participants described how they eventually became very comfortable, and almost desensitized to the process because they were more concerned with clients' well-being in those moments rather than associating stigma or moral judgments with that particular behaviour.

### 5.2.3. Balancing Relationships and Autonomy

With the ultimate goal of achieving social cohesion, participants used the harm reduction framework and the act of supervising injections as an opportunity to build relationships with marginalized clients and the communities to which they belonged. This theme encompasses what it was like for participants when they worked towards social cohesion. Participants described balancing the closeness of relationships with clients and maintaining their own autonomy and that of their clients. Participants explained two key aspects of straddling this divide: (a) the benefits of connection for them and their clients and (b) the challenges of connection as they maintain autonomy.

**Benefits of connection.** As the heart of nurses' experience was about connection, relationships were the most discussed aspect of their work. Participants spoke about the benefits of connection for them personally, and for their clients. Participants reported feeling rewarded, excited, and satisfied experiencing trust and appreciation in relationships with clients. The importance of client-nurse relationships has also been well-established for nurses in other contexts such as in Intensive care units, and various hospital wards (Fu-Jin et al., 2008; Halcomb, Daly, Jackson & Davidson, 2004). The enjoyable parts of relationships with clients led to participants feeling pride, privileged, and increased commitment to their work. These findings are consistent with other research which also found nurses experienced reward and increased satisfaction at work when they had established strong rapport with a client (Belcher, 2008; De Bal, et al., 2005; Halcomb, et al., 2004). In a study with psychiatric nurses and their clients, researchers found that nurses and clients became more closely connected as trust developed in one another (O'Brien, 2000). Nurses in this study reported that the trust that developed felt good, and made their work easier.

In addition to making their work more enjoyable and meaningful, participants reported that the building of relationships improved the experience of care for clients. Similar to the findings of the present study, O'Brien (2000) found that psychiatric nurses reported how several aspects of their relationships improved care. These nurses reported how being present, allowing clients to use them, being seen as ordinary people, being concerned, and establishing trust were all necessary components to see improvements in their clients.

Validated by other research, participants in this study described several aspects of relationships that were important for improved care. For example, clients and healthcare providers increased clients' adherence to medical advice by building trusting relationships (Leonard, 2008; Rugkasa, Canvin, Sinclair, Sulman & Burns, 2014). Additionally, participants explained how humour was an important part of their connections with clients, describing how humour made the situation more enjoyable, and easier to deal with for both themselves and their clients. This was also found by Gunilla and van der Riet (2014) who describe how nurses' responses to client humour improved adherence to treatment. Consistent with O'Brien (2000), participants in this study found that relationships improved care by increasing client honesty. The presence of strong relationships helped clients to feel safe enough to disclose information that was uncomfortable or taboo.

Connection improved care because staff learned more about clients' lives outside of their drug use practices. Many other factors impacted clients' health and well-being, and building relationships provided nurses with the opportunity to learn about these other factors. Researchers found a decrease in the risky behaviours and an increase in the quality of life of injection drug users when they were able to have regular and nutritious meals, stable housing, and not be socially isolated (Anema, et al., 2010; Corneil, et al., 2006; Farris & Fenaughty, 2002).

Connections with clients helped nurses to cope when clients were difficult to work with. Having relationships with clients helped nurses to better predict what certain clients would do when they became belligerent or violent. Being able to predict client behaviour helped nurses to defuse dangerous situations and maintain safety. Having relationships with clients who were sometimes difficult also helped participants to have more compassion for them because they understood what was motivating them to act that way. Ultimately, strong relationships helped nurses to see clients as deserving of care even if they did not accept a client's behaviour in a given moment.

Participants discussed their experiences of how relationships with individual clients also facilitated a connection between healthcare and the entire community that clients belonged to. This increased social bridging capital as the two different groups

connected. One participant shared her experience of resuscitating someone who overdosed outside of Insite. She described how members of the community came to Insite to seek help for this person because the staff there were trusted and respected within the community. She explained how events like this one reminded her of the broad scope of the work, saying, “This is who we are, saving lives here with Insite. Even not just at Insite, like with the community in general, it gives you, it just reminds you that Insite is a place of *safety* for people.” Through caring, trusting relationships participants described how Insite has become a place for marginalized clients to connect with people who care about them. Similar to these findings, Macneil and Pauly (2011) found that injection drug users who connected with staff at a needle exchange program described the site as a safe haven. Injection drug users who participated in the needle exchange program in the above study reported feeling comfortable, safe, cared for, not judged, and not stigmatized, emphasizing how they felt trust for the staff there. The presence of these qualities helped individual clients connect with staff, and it also facilitated cohesion between people in a marginalized community with people who belong to a part of society with more power.

**Challenges of connection.** The challenges of connection can be seen through the difficulties participants described in building and maintaining relationships while ensuring the emotional and physical well-being of themselves as they worked with their clients. In this section, I discuss the challenges of caring in relation to (a) balancing helping with respecting client autonomy, and (b) challenges in setting boundaries.

***Balancing helping with respecting client autonomy.*** Participants explained how balancing the acts of providing help with respecting client autonomy were a challenge for them. They struggled to reserve their personal judgments about what was best for clients, tried to respect clients’ refusal for help, and worked towards empowering clients to care for themselves rather than creating a dependence on site staff. O’Brien (2000) found that community nurses who worked with a psychiatric population, experienced similar challenges. For example, they felt protective of their clients and wanted to help them as much as possible while respecting their vulnerability, and not using their power to ignore the client’s wishes.

***Challenges setting boundaries.*** Boundaries are the metaphorical walls that people place around themselves to keep others at a distance (Baron, 2001). Healthy boundaries are flexible, porous, and protect one's physical and emotional self. In the context of a relationship between nurses and clients, healthy boundaries outline the limits of the caring relationship between them.

Several participants reported difficulty in setting boundaries in order to maintain their physical and emotional safety when they experienced a strong desire to help clients. Peternelj-Taylor and Yonge (2003) explain how the desire to help is commonly a cause for boundary crossings or violations between nurses and clients. Participants reported concerns that setting boundaries with clients would push that client away, harm the relationship they had, and prevent the client seeking further help.

Even though setting boundaries was deemed necessary to protect themselves, nurses found the balance of doing this, while still maintaining the relationship, to be stressful and exhausting. O'Brien (2000) also found that nurses felt stressed and exhausted at always trying to be there for clients and maintain their supportive role.

### 5.2.4. Working on the Edge of Trauma

This theme includes the experiences of participants as they worked in an environment that had potential for violence, and worked very closely with clients who had experienced a great deal of trauma. Participants described how being connected with clients while experiencing trauma first-hand or secondarily took a toll on their well-being. In order to understand the costs of connecting with clients, it is important to explore nurses' experiences of: (a) traumatic stress, (b) secondary traumatic stress, (c) responses to traumatic stress, and (d) differences in empathic engagement.

**Traumatic stress.** Many of the dangerous events experienced by participants meet some of the criteria for traumatic events. Events are considered traumatic if they expose a person to actual or threatened death, serious injury, or sexual violation (American Psychological Association, 2013). Participants primarily described being exposed to serious injury, or the threat of serious injury. Their exposure to these

traumatic events tended to be first-hand, or they witnessed or heard about a colleague or client being harmed.

Balancing staff safety with opening the door to everyone in this low-threshold service was particularly concerning for nurses because of the number of unpredictable and possibly violent clients that use Insite. Because Insite's mandate is to keep the site low threshold, there is no security on site to protect staff or clients. This lack of security means staff must call the police if they decide a situation is too dangerous or difficult for them to handle. When staff and clients are not clear about what situations the police will be called for, clients may not feel safe enough to use the site because they are afraid about having to interact with the police. Keeping the site low-threshold means that repeatedly violent clients are allowed to return after being barred from other sites, or being barred from Insite for a short period of time. In addition to working with repeatedly violent clients, the other main concern for participants was a lack of staff unity in what to do with these types of clients.

**Secondary traumatic stress.** According to Figley (1995), secondary traumatic stress (STS) involves normal consequential behaviours and emotions that are a response to knowing about traumatic events experienced by someone else, and the stress that comes from trying to help someone who has experienced trauma. Signs of STS are characterized by a shift in the helper's feelings and behaviours immediately after witnessing the trauma and suffering of another. With STS, nurses may present with symptoms very much like what would be expected with a diagnosis of post-traumatic stress disorder (PTSD). The four symptom clusters of PTSD are intrusion or re-experiencing, avoidance, negative alterations in mood or cognitions, and increased arousal (American Psychiatric Association, 2013). Based on nurses' reports, STS is a possible result of their relationships with clients who have experienced a great deal of trauma. Several participants described hearing stories about client's experiences that caused, "sleepless nights." For example, one participant said:

> The worst, the *absolute* worst thing is when you see them come in the door crying, and you know what just happened. Like you *know*, it's just like your heart, like your stomach just drops into your chest because then you go in the treatment room and they tell you, 'oh I just woke up, I think I was raped, I don't know, or like I was just locked in a room, there were 3

> guys there and I don't know what happened, I was really drugged, and I just escaped that.' And you're just like, oh man, that is the darkest.

Another participant described the difficulty she had in seeing a client experience continual trauma. She said, "It can be hard sometimes. I worry about people. There are times, when someone's in an abusive relationship and we're seeing that female participant get abused over and over again."

Watching people suffer over time, and not being able to alleviate that suffering has been demonstrated to be very challenging for nurses in many settings (Halcomb, Daly, Jackson, & Davidson, 2004; Walsh & Buchanan, 2011). Participants also commented on the difficulty of witnessing people deteriorate over time as they became more and more ill. One participant explained that the most difficult experience for her was to witness someone's transition to a lifestyle that she thinks will lead to further trauma, illness, and suffering. She said:

> The thing that impacts me most when I watch somebody inject is watching the young women who are of kind of new. And they sort of lie to us about how experienced they are so that they can gain admission to the facility. And then you get to their booth to do their sort of injection admission intake, and you're just like, oh, this is not something that they've done a lot of times before. And so when we talk about, I mean we have some questions about what keeps you up at night? What are the experiences that are horrifying? It's when a particularly young woman. . . . like it sucks to see a really young bright beautiful woman with all kinds of inherent strengths who is attracted to this particular environment because it's more stimulating than where they were, because they believe it will be less traumatizing than where they were, or because to them it seems like an avenue of independence.

There was a sense of helplessness in what this participant described as she went on to explain how she copes with her distress seeing these young women. She said, "in the moment you kind of just perform like, it's a performance, you have to really set that aside, but I mean yeah, lots of sleepless nights there, like going home from a night shift and being like yeah." She expressed how there was nothing she could do to change that client's life course at that point, all she can do is help them with what they are willing to accept at the moment.

A great deal of research has demonstrated that nurses working in a variety of settings have been deeply affected by the vulnerable patients they work with who have experienced trauma (Dominguez-Gomez & Rutledge, 2009; Quinal, Harford, & Rutledge, 2009; Townsend & Campbell, 2009). A central part of the impact of working with patients who have suffered both physical and psychological trauma is a sense of helplessness that develops through the nurses' empathy towards clients. Research with nurses who work with patients who request euthanasia, and those who work on burn units (De Bal, et al., 2006; Kornhaber, & Wilson, 2011) have reported feelings of powerlessness as the primary source of distress. Several participants described similar experiences of powerlessness as they saw clients continue to come back over and over again, and watch while clients' health deteriorate due to continued drug use. While the job description of nurses who work in burn units is different from those who supervise the injection of illicit drugs, the nature of their interactions with patients is quite similar. Several participants also described problems when they became over-invested in trying to help clients and ended up feeling 'crushed' when they were not able to help in the way they wanted to due to clients' choices or life circumstances.

**Responses to traumatic stress.** In response to these traumatic events participants reported initially feeling shock, panic, fear, and worry for their safety. Participants described two methods of detaching themselves in order to cope with a distressing situation. The first type of detachment involved a disconnect between the participant and her emotions. This resulted in participants not being impacted by a distressing situation in the moment it was happening. One participant described being able to disconnect from her emotions when someone who was hostile yelled cruel and hurtful things at her. She described how in that moment she was able put up a wall between herself and her emotions so that clients could take out their anger on her without her taking it personally. Nurses in a setting with clients who self-harmed reported a similar ability to turn off their emotions when they became overwhelmed as a way to cope and continue the moment-to-moment work with difficult clients (Wilstrand, Lindgren, Gilje, & Olofsson, 2007).

The second method of detachment that participants described was a tendency to become very task-oriented in the moment in order to cope with the crisis in front of them.

They described not being aware of feeling anything in a moment of crisis, and becoming very task-oriented as they moved through the motions they were trained to do. Whitehead (2012) found that physicians working with palliative patients reported a "functional disconnect" that allowed them to disconnect from their own emotional responses, and from seeing the patient as a person. Becoming task-oriented, may also serve as a means to disconnect from clients in moments when feeling connected could get in the way of completing important care activities. Both of these methods were effective in helping participants do what needed to be done to defuse a hostile situation, or to help a client who was overdosing.

Participants reported having intense emotional responses after the event had ended, saying that at work and at home they sometimes felt shaky, anxious, exhausted, fuzzy, and would cry before returning work. Participants also reported having intrusive thoughts about their work. Some participants found themselves thinking about a negative interaction over and over again, dreaming about work, and experiencing distress when reminded of past incidents. Sometimes these experiences left participants: avoiding taking care of themselves, developing trouble sleeping, or questioning whether they should continue doing this work. Sometimes participants experienced these symptoms for days after the event, and sometimes they lasted for periods of several months. According to the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychological Association, 2013) many of these experiences meet the criteria for being problematic posttraumatic stress.

While some nurses reported experiencing symptoms of posttraumatic stress, they seemed very aware of the need to take care of themselves in response to these experiences. For example, one nurse shared her awareness of how the work impacts her. She said, "Things that mainly stick with me is the trauma someone relates . . . I think it's called secondary trauma. It's when you hear traumatic events you are kind of traumatized a little bit in a way." Participants also spoke at length about the importance of self-care and the need to give themselves time and space to cope with stress from work. The *clinical implications* section below will include ways in which staff at Insite can be best supported to effectively cope with these stressful experiences.

**Differences in empathic engagement.** The dangers of compassion and deep empathic engagement were demonstrated from participant's responses above. Based on their responses about connections with clients, the ability to use boundaries, and what they thought about the level of support provided at work, participants were found to vary on the amount of empathic engagement they used with clients. Whitehead, Pearson and Cave (2013), explain a *window of effective empathic engagement* in which helpers empathic connection with clients falls along a range between *empathic overarousal* and *empathic silencing*. They argue that the most effective empathy occurs when helpers fall in the middle of the two extremes in which they do not over-identify with clients, or experience an avoidance of empathizing with clients.

Some participants in this study who showed signs of over-identification with their clients explained how they had a difficult time setting boundaries with clients because they felt responsible for the client's satisfaction or well-being, and for the quality of the relationship. These participants also expressed how there was not enough support at Insite, and that team unity was a large problem. In contrast, several participants fell lower in the *window of effective empathic engagement* and described experiences that were closer to emotional silencing. These participants explained how after some practice they had no trouble setting boundaries, how they were less likely to stay in a potentially dangerous situation, and how they did not take on as much responsibility for clients. While still showing up to work and enjoying connecting with clients, they did not report engaging with clients as deeply as other participants. These participants reported they were satisfied with the amount of support they received at work, and they enjoyed the unity of their team of colleagues.

In considering these differences, it is important to note that all participants expressed the need for a formal debrief at work. Even those who felt well-supported at work reported struggling to cope due to the lack of time to do more than a quick 'check-in' with coworkers coming on and off shift.

## 5.3. Clinical Implications

### 5.3.1. Implications for Nurses

The findings of this study hold implications for the value of the nurse-client relationship in facilitating care for individuals, as well as connecting with people who are disconnected from healthcare and mainstream society. Nurses have the opportunity to participate in services like Insite to connect with and advocate for marginalized clients, while at the same time, contributing to broader social change. One participant commented on the importance of using the authority of her position to create change in policy that will allow the creation of more SIFs and expand their scope.

While nurses in this study reported how self-care was very important for them, many participants explained how their needs to debrief were not met. While some site-wide changes around supporting staff are important, nurses may also need to take more steps to protect themselves. Many nurses discussed how they used colleagues and friends and family outside of work to fill their need for debrief. Creating a wellness plan to outline strategies and their intentions with specific activities may also be helpful for nurses. Nurses may also need to use more preventative measures such as taking the initiative to learn about the warning signs of traumatic stress, exploring how their own responses to stress, reflecting on relational processes and use of boundaries at work and outside of work, and making time for regular relaxation rather than only using it when feeling unwell. Some participants described using preventative measures like these, while other participants only commented on using self-care when they noticed that they were feeling burnt-out. Viewing self-care as a professional responsibility may help nurses to take preventative measures in addressing how they can cope more effectively with traumatic experiences rather than dealing with the symptoms afterwards.

Moments of escape at work were also included in participants' descriptions of self-care. Several participants said it was helpful to step outside for a minute and into their own world--to use their phone, or go on social media for a few minutes to escape from a world of drug use and trauma. Being aware of what one's own small escapes are, and making time for them, may help nurses to cope with stress while at work.

In addition to nurses advocating for their clients, they can also advocate for themselves. By including themselves in their model of care, nurses can request the changes they want or need with respect to how staff are treated, what they may need for scheduling, taking leave, and maintaining safety. Several nurses expressed their satisfaction with management's positive response when they asked for part-time shifts, but many other concerns have not yet been resolved.

### 5.3.2. Implications for Counsellors

The implications of this research for counsellors working with healthcare providers is to understand the high intensity of this work, and challenges they may experience. Counsellors should approach working with these healthcare providers from a trauma-informed model as they may be experiencing the symptoms of traumatic stress or secondary traumatic stress. Psychoeducation about normal responses to trauma, and skill-building around coping with intense and dysregulated emotions should be integrated into counsellor's approach when working with this group.

Counsellors may also encounter healthcare providers who report challenges through their relationships with clients. Many participants in this study described boundaries as a solid wall between them and their client rather than a porous and flexible barrier. Further education about what healthy boundaries look like, the benefits they provide for both parties, and practice implementing them may be helpful for this group. This education may be conducted best through discussion with other nurses who experience the same situations. Facilitating discussion that helps nurses to explore what it is like when their use of boundaries is sufficient or insufficient, and what to do with those situations may be most helpful for them.

Counsellors need to be aware of how nurses doing this work may immediately respond to a dangerous interaction. Several participants reported becoming task-oriented when facing dangerous situations. They explained that after a moment of intense focus the emotions about the situation may be felt intensely. One participant described her belief that some of her colleagues find the danger at Insite to be stimulating, and that they may be drawn to this. Counsellors may need to explore if

some nurses are drawn to the danger of the environment because of a satisfaction in surviving it.

Counsellors who conduct therapy with nurses who do this work should consider group work as an option. Participants reported their desire to debrief with colleagues who have a deep understanding of what the work is like. Counsellors working with this group should also seek out resources that can inform them about what their client's work is like, and how they may best work with clients who work in community healthcare.

### 5.3.3. Implications for SIF Management

Working within a harm reduction model brings challenges as nurses are not always able to maintain safety while keeping the site low-threshold. Clearer rules around what is considered criminal activity and what is considered sanctioned criminal activity would help staff to make decisions when violence in the workplace becomes a problem. Participants described referring to their nursing code of ethics and the harm reduction model to make decisions in ethical dilemmas. They explained that non-nursing staff did not operate under the same guidelines and sometimes expressed preferring a different course of action. While appropriate protocol cannot be determined for every different situation, the creation of one code of ethics that combines the important parts if harm reduction and the nursing code of ethics for all Insite staff to follow could be helpful. This code should be created within the team so that it is consistent with their experiences, and serves a means to create cohesion among staff. When disagreements arise, all staff would be able to follow the same ethical decision-making model to determine the most ethical choice. Participants also expressed a strong need to debrief instances where ethical dilemmas caused division in staff, and sometimes created unsafe working conditions. Making time to address these issues in team meetings might be helpful in ensuring the safety of staff and clients and in creating more cohesion among staff.

Creating a culture where people value and accept self-care, is a professional responsibility. By approaching how self-care is treated by management, the culture around self-care can change. Some participants described how they felt ashamed when they had to take time off because of stress, or when they had to disengage from a client

to protect themselves. Because relationship-building is such an important part of nurses' work, they must view themselves as the instrument through which change happens. Viewing self-care as a professional responsibility to ensure the good functioning of that instrument is essential to creating a widespread acceptance that nurses need to prioritize their own well-being in order to help their clients.

The main issue that arose for participants in this study was a lack of a formal debrief at work. They described implementing various strategies to debrief on their own time, but the lack of a formal debrief was described as being problematic for nurses' mental well-being and for sharing important information about regular clients. While it may be difficult to allocate funding to set aside time for a formal debrief, management needs to make it a priority to ensure that nurses are best supported in their work. One participant suggested hiring another nurse to overlap the shift change, so that the morning shift could have some time to meet and discuss. If meeting as a team is difficult to organize, management could have a person on-site who is designated to be the debrief person at any given time. Employees who fill this position could be responsible for ensuring staff's well-being to share difficult stories, and also to collect information about clients who pose challenges for staff.

Participants described several logistical problems that make their work difficult. They explained how only having two nurses on shift left them struggling to complete tasks, and unable to take time to provide in-depth support to individual clients. They commented on how this makes their work difficult and had a negative impact on the quality of client care. More support is needed for nurses to do their work effectively. Hiring another nurse to overlap the shift change would alleviate some of the challenges associated with not having enough staff and provide opportunities for debriefing when early staff go off shift. Nurses also commented on several logistical barriers that they found frustrating because of their negative impact on client care. For example, they reported a desire to have more space to work individually with clients, be able to test drug content for clients, and have better protocols for clients who had been sexually assaulted.

## 5.4. Limitations

The purpose of a phenomenological approach is not to generalize findings to a larger population, as this approach seeks to understand the meaning of participants' lived experience; thus, generalizing the findings to larger populations is not possible. However, information gleaned from the findings can be used to gain a rich understanding of the meaning of a particular phenomenon as it is lived. While other qualitative research explores the experience of one or more participants, phenomenology reports on the common meaning of that experience for several individuals (Creswell, 2013). This approach considers *what* was experienced, and *how* it was experienced, allowing the development of a depth of understanding about human experience as it is lived.

While the participants in this study were from different ethnic and cultural backgrounds, all participants were female. Participants also varied in the amount that they worked at Insite, and unfortunately only one SIF was included in this study. Greater diversity in participant backgrounds and sites for data collection would ensure greater triangulation of data, thus increasing credibility.

The benefits of this research have been to gain an understanding of nurses' experiences working in SIFs, and what those experiences mean for them. Several participants said participating in the study was enjoyable for them because they were able to hear themselves talk about some of the things they struggled with at work. They also explained how participating provided them with the opportunity to reflect upon how they were impacted by the work.

## 5.5. Future Directions

A vast amount of research has been conducted with the clients of Insite regarding the overall effectiveness of the site for clients and the community (Hedrich, 2004; Kerr et al., 2005; Krusi, Small, Wood, Kerr, 2009; Semaan et al., 2011; Stoltz et al., 2007). At the current time there is very little research focused on staff experiences of working in any safe injection facilities. This research demonstrated that nurses, and the

relationships they build with clients, are an extremely important part of clients' success. Relationships with clients were also reported to be an essential part of why staff wanted to work in the community, and what kept them committed to the work.

Advocating for the rights of individual clients and working to change society's perception of injection drug users was an important part of participants' experience. Nurses in this study advocated for clients by empowering them and respecting their autonomy. Further research into the components of advocating for marginalized clients through empowerment would be informative in understanding nurses' role in social justice.

The intensity of the work seems to have an impact on staff retention, as many participants explained how it was necessary to limit the amount of time they worked at Insite in order to avoid what they called burnout. More research needs to be done to explore factors of resiliency in nurses who work in similar settings in order to provide information about what differentiates nurses who continue to do the work over longer periods, and those who leave the workplace after a shorter time. Factors impacting resiliency are also important to explore in terms of what would be most effective in supporting nurses doing this work, so that staff turnover is reduced. This is especially important in terms of the effort nurses make in building relationships with the clients and their larger community. Nurses spoke about the challenges of building relationships with clients with whom it was difficult to earn trust; thus, time is needed for these bonds to form. Research examining what factors improve resiliency in nurses and decrease staff turnover would help in understanding what affects the quality of relationships between staff and clients.

Participants in this study commented on their experiences outside of community-based nursing (i.e., working in hospitals). In their discussion of the two different approaches to healthcare they spoke about how the community model fits well for them, and they also explained how they disagreed with the approach to care that is used in hospitals. They described being very uncomfortable with the judgmental attitudes of other healthcare providers in hospital settings, and complained about how other nurses looked down on injection drug users. This points to implications for division that may be

present within the culture of nursing. Further research to explore how nurses may be marginalized or stigmatized when they supervise the injection of illicit drugs, or work closely with stigmatized groups, is important. Possible stigmatization of these nurses may occur within the culture of nursing, as well as in the broader community.

This research could be broadened to include other healthcare professionals who interact with the same population in similar roles. For example, healthcare providers in needle exchanges and clinics that serve marginalized communities with heavy drug use could be included to explore the environmental circumstances that allow for strong relationships to form between clients and healthcare providers.

## 5.6. Conclusion

As a helper in a field other than nursing, I found that many of the experiences nurses described resonated with me. Through my volunteer role at the Dr. Peter Centre, an organization that provides an SIF, I had an idea of what it could be like for nurses who reported their experiences. I was surprised by nurses' response to regular clients who disappeared. At the Dr. Peter Centre my experience of what happens when clients disappear is very different than what takes place at Insite because staff at Insite are prevented from searching for the person unlike at the Dr. Peter Centre. Because of these restrictions, participants reported how they were not upset by disappearances, but rather, how they just hoped for the best. Additionally, while I thought that relationships would play a very large and important role of nurses' experiences, I was surprised at the extent to which nurses discussed this aspect of their experience. Nearly every question asked during the interview was met with a response about nurse-client relationships.

The findings of this study demonstrate the importance of nurses' prioritization of the building and maintenance of relationships with injection drug users beyond the importance of other treatment goals (i.e., prioritizing social justice via connection over traditional approaches of getting people to stop using drugs). Nurses' facilitation of this connection served as a means of broader social change that demonstrated their active participation in social justice work. Supervised injection facilities provide the opportunity for healthcare providers to connect with a highly marginalized group, and include them in

the rest of society by creating trust and a sense of belonging for people in those groups. Participants described fighting social exclusion and stigmatization by working against a dehumanizing discourse that views some people as being less worthy than others. Nurses found that striving for these systemic changes brought a great deal of meaning and reward to them personally. They also reported many struggles in connecting with people who were sometimes difficult to connect with. The costs of continued compassionate connection threaten nurses' ability to continue striving for these changes. As a result, nurses in these settings need far more support, and must include themselves in the circle of care they create so deeply and sincerely for their clients. The ultimate rejection of an us-versus-them mentality means nurses' approach to the provision of care is a reciprocal action--they are also impacted by interactions with their clients, and they matter as an important part of a mutual need for care.

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# Appendix A.

# Recruitment Poster

Application number: 2014s0027

**Simon Fraser University**

SFU

## Attention Nurses:

**Would you like to participate in a research study looking at nurses' experience supervising the injection of illicit drugs?**

Researchers at Simon Fraser University (SFU) are looking for volunteers to participate in a study that asks nurses about their experience supervising injection at work. This information will be helpful in understanding how this unique experience impacts nurses working in safe injection facilities. We believe that this information will provide insight into the types of difficulties that nurses face, and how to best support them in their work.

### Participation

We are currently inviting registered nurses or nurse-practitioners who have supervised at least 20 injections over a period of 6 months to share their experiences. A one-time interview of 50-60 minutes will provide you with the opportunity to share your experiences supervising injection and working within a harm reduction framework. Interviews will be scheduled at your convenience and will take place at your work place or at one of SFU's campuses in Burnaby, Surrey or downtown Vancouver. All interview questions will be given to you in advance.

If you would like further information or would like to participate please contact the principle investigator, Jennifer Vishloff.

[redacted]

[redacted]

Version Date Mar 1, 2014

# Appendix B.

# Informed Consent

Application number: 2014s0027

**Simon Fraser University**

SFU

## RESEARCH STUDY INFORMATION and CONSENT TO PARTICIPATE

PROJECT TITLE: **A Phenomenological Examination of Nurses' Experience Supervising the Injection of Illicit Drugs.**


INVESTIGATORS:

| | | | |
|---|---|---|---|
| Jennifer Vishloff, B.A. | SFU | Principal Investigator | [redacted] |
| Patrice Keats, Ph.D. | SFU | Co-Investigator | |


Simon Fraser University and the project researchers subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort, and safety of study participants. This form and the information it contains are given to you for your own protection and full understanding of the procedures. Your signature on this form will indicate that you have received a document, which describes the procedures, possible risks, and benefits of this research project, that you have had adequate opportunity to consider the information in the document, and that you voluntarily agree to participate in this project. You can refuse to participate or withdraw from the study at any time.

**Purpose**

This study will investigate the individual experiences of nurses who supervise the injection of illicit drugs in safe injection facilities located in Vancouver, BC. This information will be helpful in understanding how this unique experience impacts nurses working in safe injection facilities. We believe that this information will provide insight into the types of difficulties that nurses face, and how to best support them in their work.

**Participation**

All participants must be registered nurses or nurse practitioners who have worked in a facility in which they regularly supervise the injection of illicit drugs. Participants must have occupied this position for a minimum of six months, and must have supervised at least twenty injections with at least five different clients to ensure they have adequate experiences that can be commented on.

If you choose to participate you will be asked to sit down with a researcher for a one-hour period during which we will ask you questions about your experiences supervising patients while they inject illicit drugs. You are not required or encouraged to breach the confidentiality of your patient's privacy, as we will ask about *your* experiences working with clients, as well as your experiences working within an organization that operates from a harm reduction model. You may find that some of the questions that we ask may seem too sensitive or personal. You do not have to answer any questions that you do not want to, and you do not have to provide a reason why. The audio from all interviews will be recorded so that they can be transcribed for better understanding of the information that you provide.

# Simon Fraser University

SFU

**Risks and Benefits**
The risks of this study are related to the specific information you choose to provide in interviews. You may find that discussing some of the challenging and/or traumatic incidents that you have experienced at work to be upsetting and stressful during or after the interview. If this does happen, please inform the researcher you meet or any other individuals whose contact information is recorded on this form so that we can offer you assistance through self-care activities, counselling referrals, or other services you may require.

There is also a chance that colleagues at your work may ask you if you have participated in this study and wonder what it was like. While we do not disclose or publish any identifying information about your participation with others, you may choose to answer their questions at your discretion.

The findings of this study will be used as part of a Master of Art thesis project and may be published in academic journals or presented at academic conferences once complete. The results may provide a greater understanding about the unique experience of supervising the injection of illicit drugs so that effective support can be provided to nurses who may experience work related stress. The findings of this study may also inform practitioners' protocols and bring to light any difficulties with current protocols at safe injection facilities.

**Confidentiality**
Any information you provide will be kept confidential to the full extent of the law in Canada. The information you provide will be given a code number, and your name will not appear on any papers or documents that contain information that you have provided. The audio recordings will be uploaded to a computer that is not connected to the internet and that is kept in a locked room.

All materials will be held in secure locations and destroyed through shredding any papers and destroying any audio files after a seven (7) year period. However, it is possible that, as a result of legal action, the researchers may be required to divulge information obtained in the course of this research to a court or other legal body if any harm to a child, another person, or yourself is disclosed.

**Compensation**
You will receive a $15 gift card to a coffee shop as compensation for your participation in this study.

**Contact**
You can contact the principal investigator, Jennifer Vishloff, at [redacted] or [redacted] if you have any questions or would like more information about the study. Any concerns or complaints about the study may be brought to Dr. Jeffrey Toward, Director, Office of Research Ethics at [redacted] or [redacted]

# Appendix C.

# Pre-Interview Questionnaire

Application: 2014s0027 Participant ID: _____

**Pre-Interview Questionnaire**

Age _____

Sex _____

How do you identify your position? (Circle one)

Registered nurse Nurse Practitioner Other (specify)_____

What organization(s) do you work for in which you supervise the injection of illicit drugs?

_____

How long have you worked there? _____

Approximately how much of your work day is spent supervising injections? _____

_____

_____

Roughly how many injections have you supervised? (Circle one)

1-20 20-40 40 +

Do you think you have adequate supports to deal with work-related stress? YES/NO

Have you ever experienced a stressful event at work that upset you long after you left work that day? YES/NO

Have you ever had a client overdose while you were supervising injection? YES/NO

Version Date: March 1, 2014

# Appendix D.

# Interview Protocol

Application: 2014s0027

## Interview Protocol

**Research Question:** What is the meaning of the lived experience of nurses who supervise the injection of illicit drugs in Vancouver's safe injection sites?

**I. Information and Consent Script**

*As you are aware, the purpose of my study is to explore the experiences of nurses who supervise the injection of illicit drugs. As a participant, I will be asking you some open-ended questions, so that I can understand what it was like for you, what you might struggle with, and how you describe your experiences.*

*Prior to the interview, I just want to let you know that some people find they become emotional when they are discussing more difficult aspects of supervising injections and working closely with the clients who come to the Dr. Peter Centre/Insite. If you find you are having an uncomfortable emotional response, just let me know and we will talk about what would best help you before resuming the interview.*

Go over consent form with participants and answer any questions that they may have. Sign consent (turn on recorder and say the date, interviewer name, location, and participant ID).

**II. Interview Questions**

- What makes you want to do this type of work?
- How do your perceptions of harm reduction models relate to your work in safe injection facilities?
- What is your most memorable experience supervising injection at (Insite/Dr. Peter Centre)? What was it about the experience that made it memorable or meaningful?
- What types of experiences stay with you from this work? Describe one experience in particular.
- What is your experience with clients who come back over and over again?
- What is your experience with clients who have been regular participants in the program and then suddenly disappear?
- How would you describe your relationships with clients? What are the best parts? What are the worst parts?

**III. Check-In and conclusion**

1. How are you doing now that we are coming to the end of the interview? Emotionally upset? Yes_____ No _____

2. (If yes) Are you still feeling upset or do you feel alright now?

3. (If yes) Are you willing to contact the psychological assistance that is available to you?

Version Date: March 1, 2014

# Appendix E.

# Resources

## Resources

If you are member of Providence Health Care you are eligible for individual therapy sessions with registered psychologists and certified counsellors.

For more information or to make an appointment contact [redacted] at: [redacted].

http://www.practitionerrenewal.ca/individual_counselling.shtml

If you are an employee of Vancouver Coastal Health you can access services through the employee and family assistance program at http://www.efap.ca/

They offer individual or group debriefing for critical incidents (eg. Death of a patient) as well as short-term individual or group counselling.

If you need immediate assistance you can contact the Vancouver Crisis Line 24 hours a day at [redacted].

## Self-Care Strategies

If you find yourself experiencing a flashback to an upsetting experience and notice yourself drifting away from the present moment you can use grounding techniques. Grounding helps to bring you back to the present moment by directing your attention so something in the present rather than the past.

Here are some examples of grounding:

- Touch objects around you and describe what they feel or look like.
- Run water over your hands and describe how it feels.
- Look around the room you are in and list 5 things that you see, then 5 things that you hear, then 5 things that you feel (Eg. I feel the ground beneath my feet, I feel the softness of the couch, I feel the roughness of my coat...).
- Say the alphabet backwards.

Other self-care activities include things you know have worked for you in the past. Perhaps reaching out to a friend or partner and telling them what you are going through. Engaging in exercise, cooking, reading, or watching tv.