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EFFECTIVE NURSING RECOVERY-ORIENTED INTERVENTIONS FOR INDIVIDUALS WITH SUBSTANCE USE DISORDERS

BY

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Abstract

Nurses support the recovery of individuals with substance use disorder. However, negative attitudes adopted by nurses discourage individuals who use substances from accessing healthcare services, experiencing further health deterioration. Alternatively, nurses can enact interventions that support the recovery of individuals. Hence, it is beneficial to increase nurses' awareness of effective interventions that promote recovery. Based on the review of literature, there is a lack of Canadian studies that examine the nursing perspective. Moreover, recovery-oriented nursing interventions can be more frequently or exclusively applied within distinct settings (inpatient, outpatient, and community). These factors enhance the importance of a study examining how Canadian nurses effectively intervene with individuals with substance use disorder. The purpose of this study was to utilize Qualitative Description to explore effective nursing interventions from the perspective of inpatient nurses. Purposive sampling was utilized, and data was collected using semi-structured interviews. Lastly, data was analyzed using Qualitative Content Analysis.

Keywords: substance abuse, addiction, acute mental health, recovery, nursing role

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Chapter 1: Introduction

For various reasons such as curiosity, pleasure, relief, or better performance, individuals consume substances in their life. Substances can be those that are legal such as alcohol, cannabis, and caffeine; there are those that are considered controlled and illegal such as heroin, methamphetamines, and hallucinogens (Controlled and Illegal Drugs, 2021). Although not everyone develops a Substance Use Disorder [1] (SUD) or an addiction, a survey completed in 2012 (Pearson et al., 2013) estimated that about 1 out of 5 Canadians, 15 years of age and older met a criteria of SUD in their lifetime. SUD is defined as a "…cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues using the substances despite significant substance-related problems" (American Psychiatric Association [APA], 2013, p.483). SUDs have many consequences such as physical injuries, cognitive changes, interpersonal problems, financial hardships, unstable housing, and legal challenges. Between 2015 and 2017, healthcare costs, loss of productivity, criminal justice issues, and other direct costs of substance use amounted to 46 billion dollars (Canadian Substance Use Costs and Harms Scientific Working Group [CSUCHSWG], 2020), making it a costly illness to the Canadian society.

Although individuals with SUD seek help, they experience discrimination and stigmatization from healthcare providers (van Boekel et al., 2013). The stigmatizing experience from health care providers may lead to avoidance and delay in seeking mental health care which increases exposure to more consequences and worsening conditions (Mundy, 2012). Goffman (1968) proposed that stigma arises from a negatively perceived social attribute leading to the co-occurrence of labelling, stereotyping, separation, and social power. The stigma experienced by individuals who struggle with SUD can be explained by the moralization of substance use. Moralization is the modification of a preference into a value within a culture (Rozin & Singh,

1999). The use of substances is often viewed as a choice; much like what a person may eat in the morning. However, if behaviours lead to negative consequences, one attempts to stop or reduce the behaviour. For example, one may reduce the croissants eaten in the morning due to weight gain. Yet, Individuals with Substance Use Disorders (ISUD) have impaired control (APA, 2013) and may possess challenges with discontinuing a behaviour even if they want to. Hence, the continued substance use despite the consequences leads to a misconception that these individuals are responsible for their condition (Frank & Nagel, 2017). However, the conception of the disease model of addiction has contributed to the demoralization of addiction. The model proposes that substance use leads to changes in the brain systems responsible for reward, behaviour, and control (APA, 2013). The changes in the brain provides an explanation of why it is difficult to reduce and abstain from substance use thereby diminishing person-blaming (Lewis, 2016). Even with this advancement, addiction remains a moralized concept.

Nurses may hold stigmatizing and negative attitudes towards SUD clients (Russell et al., 2017). This is concerning as nurses are the largest group of health care providers in Canada (Canadian Nurses Association, 2013). Fortunately, nurses can specialize in psychiatry and learn how to effectively intervene with ISUD. Nursing interventions can focus on reinforcing and sustaining recovery capital, the internal (human and physical) and external factors (social and cultural) that assist one's recovery with SUD (White & Cloud, 2008) (promoting recovery capital can be difficult in inpatient settings due to a short duration of admission and frequent staffing changes). Moreover, effective interventions that promote the recovery of ISUD can be theorized within articles, guidelines, and other resources, but expertise in providing addiction care is acquired and a contextualized competency. Knowing what, when, how, and why interventions are implemented is vital to the success of such interventions. To illustrate the impact of nursing

interventions, I present three clinical case experiences that promoted the recovery of some individuals with which I previously worked.

Apprehension with treatment due to previous experiences

A young client presented to the clinic who used an extensive amount of opioids that they usually obtained from the "street". This individual used substances daily and usually injected opioids. This person had accessed treatment at another organization before but explained that they were not "properly" supported with Buprenorphine, an opioid replacement therapy. The client had Buprenorphine administered prematurely, which induced very uncomfortable withdrawal symptoms (precipitated withdrawal) and led to this person not pursuing this treatment further and subsequently, started using opioids again.

After recognizing this history, I sat down with the patient and discussed their concerns, fears, and experiences. I explained the different options that we could take and suggested that although they had an unfortunate experience in the past, we could certainly try doing a Buprenorphine induction again. I provided information about the medication's pharmacological properties, the induction process, what they could expect when we do the induction, and ways that we could prevent the previous experience from reoccurring. Reluctantly, this person agreed.

Although this person had many fears, they showed up on the day as planned. I reviewed the process and expectations again. I conducted withdrawal assessments as they presented and when it was appropriate to provide the medication, I had a discussion with the patient regarding their past experience. I proposed that we could delay the administration of Buprenorphine for another 1-2 hours to ensure that they do not experience precipitated withdrawal, but only if they were comfortable with this plan. They agreed and after some time, I administered the medication, with no adverse outcomes. The induction process was a success! This person was

thankful for the process, returned to the clinic, and was able to achieve a stable dose of the medication.

By doing appropriate assessments, utilizing the person's experience, and providing choice and education, I was able to provide a more comfortable treatment experience which resulted in the person achieving an alternative to their opioid use.

The importance of therapeutic relationships

A client who used oral opioids daily had been coming to the clinic for many years. Their opioid use was complicated with challenges of pain and a diagnosis of Borderline Personality Disorder. When I started working with this person, they were already on Methadone.

In one instance, they presented to the clinic in distress. As I was speaking with this person, they begin to raise their voice and became verbally abusive towards me. As I listened to the person, I validated their experience, yet I provided boundaries and clear expectations regarding behaviour with other clients and staff. Additionally, I highlighted that I was here to support them and would do everything I could do to provide that support. They were apologetic and disclosed that due to stress, they consumed an additional dose of Methadone. I conducted an immediate safety assessment and suggested that we would ensure their continued safety while considering how to manage future doses. They were thankful, and we were able to manage that incident. I kept seeing this patient whenever they came into the clinic and they would seek me out whenever they could.

In another instance, this same person was in distress and they informed me that they had injected opioids for the first time. I validated their experiences and reassured them that there can be challenges with substance use and although they injected, we would support them in their recovery journey. Again, that incident was managed, and the person kept returning to the clinic

and appropriately, was able to come in less frequently over time. They were able to achieve a stable dose of Methadone and utilized skills that they had learned.

By being nonjudgmental and patient, I was able to continue to build a therapeutic relationship with this patient. This resulted in the person continually seeking me out and being forthcoming with their challenges, and thus, I was able to support their recovery journey.

Recovery goals beyond the substance use

Over a couple of years, I established a relationship with an individual who kept coming into the clinic. Our conversations tended to focus on their substance use, medical challenges, and issues with housing. As we developed a relationship, I started asking about other aspects of their life. I focused on what they were trying to accomplish and any educational or vocational goals. They shared with me that they were so thankful for the support they received in our clinic that they would actually like to look at pursuing either an education or a career in addictions. We spoke about next steps they were undertaking regarding this, looked at resources, and agreed that we were going to revisit this whenever they came in.

Whenever this person came in, they were very excited to share developments regarding this goal. We reviewed their progress toward their goal and any supports I could provide. At times that I was not able to see them, they would stop me in the hallway and give me a quick update. One day when we were connecting, they informed me that they were currently going to school - a case worker program - and that they were now also employed as a peer worker in an addiction program.

By focusing on another aspect of their life, I was able to empower and instill hope, establishing goals that the person achieved.

My clinical experiences have shown me how nurses can have an extraordinary impact on the recovery and lives of ISUD. However, specific training is needed to develop expertise to work with ISUD. Moreover, there are various factors that may impact the effectiveness of nurses' interventions when working with ISUD. However, I was trained in this field and was able to develop expertise to work with ISUD. For instance, although there are theories, models, and guidelines that nurses can use when supporting ISUD, they may not fit the environments where nurses work. For example, some organizations have not adopted a recovery model, yet have policies that do not support addiction care, or have a milieu with competing priorities that present challenges when caring for ISUD. Additionally, nurses may deem certain interventions to be effective which may be contrary to the clients' perception of effective supports. For example, nurses may endorse the use of opioid maintenance therapy or provide psychoeducation about pharmacotherapy even though this does not fit the person's goals. Additionally, nursing practices may be developed before evidence-based research supports the usage of these practices; thus, nurses may be implementing novel and unsupported interventions when working with ISUD. Hence, it is important to explore evidence informed effective nursing interventions and practices that promote the recovery of ISUD. This study will equip nurses who provide care to ISUD with ways to effectively facilitate recovery; ultimately, improving the healthcare provided to ISUD.

Author's Positionality

To contextualize the conception of this research project and different phases of the research process, it is important to discuss the author's positionality. Currently, I am an advanced practice clinical leader at the academic psychiatric teaching hospital in Toronto where I conducted the study; this gave me familiarity with the current issues, policies, and context within the organization. Additionally, I am a trained addiction nurse with various experiences in the

community, and in inpatient, outpatient, and emergency psychiatric departments. I became interested in this topic when individuals who struggled with substance use shared their not so positive, stigmatizing, and dehumanizing experiences in non-specialized psychiatric units and specialized psychiatric units. I utilize the lenses of person-centred, strengths-based, equity, and social justice when providing nursing care and would like these individuals to receive the best care they can receive. I feel privileged to be working with resilient individuals who encounter many barriers and challenges. Lastly, I want to acknowledge my privilege in being able to achieve higher education and ability to conduct research at my facility. Overall, I aim to improve the care of individuals who struggle with substance use and ultimately improve the healthcare system.

Purpose

The purpose of this qualitative descriptive study was to describe the effective recovery-oriented nursing interventions that inpatient nurses apply in an academic teaching hospital in Toronto. For this research, recovery-oriented interventions will generally be defined as any behaviours, actions, or interventions that support the recovery of ISUD. While the effectiveness of interventions can have different meanings for different individuals, they are considered effective when they help ISUD progress towards their goals or recovery.

Research Questions

The central question is:

What actions, behaviours, and interventions in inpatient settings enacted by inpatient nurses promoted the recovery of ISUD within an academic teaching psychiatric hospital in Toronto – Centre for Addiction and Mental Health (CAMH)?

The sub questions are:

How do nurses view recovery?

How do nurses demonstrate recovery principles?

Are there any specific theories or models that nurses use when working with ISUD?

Are there recovery-oriented actions that are applied more frequently?

How do these interventions promote recovery?

Are some interventions more effective than others?

Are there interventions more frequently applied depending on the setting?

Significance

This study highlighted effective recovery-oriented interventions that inpatient nurses at CAMH utilize when working with ISUD. This study also shed light on the theories, frameworks, models, and interventions nurses are utilizing in practice. Nurses may use the knowledge (of effective nursing interventions) acquired from this study, thus facilitating the recovery of, and improving the care for, individuals who struggle with substance use.

This study originated from hearing the negative experiences of ISUD that I worked with, I then reflected on positive and successful nursing interventions, and established the goal to improve the care ISUD receive. By focusing on what is working well and what has been effective, nurses can implement effective interventions to improve the care experience. The study furthers nursing science within the field of SUD and will help reduce stigmatizing experiences of ISUD.

Chapter 2: Manuscript – Literature Review

Manuscript Discussion

This master's thesis is completed using a manuscript-based style. It contains one article which is in press and one published article. The first manuscript which is currently in press discusses the literature review that supports the need to pursue the thesis. It analyses the current literature and future directions that can be taken. The second published manuscript discusses the methodology that I planned to employ within my thesis, qualitative description (QD). It discusses the different aspects of QD and argues that novice nurse researchers should consider the use of QD when conducting research. Both manuscripts are embedded within Chapter 2. Given that the second manuscript is a high-level overview of QD, I will also present the diverse components of the research that I employed for the thesis in Chapter 3.

Manuscript - Literature Review

The first manuscript is of a literature review completed during the independent study course. I completed the literature review independently under the guidance and review of Dr. Annette Lane. To further nursing science, we submitted the literature review to the *Journal of Addictions Nursing,* and it was accepted in December 2020. It is in press and awaiting publication.

Effective Nursing Recovery-Oriented Interventions for Individuals with Substance Use Disorder: A Literature Review

Accessible Summary

What is known on the subject?

- Recovery is a routinely applied concept when working with individuals with substance use issues.
- Depending on the nurse's viewpoint of recovery, interventions vary; some being ineffective and some being successful.
- There are recovery guidelines, models, and frameworks that nurses may utilize. However, there is a lack of literature that examines its application and effectiveness when working with individuals with substance use disorders.

What the paper adds to existing knowledge?

- Effective nursing interventions are rooted in the themes: person-centred care, empowerment, and enhancing supports and capability.
- Some nursing interventions were more prominent from the perspectives of nurses and individuals with substance use disorder.
- Some effective nursing interventions are often disregarded.

What are the implications for practice?

- Nurses should be mindful of the theoretical and philosophical background of their actions, behaviours, and interventions when working with individuals with substance use disorder.
- Nurses should utilize effective interventions identified by individuals with substance use disorders and may integrate interventions that are possibly overlooked.
- Researchers can explore the qualitative experiences of nurses and individuals with substance use disorders within the Canadian landscape.

Abstract

Introduction

Nurses support the recovery of individuals with substance use disorder. However, diverse perspectives of recovery lead to various interventions that maybe ineffective. Alternatively, nurses can enact interventions that promote positive experiences. Hence, it is beneficial to increase nurses' awareness of effective interventions that promote recovery.

Aim

To examine effective nursing interventions that promoted the recovery of individuals with substance use disorders

Method

A literature review was conducted, and thematic analysis approaches were used.

Results

Seventeen qualitative studies were included. Nine articles focused only on the perspective of individuals with substance use disorder, five focused on nursing perspective, and three included both perspectives.

Discussion

The review identified that effective interventions were based on three major themes: person-centred care, empowerment, and maintaining supports and capability enhancement. Additionally, literature revealed that some interventions were perceived to be more effective; this depended upon whose viewpoint was examined - nurses or individuals with substance use disorders. Lastly, there are interventions based on spirituality, culture, advocacy, and self-disclosure that are often disregarded but may be effective.

Implications for Practice

Nurses should utilize the more prominent interventions as they offer the most benefit and integrate interventions that are often overlooked.

Keywords: substance abuse, addiction, acute mental health, recovery, nursing role

Introduction

Substance use is a debilitating healthcare concern, impacting the physical, psychological, and social well-being of Canadians, through individual or familial experience. In 2012, approximately "…21.6% of Canadians met the criteria for a substance use disorder during their lifetime" (Pearson, Janz, & Ali, 2013). The overall healthcare-related cost, loss of productivity, criminal justice, and other direct costs of substance use amounted to 38.4 billion dollars in 2014 (Canadian Substance Use Costs and Harms Scientific Working Group [CSUCHSWG], 2018). Between 2007-2014, healthcare costs increased and represented almost 30% (11.1 billion dollars) of the total cost in 2014 (CSUCHSWG, 2018), making it a costly illness to Canadians.

Individuals with substance use disorder (ISUD) can recover without some form of treatment (Klingemann, Sobell, & Sobell, 2010), however, there are those who seek support from clinicians. Still, ISUD often experience discrimination and stigmatization from healthcare providers (van Boekel, Brouwers, van Weeghel, & Garretsen, 2013). The stigmatizing experience leads to delay and avoidance of healthcare, increasing exposure to consequences and worsening conditions (Mundy, 2012). Since nurses are the largest group of healthcare providers in Canada (Canadian Nurses Association, 2013), nurses are well suited to provide care to ISUD. However, nurses are not immune to stigma and hold negative attitudes towards ISUD (Russell et al., 2017). These attitudes are exhibited in the form of behaviour or actions towards ISUD which can be detrimental to facilitating improvement for ISUD. To mitigate negative attitudes when caring for ISUD, nurses apply the concept of recovery.

Recovery is a routinely applied concept to the area of mental health; it originated from the 1960s and 1970s, driven by service users' oppressive experience with the mental health system (Piat & Sabetti, 2012). The previous system was mainly based on the perspectives of

professionals such as academics, lawyers, and psychiatrists (Tomes, 2006), which minimized the input of those within the system. The deficits within the mental health system experienced by its service users were identified within two thousand personal stories, leading to the production of the report *Out of the Shadows at Last*; the document outlined a need to transform mental health services and adopt recovery-oriented practice (Kirby & Keon, 2006).

Recovery can be commonly viewed in two ways: clinical recovery and personal recovery. Clinical recovery utilizes the expertise of mental health clinicians with the goal of restoration of social functioning, long-term mental stability, and *getting back to normal* (Slade, 2009; De Ruysscher, Vandevelde, Vanderplasschen, De Maeyer, & Vanheule, 2017). However, professionals can have a different, contradicting perspective on what normal is. Moreover, this mindset leads clinicians to "…diagnose and treat with the aim of curing people or reducing their symptoms" (Slade et al., 2014, p.13). Nevertheless, individuals can live a fulfilling life with the presence of symptoms and diagnosis.

Alternatively, personal recovery is defined as a "…deeply personal, unique process.... a way of living a satisfying, hopeful and contributing life even with the limitation caused by illness" (as cited in Leamy, Bird, Le Boutillier, Williams, & Slade, 2011, p. 445). This view assumes that recovery is individual, worked towards and experienced by the person with mental illness (Slade, 2009). It acknowledges and incorporates the illness and experience, becoming part of the person, rather than a focus, leading the person to develop new meaning and purpose (Anthony, 1993). Slade et al. (2012) summarized the critical aspects of personal recovery as the Connectedness, Hope, Identity, Meaning, and Empowerment (CHIME) framework. Although the study used search terms such as mental illness and psychiatric disorder, it excluded studies defining recovery from substance use disorder (SUD) (Slade et al., 2012). Additionally, the

majority of the studies focused on severe mental illness (Leamy et al., 2011), usually associated with mental illness, with psychotic features (Kinter, 2017). Thus, the CHIME framework may or may not be applicable when caring for ISUD. Moreover, De Ruysscher et al. (2017) conducted a systematic review which included those with SUD, but it focused on defining recovery. Also, the study identified care expectations and wants of participants (De Ruysscher et al., 2017); however, what supported recovery may not always align with what ISUD wanted and expected.

Nurses can rely on the Guidelines for Recovery Oriented Practice (Mental Health Commission of Canada, 2015), which outline how clinicians exemplify recovery principles. Another resource that nurses utilize is the Tidal model (Barker & Buchanan-Barker, 2005); it specifies nurses' role, caring responses, and recovery when caring for individuals with mental health concerns (Barker, 2001). Although such frameworks, guidelines, and models exist, it can take seventeen years for research evidence to reach clinical practice (Morris, Wooding, & Grant, 2011). Likewise, although it has been more than a decade, mental health reform outlined in the report *Out of the Shadows at Last* (Kirby & Keon, 2006) may not have been fully implemented. The diverse outlooks of recovery-oriented practice and health system priorities leads to a gap between the ideal and actual practice (Le Boutillier et al., 2015). Hence, it is vital to review the current literature regarding effective nursing interventions and practices that promote the recovery of ISUD.

The aim of the literature review is to examine effective nursing interventions, actions, and behaviours that support the recovery of ISUD. The following research questions were fundamental for this review. Firstly, the review focuses on nursing interventions that transpired and were perceived to be beneficial to recovery; the first question is: What were helpful nursing interventions, actions, and behaviours that promoted recovery of ISUD? Secondly, the review

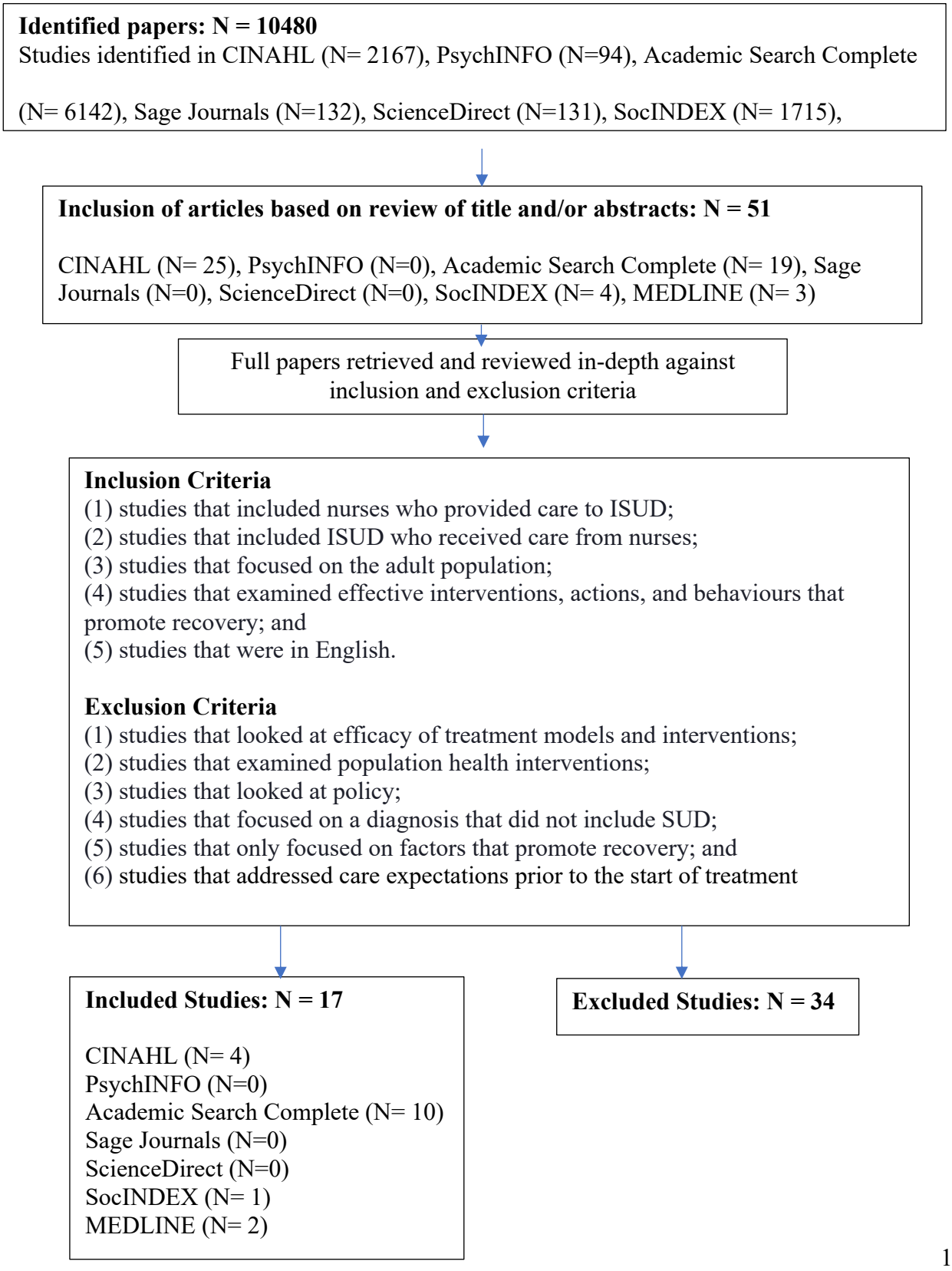
attempts to illuminate how such actions supported the recovery journey; the second question is: How does the nursing intervention promote recovery? Lastly, it is helpful to uncover if there are discrepancies in the perspective of nurses and ISUD; the third question is: What similarities and differences exists between the perspectives of nurses and ISUD?

Methods

Articles regarding effective nursing interventions that promoted recovery for ISUD were identified through a search on the database of CINAHL, PsycINFO, Academic Search Complete, Sage Journals, ScienceDirect, SocINDEX, and MEDLINE (See Figure 1). The key words 'interventions' OR 'actions' OR 'behaviour' AND 'recovery' AND 'substance use' OR 'addiction' AND 'nurs*' were used in the literature search. Articles were limited to dates between 2010 and 2019, being peer-reviewed, and the availability of full-text. The search resulted in 10480 articles. The authors utilized the following inclusion criteria: (1) studies that included nurses who provided care to ISUD; (2) studies that included ISUD who received care from nurses; (3) studies that focused on the adult population; (4) studies that examined effective interventions, actions, and behaviours that promoted recovery; and (5) studies that were in English. Moreover, the authors utilized the following exclusion criteria: (1) studies that looked at efficacy of treatment models and interventions; (2) studies that examined population health interventions; (3) studies that looked at policy; (4) studies that focused on a diagnosis that did not include SUD; (5) studies that only focused on factors that promote recovery; and (6) studies that addressed care expectations prior to the start of treatment. Each article's title was screened, and the abstract was further assessed against the inclusion and exclusion criteria; this resulted in fifty-one articles being retained for further review. These fifty-one articles were further

Figure 1

Selection of Articles– Based on PRISMA Flow Diagram



Note: The process undertaken for the inclusion of articles for the literature review.

reviewed, resulting in the inclusion of seventeen articles and rejection of thirty-four articles for the literature review.

Findings

The seventeen studies were conducted in several countries including Norway (9), Australia (2), Sweden (3), United States (2), and Canada (1) (See Table 1). All studies were qualitative; data collection was completed at one time point in fourteen studies, but there were three longitudinal studies. Studies examined the perspectives of ISUD (9); perspectives of clinicians which included nurses (3); perspectives of nurses (2); and perspective of clinicians which included nurses and ISUD (3). Lastly, the studies focused on the diagnosis of SUD (7); general psychiatry, which included SUD (4); or Concurrent Disorders (CD) (6), those that have a co-occurring mental health and SUD (Skinner, 2005). The authors utilized a thematic analysis approach when reviewing the studies. Overall, the review reveals that effective nursing interventions that promote recovery were grounded on 3 major themes and 8 subthemes (See Table 2): person-centred care (maintaining humanness of the person, recovery individualized); empowerment (collaboration and promotion of autonomy, sustaining hope and future orientation, and highlighting strengths through feedback); and maintaining supports and capability enhancement (listening and stimulating reflections, connecting and reconnecting, and practical support leading to skill acquisition).

Person-Centred Care

All except two articles discussed that it was beneficial for nurses to place ISUD in the centre of caring interaction. Subthemes that recurred were maintaining humanness of the person and recovery individualized.

Maintaining Humanness of the Person. Initially, ISUD must feel valued as a person within the caring interaction (McCallum, Mikocka-Walus, Gaughwin, Andrews, & Turnbull, 2016). Nurses achieved this by creating a welcoming environment and revealing a caring attitude (Moltu, Stefansen, Nøtnes, Skjølberg, & Veseth, 2017; Thorkildsen, Eriksson, & Råholm, 2015). They offered warm clothing, a bed, and a warm beverage when greeting the person (Thorkildsen et al., 2015). Concern was displayed by expressing a readiness to help and willingness to take part in the suffering (Thorkildsen et al., 2015). For example, nurses communicated that ISUD were in safe hands and would receive help (Thorkildsen et al., 2015). Moreover, respectful and empathetic responses allowed nurses to join the person's journey (Priebe, Wiklund-Gustin, & Fredriksson, 2018). ISUD outlined that such actions produced a feeling that nurses were "…there just for me" (Pettersen et al., 2019, p.4). ISUD revealed that seeing the nurse's personal belongings and photographs demonstrated the humanity of nurses (Priebe et al., 2018).

Moreover, ISUD noted that nurses must be mindful of stigma (Ness et al., 2017). Stigma altered a person's self-concept to the point that they see themselves as *less than* (McCallum et al., 2016). Thus, effective interventions conveyed that the nurse saw the diagnosis secondary to the person (Ness et al., 2017; Priebe et al., 2018; Thorkildsen et al., 2015). Nurses focused on getting to know the person behind the symptoms (Cruce et al., 2012) and validated unique qualities within each individual (Thorkildsen et al., 2015). A helpful strategy was to try to understand the person and the presenting problem through listening (Brekke et al., 2018; Cruce et al., 2012). Possessing core thoughts of wishing the person well (Andvig & Biong, 2014), and a core commitment to human beings and the alleviation of suffering (Thorkildsen et al., 2015) allowed nurses to focus on the person rather than the diagnosis.

Having a non-judgemental approach and response is another way to maintain the humanness of ISUD (Cruce et al., 2012; McCallum et al., 2016; Ness et al., 2017; Priebe et al., 2018;). Nurses minimized judgements and received secrets and disclosures without negative reactions (Koehn & Cutcliffe, 2012; Moltu et al., 2017). Within these vulnerable interactions, they were mindful of their body language (Ness et al., 2017). Moreover, respect was maintained when abstinence was not prioritized or when substances were used (Brekke et al., 2018). Nurses noted that it was favourable to embrace the possibility of substance use during the recovery journey (Thorkildsen et al., 2015). When relapse occurred, nurses were supportive and expressed understanding of the struggle (Brekke et al., 2018; Cruce et al., 2012).

Recovery Individualized. Helpful interventions extracted and upheld the person's recovery needs, and goals. Nurses became acquainted with the person's wishes and goals by asking general questions (Koehn & Cutcliffe, 2012). It was important to confirm that goals were realistic and specific (Koehn, & Cutcliffe, 2012; Ness et al., 2017). Nurses helped ISUD articulate smaller and attainable steps toward their goals (Koehn & Cutcliffe, 2012; Nordfjaern et al., 2010). For example, nurses co-created manageable weekly plans that incorporated barriers and resources (Biringer, Davidson, Sundfor, Ruud, & Borg, 2016). They also listened for clues and topics introduced by the person and explored it as a potential goal (Koehn & Cutcliffe, 2012). When ISUD had difficulty articulating goals, nurses proposed goals that integrated complex holistic needs (McCallum et al., 2016; Cruce et al., 2012). For example, they highlighted goals based on nutrition, activity, rest, and hygiene; goals did not always have to focus on substance use (Andvig & Biong, 2014). However, nurses necessitated that goals focused on ISUD needs rather than whatever the nurse thought was useful, this prevented them from having a paternalistic attitude (Ness et al., 2014; Ness et al., 2017).

Being accessible, patient, and flexible promoted person-centred care (Green, Yarborough, Polen, Janoff, & Yarborough, 2015; Munro, Allan, Shakeshaft, & Breen, 2017). Firstly, timely care prevented drop out (Ness et al., 2017). It was essential that nurses were available to talk when something transpired (Biringer et al., 2016; Munro et al., 2017). Even when it was against the rules, nurses were open to having conversations at nighttime (Andvig & Biong, 2014). Being available allowed ISUD to discuss serious topics from the deepest depths, such as trauma (Andvig & Biong, 2014). It was advantageous to allow individuals to approach nurses at their own pace and not be too eager to step in (Ness et al., 2017). Lastly, it was favourable to be flexible (Munro et al., 2017). For example, nurses avoided discharging ISUD who relapsed within a program (Green et al., 2015).

Empowerment

All except one study found that it was effective for nurses to focus on increasing the ability of ISUD to make changes as it increased decision-making. Subthemes that recurred were collaboration and promotion of autonomy, sustaining hope and future orientation, and highlighting strengths through feedback.

Collaboration and Promotion of Autonomy. Collaboration between nurses and ISUD supported recovery (Green et al., 2015). Vital interventions promoted active choice (Andvig & Biong, 2014). To encourage choice, nurses emphasized that ISUD will be involved in decision-making (McCallum et al., 2016; Thorkildsen et al., 2015) and have control over their care (Koehn & Cutcliffe, 2012). Nurses did not make choices on behalf of the individual with SUD, but supported the individual in decision-making (Brekke et al., 2018; Ness et al., 2014). Nurses obtained the person's preferred course of action and supported his or her choice (Ness et al., 2017). When ISUD had limited information, nurses shared ideas, tools, resources, and advice

(McCallum et al., 2016; Ness et al., 2017; Priebe et al., 2018). However, nurses were mindful that the person requested or was open to their perspective (Ness et al., 2017; Priebe et al., 2018). Some information that can be provided were about psychiatric illness, substance dependence, difficulties the illness may bring (Green et al., 2015; Priebe et al., 2018), and goal-focused treatment options (Velez, Nicolaidis, Korthuis, & Englander, 2016); this increased ISUD's understanding and decision-making (Moltu et al., 2017). Nurses inquired what previously worked for the person as it demonstrated that nurses would involve ISUD in solution building (Johansson & Wiklund-Gustin, 2016). It was also advantageous that nurses asked about the person's perspective on possible solutions to present challenges (Andvig & Biong, 2014).

Sustaining Hope and Future Orientation. Nurses must carry hopefulness and optimism that ISUD can achieve their recovery goals (Koehn & Cutcliffe, 2012; Ness et al., 2017). Thus, nurses conveyed hope to the person (Andvig & Biong, 2014). A helpful intervention was to endorse that ISUD possessed strengths and could achieve a life without substances (Ness et al., 2014; Thorkildsen et al., 2015). Hopefulness was demonstrated when nurses did not concede when individuals felt uncertain, powerless, and helpless; nurses carried hope for the person (Andvig & Biong, 2014; Ness et al., 2014). For example, nurses encouraged ISUD to stay, engage in treatment, rather than leave after multiple failed attempts (Velez et al., 2016). Nurses hoped that the person would achieve long-lasting change, especially in the presence of relapse to substance use (Thorkildsen et al., 2015). Being hopeful on behalf of the person, becoming 'holders of hope', inspired the possibility of recovery. ISUD must also have hope themselves. To instill hope, nurses inquired about the future aspirations of ISUD (Pettersen et al., 2019). By focusing on the future, ISUD saw themselves as persons with a future rather than hopeless individuals (Johansson & Wiklund-Gustin, 2016). Nurses asked ISUD to

daydream about the future (Biringer et al., 2016); this exposed them to a future with limited substance use. It was also helpful to ask persons to reflect on the past. ISUD outlined that it was helpful to think about a time that included good memories before the substance use (Pettersen et al., 2019); this reinforced a life whereby substance use was not a focus, making their goal possible.

Highlighting Strengths Through Feedback. ISUD need to believe that they can achieve their goals; this belief was reinforced when they were confident that they possessed the necessary strengths. Therefore, it was effective when nurses highlighted the person's strengths. For instance, nurses pointed out the person's positive qualities, internal resources, and commitment to his or her goal (Koehn & Cutcliffe, 2012). ISUD were encouraged when they received valuable, positive feedback from the nurse (Nordfjaern et al., 2010; Pettersen et al., 2019). Moreover, ISUD noted it was helpful to be reminded of what was going well when they were down (Moltu et al., 2017). Nurses achieved this by acknowledging the individual's progression, no matter how small (Andvig & Biong, 2014; Moltu et al., 2017). Improvements did not have to focus on substance use but on other areas, such as housing or vocation (Cruce et al., 2012). Lastly, nurses summarized all that was "…learned, accomplished, and the obstacles one overcame, and adversities that were dealt with" (Koehn & Cutcliffe, 2012, p. 91). Celebrating these achievements reinforced that the individual can achieve goals that he or she set, further reinforcing hopefulness (Cruce et al., 2012).

Maintaining Supports and Enhancing Capability

Lastly, all the studies outline that effective interventions ensured that ISUD felt supported, had the necessary supports, and had the ability to continue to tackle challenges in their recovery

journey. Subthemes that recurred were listening and stimulating reflections, connecting and reconnecting, and practical support leading to skill acquisition.

Listening and Stimulating Reflections. ISUD sought out nurses as a support during challenging times; some instances were when they felt "…out of it…" (Green et al., 2015, p.36), had low mood, and periods of misuse (Cruce et al., 2012). Active listening and reflection were helpful (Johansson & Wiklund-Gustin, 2016; McCallum et al., 2016; Ness et al., 2017; Thorkildsen et al., 2015). Firstly, nurses established a safe environment whereby individuals can share experiences, thoughts, and feelings. ISUD valued when nurses addressed confidentiality (Munro et al., 2017) and acknowledged the difficulty in talking about their struggles (Koehn & Cutcliffe, 2012). For some, it might be the first occasion when they accepted having a problem with their substance use. Thus, they conveyed that there was sufficient time by taking the time to listen and not rush into care planning (Andvig & Biong, 2014; Cruce et al., 2012; Ness et al., 2017; Priebe et al., 2018). Nurses had a good sense of timing, sensing the right moment for conversation (Andvig & Biong, 2014). Nurses primarily kept the conversation light; topics of conversation involved the individual's interest and his or her everyday life (Andvig & Biong, 2014; Priebe et al., 2018). Given the suitable moment, nurses moved onto serious topics such as familial consequences brought on by substance use (Andvig & Biong, 2014). These subtle actions helped establish that the nurse was willing to support the individual.

Moreover, ISUD found it beneficial that they were able to discuss their problems (Nordfjaern et al., 2010). ISUD appreciated nurses who made a substantial effort to listen and had a good understanding of their complex history (Cruce et al., 2012; McCallum et al., 2016). It was vital to see underneath the façade and comprehensively explore the suffering (Johansson & Wiklund-Gustin, 2016; Thorkildsen et al., 2015). It was favourable for suffering to be

verbalized, allowing growth (Priebe et al., 2018). Statements, questions, and stimulating reflection were valuable interventions. Reflections allowed ISUD to focus on their self, examine their life, clear the mind, and help them look forward (Andvig & Biong, 2014; Ness et al., 2017). Reflections can be geared towards an individual's thoughts. For example, nurses discussed the individual's thoughts and reactions to specific situations and increased awareness of his or her thought process (Biringer et al., 2016). It was helpful to clarify rather than criticize what was shared (Ness et al., 2017). Moreover, some individuals believed they did not have a problem, and through reflection, found that they needed to change (Biringer et al., 2016). Reflections also focused on feelings, which allowed the person to receive emotional support (Andvig & Biong, 2014). Furthermore, ISUD found it beneficial when topics that they did not contemplate were brought up (Biringer et al., 2016). Some examples were existential and spiritual topics, life themes such as relationships, family, and loneliness (Andvig & Biong, 2014). However, nurses needed to be mindful that the person was prepared to discuss such topics. It was also beneficial to ask about the motivators for the behaviour change; this helped enhance the person's motivation (Johansson & Wiklund-Gustin, 2016). Lastly, nurses geared the reflection on the person's ability to cope. For example, nurses asked about coping skills, stress management, and discussed what went well, not so well, and what can be done differently in particular situations (Andvig & Biong, 2014).

Connecting and Reconnecting. ISUD found it beneficial that nurses were accessible throughout the recovery journey (Green et al., 2015; Ness et al., 2017; Velez et al., 2016). It was favourable for nurses to initially increase contact, progressively becoming less with time (Brekke et al., 2018; Nordfjaern et al., 2010). Contact was maintained through arranged meetings and activities (Cruce et al., 2012). Nurses also visited them in their communities (Biringer et al.,

2016; Velez et al., 2016). If unable to visit, calling was also appreciated (Ness et al., 2014; Ness et al., 2017). In instances where contact was diminishing and the person withdrew, nurses reached out to the person (Cruce et al., 2012; Thorkildsen et al., 2015). Reaching out demonstrated that the nurses cared and were supportive, thus, strengthening the relationship (Brekke et al., 2018). Lastly, even when the caring venture was terminated, it was helpful to follow up (Nordfjaern et al., 2010).

Alternatively, supports can be those that surround the individual, such as family, friends, and peers. However, familial relationships can be affected by substance use. Thus, an effective intervention was to reconnect ISUD to established supports. First, nurses inquired about the degree of the connection and if reconnection with family members was desired (Koehn & Cutcliffe, 2012). If reconnection was wanted, nurses encouraged the involvement of family members (Green et al., 2015). For example, family members were invited to the facility and were offered the opportunity to take part in meetings (Biringer et al., 2016; Ness et al., 2014). On the contrary, there are ISUD that have limited social supports; an alternative approach was to increase their support system. Thus, nurses actively facilitated healthy connections (Koehn & Cutcliffe, 2012). ISUD found it beneficial that they were connected to their peers (Nordfjaern et al., 2010). Connections can be made by relating to other people's narratives and experiences. Thus, nurses ensured opportunities whereby ISUD can share with each other, such as groups (Pettersen et al., 2019). Encouraging participation and sharing in groups allowed for learning and connections to occur (Munro et al., 2017). Groups also allowed ISUD and their peers to process events that may occur or that had occurred (Pettersen et al., 2019). Group programming can be intimidating for some; hence, alternative excursions can be organized. For example, nurses offered various stimulating group activities, like creating art and outings (Cruce et al., 2012).

Activities provided relaxed opportunities which shifted focus on establishing bonds between individuals. Lastly, nurses invited the individual to come up with strategies to establish connections (Koehn & Cutcliffe, 2012).

Practical Support Leading to Skill Acquisition. ISUD outlined that talking can be inadequate; it was helpful to perform activities that improved their ability to deal with practical everyday problems (Ness et al., 2017). Support can be geared towards system navigation. It was vital that nurses worked alongside ISUD through the system (Ness et al., 2014); this decreased disorientation. For example, nurses connected with other clinicians to facilitate care (Ness et al., 2017). Nurses also supported ISUD to access substance treatment programs, rehabilitation, and aftercare (Green et al., 2015; Nordfjaern et al., 2010). System navigation included systems external to the healthcare system. It was vital to accompany individuals to activities they found helpful (Biringer et al., 2016; Brekke et al., 2018). For example, ISUD may require connecting with the social service system for financial and employment challenges (Biringer et al., 2016; Ness et al., 2017). Co-navigating systems increased their ability to traverse elaborate organizations.

It was beneficial when nurses helped create or re-establish routine in their lives (Munro et al., 2017; Ness et al., 2017). For example, nurses supported adherence to activities and meetings that ISUD followed every day (Cruce et al., 2012; Munro et al., 2017); the nurse supported the person to readjust (Johansson & Wiklund-Gustin, 2016). Nurses supported ISUD to relearn the practical skills that they used every day (Ness et al., 2014; Pettersen et al., 2019). For instance, nurses accompanied ISUD shop for groceries (Biringer et al., 2016), and learn how to cook and clean (Ness et al., 2017; Nordfjaern et al., 2010). Other activities would be arranging housing and rent payment (Brekke et al., 2018). Nevertheless, nurses were mindful that they did not

impose their views on how one should live (Ness et al., 2014). Routine can also include a job or a career. ISUD found it useful to receive information and be connected to opportunities and activities that can help them prepare or return to work (Ness et al., 2017). For example, vocational courses provided the necessary work-related skill, which increased pride and confidence (Cruce et al., 2012; Munro et al., 2017). Hobbies should also be incorporated into routine as it promoted self-care. Nurses supported the development of hobbies by helping ISUD look for and participate in activities (Cruce et al., 2012; Munro et al., 2017; Ness et al., 2017); these activities helped replace the pleasurable experience that substance use offers.

Lastly, ISUD outlined that they must learn various skills that assist them in their recovery journey (McCallum et al., 2016). ISUD appreciated communication and conflict resolution skills that dealt with interpersonal issues (Andvig & Biong; 2014; Koehn & Cutcliffe, 2012; Nordfjaern et al., 2010). Nurses coached ISUD to practice assertive social skills, such as learning to say no (Biringer et al., 2016; Johansson & Wiklund-Gustin, 2016). Moreover, it was beneficial to develop new coping strategies and confirm existing ones (Moltu et al., 2017). For example, ISUD appreciated learning about mindfulness, relaxation techniques, and managing negative thoughts (Biringer et al., 2016). Overall, the discussion of coping strategies must be tailored to the individual. For example, an individual revealed that it was helpful to learn about coping skills specific to each season (Pettersen et al., 2019). By supporting ISUD to navigate through the mental health system, establish routine, and generate accessible coping skills, nurses enhanced the capability of ISUD in their recovery journey.

Discussion

The literature review concurrently examines the perspectives of ISUD and nurses regarding helpful interventions enacted by nurses that promote recovery for those with SUD.

This study is the first literature review focused on nursing. The review adds to the current literature on SUD, and recovery. Three overarching themes were identified by the review: person-centred care, empowerment, and enhancing supports and capability. The themes and subthemes within the review prominently overlap with the CHIME framework (Slade et al., 2012). Additionally, the assumptions and commitments of the Tidal model (Barker & Buchanan-Barker, 2005) resonate within the themes and subthemes of the review. Lastly, interventions outlined in the review coincide with skills and behaviours in the Guidelines for Recovery Oriented Practice (MHCC, 2015). Given that the review included the perspectives of ISUD and nurses, I noted powerful subthemes and interventions that were voiced from both perspectives; some of these were maintaining the humanness of the person, collaboration and promotion of autonomy, sustaining hope and future orientation, listening and stimulating reflections, and skill acquisition. Therefore, this finding is an indication that these interventions offer the most benefit and should be prioritized. Alternatively, there were some subthemes and interventions that were unique from each perspective and some rarely suggested interventions.

Frequently Mentioned Interventions From ISUD Perspective. The interventions connecting and reconnecting, system navigation, and providing information were more prominent from the ISUD perspective. Interventions that supported the reconnection of established supports and the establishment of new social supports were mentioned more often in the articles that analyzed perspectives of ISUD. Even in the study by Ness et al. (2014), which included nurses and ISUD perspectives, reconnecting with family only came from the perspective of ISUD. Connectedness is a significant theme within the CHIME framework, displaying its importance in personal recovery (Slade et al., 2012). A finding like this suggests that nurses may undervalue such interventions and should be encouraged to reflect on the

significance of social supports. Next, interventions focused on system navigation within the subtheme of practical support were also more prominent from the ISUD perspective. Depending on the severity of the illness, some individuals may require more practical support at the beginning of the recovery journey, which may explain how important it is for some ISUD. Alternatively, care providers may see this as a routine intervention and therefore did not see this as a significant intervention that promoted the individual's recovery. Lastly, another interesting finding was that ISUD discussed receiving information as a valuable intervention that supports recovery more repeatedly than care providers; this may highlight the perceived need of ISUD to be involved in the care planning process. Overall, nurses need to be attentive to specific interventions as they might be undervalued, leading to less application and potentially decreasing the effectiveness of care provided to some ISUD.

Frequently Mentioned Interventions From Nursing Perspective. Most studies that focused on the nurses' perspective discussed being accessible and being strengths-based as an effective intervention. The increased prevalence of accessibility can be explained by the idea that the nurse needs to be present in order to apply additional recovery-oriented interventions. Conversely, nurses may have frequently utilized a strengths-based approach as they were cognizant of the challenges ISUD experienced; nurses were aware that unsuccessful efforts could lead ISUD to feel defeated. Thus, nurses may take it up as their duty to ensure that ISUD are aware of their strengths and capabilities to continue the pursuit of their goal. Nurses must scrutinize their interventions, as routinely applying interventions based on the perspective of other nurses may not be effective.

Rarely Mentioned Interventions. The study revealed rarely mentioned interventions that may be helpful. Withdrawal management was briefly mentioned in two studies. This might be

due to withdrawal management being a required competency when working with ISUD. Additionally, harm reduction was not mentioned throughout the studies. Harm reduction is an approach that reduces harm and consequences associated with substance use (Understanding harm reduction, 2020); it is particularly effective for those who are not focused on abstaining from substance use. Examples of harm reduction interventions are the discussion of safer ways to use and distribution of supplies used for consumption. The lack of discussion of harm reduction interventions may be due to the diverse healthcare system and political climate where the studies were based. Harm reduction is a prominent concept used throughout Canada. Intriguingly, interventions that promote spirituality were seldomly mentioned. Interventions focusing on spirituality are helpful for SUD (Hai et al., 2019). Programs rooted in spiritually such as Alcoholics Anonymous and Narcotics Anonymous are routinely recommended to ISUD in practice. Shockingly, interventions focused on culture was only mentioned in the study completed by Munro et al. (2017). Only six of the possible twelve articles reported the demographic data of ISUD; of these six studies, three had a majority of Caucasian participants (Green et al., 2015; McCallum et al., 2016; Ness et al., 2017), and three had more diverse participants (Koehn & Cutcliffe, 2012; Munro et al., 2017; Velez et al., 2016). The Guidelines for Recovery Oriented Practice (MHCC, 2015) discusses that recovery-oriented practice requires care providers to respond to the diverse needs and culture of the individual. Moreover, the use of self-disclosure and lived experience were minimal in the studies. Although the College of Nurses of Ontario (2006) practice standard on therapeutic relationship discourages self- disclosure, ISUD outline that hearing nurses self-disclose about their lived experience, promotes the possibility of recovery, increasing hope (Munro et al., 2017). Lastly, only Brekke et al. (2018) discussed advocacy as a helpful intervention. Given the stigmatizing and challenging experience

of ISUD, advocacy is an effective intervention that promotes recovery. Advocacy may have been infrequently discussed, as advocacy was not mandatory when speaking to other care providers who may also employ recovery-oriented principles. Additionally, advocacy at a systemic level may not be easily seen by ISUD, and advocacy leading to the systemic changes may not have an immediate effect on ISUD. Given these findings, there may be uncommonly used, effective recovery-facilitating interventions.

Recommendations For Nursing Practice. The review summarizes nursing interventions that can be more effective when working with ISUD. Nurses should familiarize themselves with the previously mentioned frameworks, guidelines, and models. Nurses should apply identified effective interventions and continually reflect on the philosophical and theoretical basis of their actions, behaviours, and interventions. Conversely, nurses should be mindful that recovery is individualistic, hence, interventions should be applied as it fits the person's context; it is unrealistic to expect that all recovery-oriented practice actions will apply for each individual. Nevertheless, nurses should be mindful that there are specific interventions that ISUD find beneficial, that nurses may overlook. Nurses should consider how they apply spirituality, culture, disclosure, and advocacy in their work. Overall, interventions applied should benefit the individual's recovery.

Limitations. The study only included studies from 2010 to the present, which may have excluded studies that could be beneficial. Since this is a literature review, it relies on published data from previous studies and inherent limitations of those studies. Lastly, the literature review included studies that focused on concepts like collaboration and hope; this may have been too focused, altering results.

Future Directions. Overall, only one study was based in Canada and was focused on inspiration of hope. Moreover, although all the studies included nurses, only three studies exclusively focused on nursing (Johansson & Wiklund-Gustin, 2016; Priebe et al., 2018; Thorkildsen et al., 2015) and none focused on effective interventions that promoted recovery. Lastly, given the recency of the recovery-oriented mental health system reform, it would be vital to explore the perspectives of either ISUD or nurses' perspectives regarding effective nursing interventions that promote recovery within the Canadian landscape. Another potential study would be to include ISUD and nurses within one study and explore if a recovery-oriented intervention enacted by a nurse was genuinely beneficial for that individual. In conjunction with this, future studies should be longitudinal. In addition to understanding what interventions by nurses effectively facilitated recovery, it would be vital to understand how such interventions facilitate recovery. Although some studies explained how effective interventions facilitate recovery, this was not consistent in all the studies. This was also suggested in the studies by De Ruysscher et al. (2017) and Leamy et al. (2011). A study focusing on how nursing interventions facilitated recovery would be rooted in the perspective of ISUD. Lastly, recovery-oriented interventions may differ depending on the setting. For example, the interventions such as performing house visits and having personal belongings visible may be inapplicable in inpatient settings. Hence, future studies should consider examining if there are specific recovery-oriented interventions that are more frequently or exclusively applied within distinct settings (inpatient, outpatient, and community).

Conclusion

The identification of effective nursing interventions that promote recovery is fundamental so more nurses can assist the recovery journey of ISUD. The literature review identified that

effective nursing interventions are based on person-centred care, empowerment, and enhancing supports and capability. The review highlighted interventions that were more frequently mentioned from the perspectives of nurses and ISUD and interventions that were rarely mentioned. When providing care to ISUD, nurses should ensure that their actions are based on the themes identified; this also emphasizes the importance of guidelines, frameworks and theories. Overall, nurses have an obligation to ensure that the profession moves beyond the theoretical aspect of recovery and employ actions that exemplify recovery-oriented principles. Further application of recovery-oriented practices will ensure improvement in the healthcare system, humanizing the experiences of ISUD.

Table 1

Included Articles

Author	Country	Aims	Focus (substance use [SUD], concurrent [CD], general psychiatric [GEN])	Method/Data Collection	Participants	Setting	Timeline
CINAHL (4)							
ISUD perspective (2)							
Ness, Kvello, Borg, Semb, & Davidson (2017)	Norway	To explore collaborative practices from perspectives of CD patients	CD	Qualitative: Semi-structured interview	7 patients	Community-psychiatry	One-time with follow up interview
McCallum, Mikocka-Walus, Gaughwin, Andrews, & Turnbull (2016)	Australia	To compare experiences of SUD and CD patients	CD	Qualitative: Cross-sectional semi structured interview	34 patients	Inpatient, outpatient, detox, community	One-time
Clinician's perspective (2)							
Johansson & Wiklund-Gustin (2016)	Sweden	To describe how nurses working in inpatient psychiatry experience caring encounters with ISUD	SUD	Qualitative: Reflective group dialogues	***6 nurses***	Inpatient psychiatry	One-time
Thorkildsen,Eriksson, & Råholm (2015)	Norway	To gain an understanding of the core of love when caring for ISUD	SUD	Qualitative: Hermeneutic, interview	***4 nurses***	Detox in emergency	One-time
MEDLINE (2)							
Patient perspective (2)							

Author	Country	Aims	Focus (substance use [SUD], concurrent [CD], general psychiatric [GEN])	Method/Data Collection	Participants	Setting	Timeline
Priebe, Wiklund-Gustin, & Fredriksson (2018)	Sweden	To illuminate ways a patient with CD experience conversation with ***nurses*** to be caring	CD	Qualitative: Semi-structured interview, Hermeneutic, phenomenology	5 patients	Outpatient addiction clinic	One-time
Nordfjaern, Rundmo, & Hole (2010)	Norway	To examine negative and positive perceptions of treatment and recovery from perspectives of ISUD	SUD	Qualitative: Semi structured interview	13 patients	Inpatient, and outpatient addiction clinic	One-time
SocINDEX (1)							
Both ISUD and clinician's perspective (1)							
Koehn, & Cutcliffe (2012)	Canada	To examine if substance use counsellors inspire hope in ISUD	SUD	Qualitative: Grounded theory, semi-structured interview	7 counsellors 3 patients	Outpatient, residential, private SUD practice	One-time with follow up interview
Academic Search Complete (10)							
ISUD perspective (5)							
Biringer, Davidson, Sundfør, Ruud, & Borg (2016)	Norway	To explore how service users' expectations for treatment, goals, hopes for	GEN	Qualitative: Hermeneutic – Phenomenological Semi-structured interview	8 patients	Inpatient and outpatient psychiatry	Longitudinal – two interviews, separated by 27-30 months

Author	Country	Aims	Focus (substance use [SUD], concurrent [CD], general psychiatric [GEN])	Method/Data Collection	Participants	Setting	Timeline
		recovery at the beginning of their contact was supported by clinicians during their treatment.					
Pettersen, Landheim, Skeie, Biong, Brodahl, Benson, & Davidson (2019)	Norway	To explore the experiences of those with long term SUDs and aspects they found helpful during treatment and long-term recovery	SUD	Qualitative: Semi-structured interview	18 patients (had SUD and abstinent for 5 years)	Unspecified	One-time
Velez, Nicolaidis, Korthuis, & Englander (2017)	US	To explore the experiences of hospitalized ISUD	SUD	Qualitative: interviews	32 patients	Inpatient medical and surgical unit	One-time
Cruce, Öjehagen, & Nordström (2012)	Sweden	To explore recovery promoting care as experienced by individuals with CD	CD	Qualitative: Semi-structured interviews	8 patients	Outpatient CD program	One-time with follow up interview after one-week

Author	Country	Aims	Focus (substance use [SUD], concurrent [CD], general psychiatric [GEN])	Method/Data Collection	Participants	Setting	Timeline
Green, Yarborough, Polen, Janoff, & Yarborough (2015)	US	To explore individual's perspective regarding their CD recovery experience	CD	Qualitative: Interviews	177 patients	Unspecified	Longitudinal - Four interviews (two at baseline, one at one- and two-year follow up)
Clinician's perspective (3)							
Brekke, Lien, Nysyeen, Biong (2018)	Norway	To explore and describe staff experiences and dilemmas in recovery-oriented practice when working with individuals with CD	CD	Qualitative: Focus groups	10 Care providers support workers (2), mental health workers (2), peer support workers (2), specialist nurses (2), social workers (1), and psychologists (1).	Community psychiatry	Three focus groups over two years.
Andvig & Biong (2014)	Norway	To describe and explore what health professionals focused on in recovery-oriented conversations	GEN	Qualitative: Explorative design, action research project	15 Care providers six mental health nurses, three auxiliary nurses, three social educators, two occupational therapists	Community psychiatry	One-time

Author	Country	Aims	Focus (substance use [SUD], concurrent [CD], general psychiatric [GEN])	Method/Data Collection	Participants	Setting	Timeline
					and one social worker		
Ness, Borg, Semb, & Karlsson (2014)	Norway	To identify ways in which mental health practitioners collaborate with service users	GEN	Qualitative: Multi-staged focus group	10 care providers - 8 mental health nurses 2 SW	Community psychiatry	Longitudinal – monthly focus group over 3 months
ISUD and Clinician's perspective (2)							
Munro, Allan, Shakeshaft, & Breen (2017)	Australia	To explore the nature and quality of therapeutic components and relations with staff	SUD	Qualitative: semi structured interviews	12 patients 9 clinicians	3-month SUD residential program – mainly for indigenous individuals	One-time interview at two time-points
Moltu, Stefansen, Nøtnes, Skjølberg, & Veseth (2017)	Norway	To explore what constitutes as a meaningful outcome in the experiences of those with long and complex mental health experience	GEN	Qualitative: Semi-structured interview Focus group and in-depth interviews	50 participants 18 patients (7 had CD) 12 psychiatric nurses 20 therapists	Inpatient and outpatient psychiatry	One-time

Author	**Country**	**Aims**	**Focus (substance use [SUD], concurrent [CD], general psychiatric [GEN])**	**Method/Data Collection**	**Participants**	**Setting**	**Timeline**
17 articles in total	Norway (9) Australia (2) Sweden (3) Canada (1) US (2)		4 GEN 6 CD 7 SUD	17 Qualitative	3 focused on ISUD and clinicians 5 were clinician-focused (2 nursing specific) 9 were ISUD-focused (1 nursing specific)	4 Community 5 Mix 1 Residential 1 inpatient medical 1 inpatient psychiatry 2 Unspecified 1 outpatient CD program 1 outpatient addiction 1 detox	3 longitudinal studies 14 One-time point

Table 2

Themes and Subthemes of Effective Nursing Interventions

Person-centred care	
Maintaining humanness of the person	• Create a welcoming environment • Reveal a caring attitude and readiness to help • Have respectful and empathetic responses • Have personal belongings • Make diagnosis secondary to person • Non-judgemental attitude • Accepting potential substance use
Recovery individualized	• Extract the person's goals • Co-create manageable and attainable goals • Propose holistic goals • Be accessible and flexible • Let person approach you
Empowerment	
Collaboration and promotion of autonomy	• Promote active choice • Do not make choices on behalf of person • Share ideas and resources when requested • Inquire about preferred action and previous solutions
Sustaining hope and future orientation	• Convey hope to the person • Do not concede when facing challenges • Inquire about aspirations • Daydream about the past
Highlighting strengths through feedback	• Highlight positive qualities and commitment • Remind the person of what is going well • Summarize achievements
Maintaining supports and capability enhancement	
Listening and stimulating reflections	• Establish a safe environment • Sense the right moment for conversation • Allow the person to speak about their experience • Clarify rather than criticize • Gear reflections towards thoughts, feelings, and coping
Connecting and reconnecting	• Be a support • Maintain contact • Re-establish connections with family and friends • Connect the person to their peers
Practical support leading to skill acquisition	• Co-navigate multiple systems • Help create or re-establish routine • Provide information for opportunities and activities • Assist the person to gain valued skills

Chapter 3: Manuscript - Methodology

Manuscript - Methodology

This manuscript was completed during the Nursing 712: Advanced Qualitative Research course. I completed the paper about QD independently. To further nursing science, Dr. Annette Lane, Dr. Georgia Dewart, and I discussed revising and submitting the paper. It was submitted and published in the *International Journal of Nursing Student Scholarship* in December, 2020. To cover the methodology used within the thesis, I discuss different components after the presentation of the manuscript. The manuscript can be retrieved here: https://journalhosting.ucalgary.ca/index.php/ijnss/article/view/71786/54608

Please note that the term method was used rather than methodology in the published manuscript based on the feedback from the reviewers.

Qualitative Description:

An Examination of a Methodology for Novice Nursing Researchers

Abstract

According to Bradshaw and associates (2017), a qualitative description (QD) design focuses on describing and defining a phenomenon, answering who, what, where, and why of the experience from the particular viewpoint from those involved. Although not limited to, nurses in psychiatry, obstetrics, pediatrics, and education find QD beneficial in accessing unique perspectives as there is a limited need to employ a time-intensive, complex research approach. QD offers an accessible approach to qualitative research for many beginning nursing researchers but has been often overlooked or confused with other descriptive methodologies such as case study, phenomenology, grounded theory, and ethnography. Given the value and applicability to the nursing profession, this paper aims to provide novice and student nursing researchers with a robust understanding of the QD approach to help guide their work. Drawing from the literature, we present an in-depth overview of the approach by focusing on the purpose, guiding principles, and methods within QD. We also provide a comparative analysis of QD in relation to other qualitative methodologies as well as outlining the value of the QD approach for novice or student, nursing researchers.

Key Words: Qualitative Description; Qualitative Research; Novice Researchers; Student Researchers; Nursing

Qualitative Description:

An Examination of a Methodology for Novice Nursing Researchers

Multiple approaches support researchers to uncover answers to research questions. However, novice researchers may apply methodologies without understanding important components, such as theories, that underpin the approach. Uncertainty regarding the research approach may lead to findings that are incongruent with the underlying theoretical foundation, rendering a less compelling study. Moreover, beginning researchers, such as students, may feel the need to align with traditional qualitative approaches, such as phenomenology or hermeneutics, and they may feel that they are conducting a study guided by the philosophies behind either approach, and may in fact, not be doing so (Neergaard et al., 2009). Thus, it is important to carefully explore and understand a research approach that one may potentially use in research. An approach that is inadequately discussed and is often disregarded as a valid approach is qualitative description (Kim et al., 2016).

Sandelowski (2000, p.335) described qualitative description (QD) studies as "...basic or fundamental…", distinct from other qualitative approaches. QD is an accessible research approach for novice nursing researchers, such as students, to explore diverse topics of investigations rooted in the description of participant experiences or perspectives. These experiences are learned from the unique interactions between the participants that experienced such phenomena and the researcher, with their theoretical and experiential predispositions (Bradshaw et al., 2017). QD produces emic knowledge that allow others (outsiders) a unique opportunity to learn how such individuals see their world (Bradshaw et al., 2017). While QD embodies many of the same principles, research phases, and methods of data collection of other qualitative research, such as phenomenology, there are some distinct differences. Within the

paper, we will outline similarities between QD and other research methodologies and describe the differences, such as staying close to the data (direct words of participants) with minimal inferences, as well as being less theoretical than other qualitative methodologies. The fundamentals of QD will be discussed, as well as the distinct differences between QD and other methodologies that make it particularly suitable for beginning nursing researchers, such as students (Turale, 2020).

Purpose of QD

Due to similarities with other qualitative approaches, QD can be confused with other methodologies. For example, phenomenology, grounded theory, and ethnography can be descriptive; however, such methods are not exclusively descriptive (Sandelowski, 2000). Explicating its purpose and features can help differentiate QD from other methodologies. Primarily, QD aims to uncover, understand, and describe a specific population's perception and experience regarding a particular phenomenon or concept of interest (Bradshaw et al., 2017; Neergard et al., 2009). Such a phenomenon can be thought of as any situation, behaviour, event, and context (Purdy & Popan, 2018), which may profoundly impact a population. The main objective is to produce a comprehensive, yet, surface-level summary, rooted in the description of the participants' experience (Colorafi & Evans, 2016; Neergard et al., 2009; Sandelowski, 2000; Willis et al., 2016); establishing causality is not the goal (Dulock, 1993). Researchers may identify the need for the study due to simple questions (Magilvy & Thomas, 2009) brought about by real-life issues or from a gap in the literature (Creswell & Poth, 2018).

Generally, QD focuses on answering who, what, and where questions (Dulock, 1993; Kim et al., 2016; Neergard et al., 2009; Sandelowski, 2000; Swatzell & Jennings, 2007). Researchers may use QD to describe and define a new phenomenon, when there is insufficient

research regarding that phenomenon (Cohen & Tarzian, 2017). For example, Lane et al. (2017) conducted a QD research study due to a paucity of literature regarding the needs of family members when their aging relatives transitioned to nursing homes. QD research may be conducted to establish the foundation for interventional studies and to develop and refine interventions or questionnaires (Kim et al., 2016). For instance, Mc Auliffe and Hynes (2019) completed a QD focusing on individuals with multiple sclerosis and their occupations; this resulted in identifying a need for interventions that address daily issues stemming from cognitive challenges for people with multiple sclerosis. QD can also assist researchers to obtain a new perspective on a well-researched phenomenon (Cohen & Tarzian, 2017). This is because participants' views on a particular phenomenon can be dependent upon their profession or relationship to the healthcare system. To illustrate, nurses may have distinctive viewpoints compared to physicians, while recipients of care may view a phenomenon differently than care providers. Even within the same discipline such as nursing, the contextual background can lead to a unique perspective. For example, although self-care has been studied within nursing, the QD by Opare et al. (2020) provided a different insight on self-care, as the study sample of psychiatric nurses were situated in the community, rather than in the hospital. As such, the purposes of QD are varied and may overlap with other qualitative methodologies; recognition of its distinct features can separate it from other qualitative studies.

Features of QD

Although QD researchers choose a phenomenon to study, they cannot know for certain what will emerge from the study. As with other forms of qualitative research, in QD, specific foci are usually not predetermined (Lambert & Lambert, 2012), and a hypothesis is usually not stated (Dulock, 1993). However, this does not prevent QD researchers from predicting elements

of a phenomenon and hypothesizing based on previous studies, theories, or frameworks. The defining features of QD are utilizing less inference and being less theoretical than other qualitative approaches. Due to these features, the goals of QD are different from other qualitative methodologies. Unlike ethnography, which aims to produce thick descriptions of a culture, case study, which endeavours to acquire an in depth understanding of a problem from a unique case, and grounded theory, which intends to develop theory (Creswell & Poth, 2018), QD aims to produce rich description of an event or experience (Neergaard et al., 2009). Since these rich descriptions originated from staying close to participants' words, the amount of inference is reduced. Inference, applied during the data analysis and representation phase, is defined as the "...the amount of logical reasoning required to move from a data-based premise to a conclusion." (Colorafi & Evans, 2016, p.17). QD employs lower inference levels, unlike other qualitative studies like phenomenology (Colorafi & Evans, 2016). Lower levels of inference allow findings to be grounded closer to the participants' description and increases the likelihood that readers can rationalize the findings of the study (Colorafi & Evans, 2016; Seixas et al., 2018). Thus, QD applies inductive logic and bases findings from the data rather than theory (Creswell & Poth, 2018).

As previously mentioned, an important feature of QD studies is that they are less theoretical than other qualitative research methodologies (Kim et al., 2017; Lambert & Lambert, 2012; Neergaard et al., 2009; Sandelowski, 2000). This means that it does not rely too heavily on theories and frameworks. This is a beneficial feature for novice nursing researchers, such as students, as they are not obligated to make findings "fit" with the theoretical framework. Moreover, QD studies do not have intricate philosophical backgrounds which require understanding and explication. For example, phenomenology requires the discussion between

which philosopher's viewpoint (Husserl, Heidegger, Merleau-Ponty) is utilized for the study (Creswell & Poth, 2018; Willis et al., 2016). Thus, allowing results in QD studies to develop without figuring out how they fit with a specific framework or theory (Kim et al., 2017; Lambert & Lambert, 2012) inspires receptiveness for findings which depend on data, rather than previously established theories or interpretations. Although QD can adopt any theoretical or philosophical lens to guide the study, QD is not attached to lenses and readily alters these at any point in the study (Colorafi & Evans, 2016; Willis et al., 2016). For example, a researcher may focus on concepts from a theory related to the phenomenon; if the preliminary findings steer toward a different concept, the researcher should alter the focus of the study to fit the emerging data instead. Thus, QD utilizes emerging design, being flexible and adapting various parts of the research process to support the study (Creswell & Poth, 2018).

As will be outlined in the next section, however, is that QD studies share similarities with other qualitive methodologies. For instance, QD researchers use similar methods for data collection as their counterparts utilizing other approaches; some differences can be overt. An example would be that case studies may examine multiple sources for data collection such as interviews, observations, documents, and artifacts (Creswell & Poth, 2018), whereas QD will usually gather data through only one type of data collection method such as interviews (Kim et al., 2017). QD researchers may also borrow data analysis techniques from other qualitative approaches such as grounded theory (Lambert & Lambert, 2012; Sandelowski, 2000). For example, QD can use constant comparative analysis in data analysis, which is also used in grounded theory (Sandelowski, 2000). On the contrary, some approaches like case study utilize within-case analysis which is different from what QD will use in data analysis (Creswell & Poth,

2018). Researchers utilizing QD must be aware of the differences and similarities between QD and other qualitative methodologies and be able to articulate their rationale for using QD.

Data Collection

Sampling

When considering who will participate in a qualitative study, researchers consider types of sampling and sample sizes. Similar to other qualitative methodologies, QD researchers may utilize purposive sampling. Purposive sampling is chosen as information that is "...required directly from those experiencing the phenomenon under investigation..." (Bradshaw et al., 2017, p. 1). Within this sampling strategy participants have first-hand experience with the phenomenon, the ability to communicate with the researcher, and willingness to tell their story (Magilvy & Thomas, 2009).

Researchers should also consider the number of individuals to include in the study. In one systematic review of QD, Kim et al. (2017) reported sample sizes ranging from eight to one thousand nine hundred and thirty-two. However, larger sample sizes were utilized by open-ended surveys while smaller sample sizes were applicable to individual interviews and focus groups (Kim et al., 2017). A consensus is that the sample size tends to be small as the importance is on what makes the experience unique rather than generalizability (Bradshaw et al., 2017).

Still, data saturation should be considered when thinking about sample size. Data saturation is the researcher's attempt to continuously interview participants until there are no new categories or information that arise from the interview (Creswell & Poth, 2018). Within QD, interviews can occur until saturation is achieved (Willis et al., 2016). However, researchers can find, that given each participant's unique perspective, data saturation may be unachievable (Bradshaw et al., 2017).

Data Collection Method

Similar to other qualitative research methods, QD utilizes case studies, observations, and interviews for data collection (Bradshaw et al., 2017; Dulock, 1993; Purdy & Popan, 2018; Stangor & Walinga, 2014). Kim et al. (2017) found a majority of QD studies employed semi-structured individual interviews or focus groups. Interviewing is a helpful method that gathers and relies on the participants' reports (Seixas et al., 2018). Moreover, this is where the researchers and participants interact to co-construct knowledge (Creswell & Poth, 2018). Utilizing focus groups is beneficial when potential interactions between participants produce the best information, when participants are similar and cooperative, when there are time limitations, or when participants may be hesitant to provide information individually (Creswell & Poth, 2018).

Although researchers can interview without some structure, it can be useful to have a guide to assist in the interview. When researchers engage in interviews without preparation, interviews can lead to more noise than data (Arsel, 2017). An interview protocol, a document that outlines a brief description of the study, the consent-gathering, critical points of exploration through over-arching questions, and potential probes and transitions, can support QD researchers (Arsel, 2017). Interview protocols can help researchers focus on the relevant concepts to discuss during the interview, giving a sense of control, and reigniting or redirecting conversations (Arsel, 2017). Questions in the interview protocol tend to be open-ended (Kim et al., 2017; Lambert & Lambert, 2012; Neergaard et al., 2009), which allows the researcher to capture broader viewpoints and minimizes restrictions. Questions can be constructed based on the researcher's intuition and curiosity; however, interview questions can potentially incorporate theoretical and conceptual ideas. Willis et al. (2016) outline that such theories and concepts can initially help

guide the interview questions. However, depending on responses, QD researchers are not obliged to stay within such theories and frameworks, especially if data indicates a poor fit; they can thus make changes to their interview guide (Willis et al., 2016; Vaismoradi et al., 2013). For example, illuminating descriptions may be brought up by participants that researchers did not consider, and thus, researchers can utilize these descriptions and knowledge gained through interviews to guide and revise their questions. If theories are utilized for the conceptual framework, it is important to ensure that this is visible within a section of the paper. Contrastingly, revision of the interview protocol can also occur before data collection. Yin (2014, as cited in Creswell & Poth, 2018) argued that before data collection, researchers should pilot test their interview protocol to refine it. Generally, data collection and data analysis are intertwined in an iterative circle that continuously reverts between each step; thus, researchers will continue to refine their interview protocol as they analyze data (Arsel, 2017).

Data Analysis

Researchers utilizing QD employ either Thematic Analysis (TA) or Qualitative Content Analysis (QCA) to complete their data analysis (Bradshaw et al., 2017). A profound distinction is that TA is interpretive and therefore employs a higher level of inference whereas, QCA tends to apply lower levels of interpretation, being less abstract (Vaismoradi & Snelgrove, 2019). As QCA is less inferential, it is generally preferred with QD studies (Kim et al., 2017). The aim and activities of the data analysis are similar regardless of the tool used (Vaismoradi et al., 2013). QCA and TA examine collected data by employing a systematic coding and categorizing approach, to illuminates themes (Vaismoradi et al., 2013). Colorafi and Evans (2016) proposed the following steps for data analysis: (1) create a coding framework; (2) format transcribed documents to include spaces for codes and memos; (3) apply the first level of coding; (4)

categorize codes and apply the second level of coding; (5) revise and redefine codes; (6) add memos; (7) visualize data; and (8) represent the data. Contrastingly, the researcher can apply the first level of coding on the first few transcripts and develop a coding framework based on the codes. Data collection, and analysis occur simultaneously as part of an iterative and recursive process (Colorafi & Evans, 2016; Creswell & Poth, 2018).

Coding, core to qualitative data analysis, is the process of assigning a label to a portion of text that reflects an idea (Miles et al., 2014). Creswell and Poth (2018) suggested applying lean coding; starting with a shortlist, only expanding the list when necessary, and having no more than a final twenty-five to thirty code list. After applying the initial level of coding, the researcher reviews the codes, clusters similar codes, and applies a more abstract label, identified as a theme (Colorafi & Evans, 2016). While coding, researchers may find themselves revisiting, rechecking, and revising codes and definitions; this continues throughout the data analysis. Although QD researchers readily apply induction to ground the data's findings, coding requires inferences, which necessitates QD researchers to also apply deduction. The induction-deduction dependent role of researchers continues into the data representation.

Throughout the data analysis phase, the use of a coding framework can help clarify the thought process of the researcher. A coding framework can initially include a priori codes, codes based on theories, literature, and preliminary data (Creswell & Poth, 2018). However, a priori codes can limit the analysis to the pre-identified codes rather than the insights of the participants (Creswell & Poth, 2018). Researchers can also include the name, definitions, and examples of each code within a coding framework (Colorafi & Evans, 2016). This can rationalize the connection of data to the code to other researchers and readers. After a researcher transcribes the documents, Agar (1980, as cited in Creswell & Poth, 2018) outlined that it might be beneficial to

read the transcripts multiple times to immerse oneself in the data. During this immersion, adding memos may be useful rather than after coding has taken place. Memos outline the researcher's insights that capture initial ideas, elucidate how concepts evolved and how insights were integrated (Creswell & Poth, 2018). Memoing clarifies the researcher's thinking process, acting as an audit trail throughout the research process (Creswell & Poth, 2018).

Reflexivity is important in all qualitative research, including QD (Vaismoradi et al., 2013; Willis et al., 2016). Reflexivity is a process whereby researchers engage in continuous critical reflection throughout the research process which document their thought process, actions, and choices taken (Orange, 2016; Ortlipp, 2008). While this will be discussed, in greater detail later in the paper, briefly, this involves researchers understanding how their background (work, history, culture) influences their interpretation of the data (Creswell & Poth, 2018), and involves documenting their thoughts in research diaries or memos (Woo, 2019).

Data Representation

QD presents its findings in a straightforward logical manner, usually through summarization (Kim et al., 2017; Lambert & Lambert, 2012). Summaries are presented in simple, easy to understand, everyday language (Sandelowski, 2000), encompassing the description of the participants' experiences and perceptions, and echoes the participant's language (Neergaard et al., 2009). The use of simple language and the participant's language make the findings easy to comprehend. Various ways to present the data are through the chronology, prevalence of themes, broad to a specific focus, timeline-based, or through multiple perspectives (Sandelowski, 2000). Overall, the synthesis of data representation varies depending on the findings of the study; however, this can also differ depending on the researcher

conducting study. Hence, it is also essential to discuss how QD researchers can enhance trustworthiness.

Trustworthiness

Rigour is normally used to describe quantitative research and uses terms such as internal validity and generalizability (Bhattacherjee, 2012). However, due to differing ontological and epistemological assumptions, internal validity, and generalizability do not apply (Bhattacherjee, 2012). As such, qualitative studies aim to establish trustworthiness by using confirmability, dependability, credibility, and transferability (Hanson et al., 2011; Morrow, 2005). Generally, QD strives to achieve confirmability, credibility, and transferability (Bradshaw et al., 2017; Vaismoradi et al., 2013).

Confirmability is the researcher's attempt to minimize subjectivity and acknowledge that objectivity is difficult to achieve (Morrow, 2005). Credibility is the establishment of how believable the findings of the study are (Colorafi & Evans, 2016). However, as QD bases the findings from the data gathered in the interview rather than applying conforming data to theory, it has a much easier time than other qualitative methodologies in establishing credibility. Transferability, the ability to apply findings of the study to other settings or studies, may be enhanced by providing detailed, thick descriptions of the participants and the setting (Colorafi & Evans, 2016). By providing this, readers can employ analytic generalization, identifying similarities and differences between their own and the study's context, and identify if the findings can be adopted in their areas of practice (Clark & Vealé, 2018).

Although qualitative researchers attempt to be neutral and bias-free, they cannot achieve full objectivity as each individual carries theoretical preferences and experiences, which impact how we see and interpret the world (Arsel, 2017). Within QD, the researcher is the main

instrument that collects, analyzes, and interprets the data (Clark & Vealé, 2018). Their experiences and context concerning the research, impact how the study is completed. Thus, researchers can discuss their positionality, social position, experiences, beliefs and assumptions (Creswell & Poth, 2018).

Practices to Enhance Trustworthiness

There are practices to enhance the trustworthiness of the findings in qualitative research, including QD. These include the researchers discussing their positionality, as well as practices used by researchers to enhance reflexivity.

Positionality should be revealed at the beginning of the study as it highlights ethical challenges such as accessing sites and participants. For example, researchers may not belong to the participant's culture or background and may have difficulties with building trust. Such factors may warrant the use of gatekeepers, individuals who can permit the connection between the researcher and participants (Creswell & Poth, 2018).

Practices to enhance reflexivity include addressing biases by maintaining a reflexive journal. Although biases cannot be entirely removed from a study, researchers can minimize this in QD through attentiveness to the perspectives of participants as well as the impact of the research process. Other things to consider within reflexive journals are what questions to ask participants and also, to identify interventions to use if adverse instances arise during the interviews. During data collection and data analysis, researchers may reflect on the impact of the interview questions on the participants (Pietkiewicz & Smith, 2014) and if the interview questions contribute or prevent answering the research question. When publishing and representing data, researchers can reflect on how the findings may influence the study site and participants (Creswell & Poth, 2018). Remaining reflexive can help produce solutions such as

masking participants' identity due to confidentiality and reframing negative findings as challenges or areas of improvement (Creswell & Poth, 2018).

Besides journaling, there are other practices that can enhance reflexivity. Going back to the original data (e.g., transcripts) can also help the researcher remain true to the data to ensure that findings are consistent with participants' perspectives (Probst, 2015). Researchers can employ triangulation and member checking (Colorafi & Evans, 2016). Triangulation can be described as drawing from multiple sources, methods, and theories to ensure that findings are comprehensive (Creswell & Poth, 2018). Depending on the study, QD researchers may employ any of the four triangulation strategies: data triangulation, investigator triangulation, theory triangulation, and methodological triangulation (Salkind, 2010). For example, QD can involve multiple researchers in data collection and analysis through investigator triangulation; this helps audit the consistency of data, minimizing bias (Salkind, 2010). Another way to increase credibility is to utilize member checking to solicit participant feedback regarding the findings and interpretation (Creswell & Poth, 2018). Member checking is crucial as it allows the researcher to verify if the findings make sense or if there was a deviation from the participant's perspective. Overall, engaging in such activities can help increase confirmability.

Reflexivity also allows the researcher to consider the ethical implications throughout the research process (Creswell & Poth, 2018), especially when working with vulnerable populations. This can be challenging for researchers, but important. Dahlke et al. (2015) engaged in participant observation of nurses working with older, hospitalized adults. Reflexivity involved remaining or exiting difficult situations with patients. For instance, changes in a patient's comfort level or in the physical health of an older patient, required reflexivity on the part of the researcher to respond ethically and sensitively to situations. Although these patients had

provided consent to participate, she withdrew in one situation, and in another, moved to the background of the situation. Reflexivity also involved navigating complexities of securing informed consent among patients, family members and frequently changing health care providers. When patients would choose to give verbal consent but not written consent, nurses' work with them was not included in the data.

Other challenges to enhancing reflexivity involve the time invested in this activity; the time required may not work with professional timelines to finish a project. Also, while researchers may value reflexivity in theory, both the practice and evaluation of reflexivity remains challenging (Probst, 2015). The ability to assess a researcher's reflexive practice leads into other critiques that QD faces within the research community.

Limitations

QD is often criticized for its lack of credibility, as well as its similarities with other qualitative methodologies (Neergard et al., 2009). Sandelowski (2000) described that descriptive research is often considered one of the lesser forms of research design. Yet even with these concerns, Neergaard et al. (2009) supports the use of QD as an appropriate method for researchers, especially those who are interested in establishing a clearer phenomenological description. Thus, these critiques are not limitations or a reason to not pursue QD research. Instead, they serve as a reminder for researchers to clearly articulate methodological underpinnings and to remain attentive to trustworthiness.

Conclusion

QD is a reliable qualitative descriptive approach that novice nursing researchers, such as students, can employ to study phenomena, experiences, and perspectives. It differentiates itself from other qualitative methodologies, such as phenomenology, by being less inferential and less

theoretical. QD focuses on describing the who, what, where, and why of the experience which is different from the aims of grounded theory (to develop theory), ethnography (to understand and describe culture), phenomenology (to comprehensively describe lived experiences), and case study (to explore process). By not being caught up in the complexities of theories, philosophies, and deduction, beginning nursing researchers can easily initiate a QD study. By limiting the need to learn and employ time-intensive complex research approaches, nurses in multiple specialties, such as psychiatry, obstetrics, pediatrics, and education have utilized QD. Furthermore, in addition to QD being an easy approach to use, it is applicable to numerous research questions, makes the findings easy to connect with the data, and offers flexibility with the application of theory. QD often utilizes purposeful sampling and semi-structured interviews. QD can adopt either TA and QCA for data analysis and represent findings in simple, straightforward language. Lastly, it employs strategies based on confirmability, credibility, and transferability to establish trustworthiness. The examination of varying components of QD can help ensure congruence throughout the research process, making a case for a more effective research study. Overall, novice nursing researchers should not abstain from QD as it is a valid qualitative research approach that offers multiple benefits for those new to research.

Specifics of Project Methodology

This following section discusses the methodology employed to obtain the findings within the thesis. Below, I discuss the study design, study population, data collection, data analysis, trustworthiness, ethical considerations, and limitations.

Study Design

The study utilized QD to draw upon the perspective of nurses. QD is an approach that can answer the proposed research question as QD aims to uncover, understand, and describe a specific population's perception and experience of a particular phenomenon or concept of interest (Bradshaw et al., 2017; Neergard et al., 2009).

Interpretive Framework. Interpretive framework is important to a research study as it sets a philosophical precedent and helps align different components within the research study (Creswell & Poth, 2018). I chose QD as a methodology and discuss the underlying ontological and epistemological assumptions when utilizing social constructivism as an interpretive framework. Although QD is less theoretical than other qualitative research approaches, I believe that QD utilizes social constructivism as an interpretive framework with ontological and epistemological assumptions. Ontology can be described as how one views reality and is concerned about what constitutes reality (Bradshaw et al., 2017; Creswell & Poth, 2018). Ontologically, QD assumes that reality is socially constructed, is context-specific, and changes over time (Plack, 2005); thus, there are multiple realities (Creswell & Poth, 2018). Even if there is a unique phenomenon of concern, experiences can vary depending on the individuals and population involved. Epistemology is concerned about what suffices as knowledge and how knowledge is created, justified and revealed (Bradshaw et al., 2017; Creswell & Poth, 2018). Epistemologically, QD assumes that there is no such thing as objective knowledge and that the

truth is relative, based on the subjective interpretations and experiences of individuals participating in the study (Gephart, 1999). The individual's knowledge is based on complex interactions between their context, experiences, and interpretations. Consequently, QD researchers attempt to retrieve and illuminate this subjective knowledge that can only come from the participants. Moreover, much like the participants, researchers also have subjective knowledge, which influences how knowledge is retrieved, co-constructed, and reproduced (Creswell & Poth, 2018). Overall, researchers must be aware of their role and contribution to research, especially during the data collection and data analysis.

Study Population

Sampling. I utilized purposeful sampling. As QD samples are often small and this is a master's level study, I targeted five to eight inpatient nurses at an academic teaching psychiatric hospital.

Participant Recruitment. I requested that managers send out an email with the invitation to participate in addition to the recruitment posters for participants. I also requested that managers send a reminder email (using the email reminder script) to the teams, 1-2 weeks after the initial email had been sent. Within the invitation to participate and recruitment posters, participants were asked to connect with me via email or phone if they wanted to participate. Participants were required to meet all inclusion and exclusion criteria. The inclusion and exclusion criteria were reviewed with each participant during the initial contact with the condition that all criteria must be met.

The participant inclusion criteria were:

1. Age between 18 and 64 years, inclusively;
2. Must be a practicing Registered Practical Nurse (RPN) or Registered Nurse (RN);

3. Must have provided care to ISUD
4. Be able to provide written informed consent;
5. Be willing to comply with study procedures;
6. Be able to communicate in English;
7. Be able to utilize the video conferencing platform of Webex.

Participants were also assessed to meet the following exclusion criteria:

1. Belongs to a discipline other than Nursing;
2. Practicing Nurse Practitioners;
3. Have not provided care to ISUD.

The initial recruitment included two inpatient units that specialized in providing care to ISUD. However, due to difficulties with participant recruitment, I expanded recruitment to include four additional psychiatric units and the amendment of the inclusion criteria. Recruitment challenges may have stemmed from the emergence of Coronavirus disease, resulting in rapid changes to the healthcare system, and workforce fatigue. Recruitment started on June 9th, 2021 and ended on September 10th, 2021. This resulted in the recruitment of four participants for the study.

Consent. When participants expressed that they wanted to participate, I contacted them and utilized the initial email contact script and/or initial telephone script. I retrieved the expressed consent to communicate via email and pertinent information for the master list. I also ensured that the participants met the inclusion criteria. Afterwards, I scheduled the informed consent meeting and provided participants with a link to a read-only copy of the Informed Consent Form (ICF) via REDCap prior to conducting the consent discussion. The link could be used by participants as many times as they wished (it was not single use). Upon clicking the link,

participants could review the landing page, and continue to the ICF text. The entire contents of the ICF was displayed according to the Research Ethics Board (REB) approved consent form, except the signature/attestation page(s).

At the scheduled Informed consent meeting, I reviewed the consent form with the participant. Following the consent discussion, the prospective participant was sent a link to the e-consent via email. The participant completed the e-consent. I then completed the Informed Consent process checklist. Following the participant signature, I completed the Person Conducting Consent Discussion Attestation Page. PDF copies of the signed ICFs and Attestation pages were retained in the REDCap File Repository. I provided the participant with a copy of the fully signed ICF via email. Then, I scheduled the data collection meeting via a Webex meeting invite which included the Webex email script. Webex by Cisco (see https://www.webex.com/) is the approved web conferencing platform at the hospital.

Data Collection

Given limitations posed by COVID 19, data was collected virtually (through Webex) using semi-structured interviews. Interviews were one hour in length. Interviews were audio and video recorded for transcription purposes. For the study, an interview protocol was utilized. I pilot tested and sought feedback regarding the interview tool from nurses who had experience in addiction and the leadership of the program and incorporated any suggested changes prior to using with the four participants. Additionally, after the first interview, I reviewed the interview protocol, the approach, and data collected with my supervisor and refined the interview protocol to complete the remaining interviews.

Data Analysis

After the data was collected, I listened and reviewed the recorded interviews. Additionally, I transcribed the interviews which helped with the data analysis. I utilized Qualitative Content Analysis (QCA) for the proposed study due to the application of lower levels of interpretation and less inference which allows for the findings to be rooted in the participants perception (Kim et al., 2017). To aid in this process, I utilized the NVivo12 by QSR International (see www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home) software.

Trustworthiness

Previously in this thesis, I discussed my positionality as part of ensuring trustworthiness. Further, I utilized bracketing (Creswell & Poth, 2018). I also engaged in reflexivity (Vaismoradi et al., 2013; Willis et al., 2016) during the study and utilized coding in vivo and used quotes in data representation. Although I offered member checking, none of the participants were interested in this. To increase transferability, I included detailed and thick descriptions of the participants and the setting.

Ethical Considerations

I completed the Tri-Council Policy Statement 2 in preparation for this study (Canadian Institutes of Health Research et al., 2018). A REB approval was received from Athabasca University. Once ethics approval was granted, I received approval from the REB of the academic psychiatric teaching hospital.

Data was stored in a password-protected file on the principal investigator's computer. Any hardcopies of data have been stored in a locked filing cabinet. All recordings were password protected. The computer is password protected and will be safely stored at all times. Data will be retained for 5 years after the completion of the study, and then destroyed.

Compensation. I included a lottery of one twenty-dollar gift card to Starbucks for those that chose to participate in the study. This was a gesture of goodwill and appreciation of participation.

Managing Risk. There were minimal physical, social, and economic risks involved by participating in the study. However, there could have been psychological and spiritual risks. The risks were due to the author requesting participants to think about their experiences in the past. These can include traumatizing and non-positive experiences which can impact their emotional state. If any psychological or spiritual risks had arisen, I would have immediately connected participants to the CAMH principal investigator, who is a licensed Nurse Practitioner with extensive clinical experience, who could then conduct an assessment and implement interventions. Interventions could have included providing participants with a list of organizational supports for employees or crisis resources. If there was an extreme risk, interventions might have included the principal investigator and I contacting emergency services to provide support to the participant. However, no risks emerged in the data collection.

Limitations

Due to the contextualized uniqueness of the research site, it would be difficult to generalize the findings of the study. What may work for nurses in the hospital study setting may not necessarily work for other nurses in other settings. For example, the addiction units usually work with individuals that are voluntary under the Mental Health Act. This may hamper transferability of findings to units with involuntary clients. Moreover, given the chosen participants, it would be limited to the nurses' perception and may not reflect the perception of ISUD. Thus, ISUD may not perceive the findings to be useful to them. Additionally, due to the small number of participants, the knowledge produced was limited to the information provided

by the participants. Thus, there may be other effective interventions that were not discussed in the study, due to the small sample size. Given that I conducted research in the hospital where I work, this introduces bias. Firstly, given the self-reporting nature of the interview, there may have been recall bias. Recall bias accounts for the variance in participant response which depends on the participant's motivation, memory, and ability to respond (Bhattacherjee, 2012). For example, were the nurses participating in this interview during a busy work shift or after a night shift? To counteract this, I attempted to schedule a time that worked for the participant. Secondly, the study was also exposed to social desirability bias, the act of providing anticipated answers to act in a socially desirable manner to avoid negative opinions (Bhattacherjee, 2012). For example, participants could have provided all the "right" answers to demonstrate that they abide by the best nursing addiction practice. To limit this, I acknowledged my position within the institution and discussed confidentiality; I had a researcher lens on rather than an educator lens and informed participants that what was said and by whom during the interview would not be shared with the institution. Additionally, I highlighted that the purpose was to look at what were effective recovery-oriented nursing interventions rather than deficits in practice.

Chapter 4: Findings

Within this chapter, I will discuss the demographics of the research participants and discuss the findings of the study. Research participants discussed how they utilized effective recovery-oriented interventions. (Please note that although the word client is used within this section, it is interchangeable with the term patient, person, or individual. The term patient is typically what is being used in the hospital inpatient setting). Based on the interviews, findings were broken down to highlight the participants' view of recovery, theoretical and practical approaches applied when caring for ISUD, and interventions rooted in the themes: person-centred, empowerment and promotion of hope, and a holistic approach.

Demographics

In total, there were four participants between the ages of 23 and 39 that took part in the study (See Table 3). There were two male participants, one female participant, and one non-binary participant. Three participants had their RN license and one was a RPN who was completing their Bachelor of Nursing degree. Three participants worked in addiction specific inpatient units and one participant worked in a general psychiatric inpatient unit. Two out of the three RNs had their Canadian Nurses' Association (CNA) psychiatric certification. Participants had between 3 to 9 years of experience working with ISUD.

View of Recovery

Given the diverse definitions and approaches when thinking of recovery, participants were asked how they viewed recovery. This helped identify if there was a definition of recovery that resonated with nurses who work with ISUD. The study reveals that participants view recovery as a process with general goals rooted in abstinence (Participants 1, 2, 3, 4) or harm

reduction (Participants 2, 3, 4), and it is largely driven by the person receiving care (Participants 2, 3, 4).

Table 3

Participant Characteristics

	Participant 1	Participant 2	Participant 3	Participant 4
Age	28	39	23	34
Gender	Male	Female	Male	Non-Binary
RN or RPN	RN	RN	RPN	RN
CNA psychiatric certification	Yes	None	None	CNA certification
Workplace (Addiction specific or General psychiatry)	Addiction Specific	Addiction Specific	Addiction Specific	General Psychiatry
Length of time working with ISUD	5 years	9 years	3 years	4 years
Additional Education	Addiction courses Sublocade Certification	Motivational Interviewing	Psychiatric Certifications	Motivational Interviewing (MI)

Recovery as a Process

Participants discussed how they viewed recovery and how it gets integrated into the care of ISUD. Participants identified that recovery is a continuous process that ISUD go through. Participant 1 outlined:

> Recovery I think, is a whole process, all about getting back to normal state, or normal functioning of the person. It is a continuous, lifelong process that clients go through. It involves mental, physical, psychosocial components of the client.

Many factors may contribute and influence an individual's recovery goals and what the person identifies as essential to their recovery. Thus, there is variability with how recovery is viewed throughout the recovery journey. Participant 3 discussed the fluid and non-linear nature of recovery:

> Um, I'd say it's not like a linear process, like uh, maybe there's steps to recovery you know, but it's not, you start with taking a step and may have a relapse, that's ok, that's part of the process. I think that process is different for everybody, there's no one clear view of recovery the way it is.

General Goals

When thinking about recovery, ISUD can have diverse goals. For some, it is getting back to a *normal functioning*; it might be rooted in their physical state. For example, Participant 1 discussed the withdrawal process as substances have contributed to an altered physical state:

> In my experience, their recovery, part of the recovery is them. You know, going through the withdrawal process and then getting back to a normal state of their health. And, I feel like the clients I had in the past, uhm even in Medical Withdrawal Services (MWS), it's very acute in there so they think about recovery, they think about to go through withdrawal process.

However, there is a need to go beyond the physical needs of the person, treating more than one aspect, and having a holistic view. Participant 2 discussed how a team can work with an ISUD holistically:

> ...we have family medicine addiction doctors...where they might deal with the biological treatment of addiction.... we also have psychiatrists who might deal with the psychological effects of addiction...as well as Social Worker (SW) and Occupational Therapist (OT), there's a whole team to treat the whole picture, a holistic picture of the client versus just a biological intervention. So, the social part is getting them connected in the community, having families as a part of their care, whoever they define as their family. Just making sure that the three pieces are all treated. Because if one, if their care is missing in one of those domains...then the chances that they...their recovery is not successful is higher if we don't treat the whole picture.

Although ISUD have diverse goals, recovery goals can focus on substance use due to its positive and negative impacts on one's life. Some ISUD can opt to try to completely stop using substances (abstinence) and some may decide to take a harm reduction approach. All four participants discussed exploring the client's preference regarding this. Participant 4 outlines this approach:

> I find engaging them in a discussion and specifically in the context of substance use, uhm...you know there's a lot of clients who may define recovery for themselves as abstinence and then there's a lot of clients who may take a harm reduction approach.

Person Driven

Lastly, participants (Participants 2, 3, 4) highlighted the importance of letting ISUD guide their care and recovery. It is imperative to explore what recovery means for the person and to identify their goals. Although the nurse may have a view of recovery or what can be helpful for the individual, the participants identified that it is imperative for the individual to guide the

whole care journey. Additionally, it accounts for the diverse views, goals, and experiences of individuals. Participant 4 explicated the following:

> So, I think the important thing about recovery is that it's not about how I view it as a nurse, it's about how each individual client views their own recovery and they're the ones who define it for themselves. It looks different for everyone but like from a working point of view, meeting people where they are, making them be...I don't know, letting them define what recovery is for them?

Theory or Approaches

All participants discussed diverse theories, approaches, and perspectives that they apply when caring for ISUD. Theories and approaches include the biopsychosocial model and concurrent disorder, destigmatizing approach, trauma-informed approach, stages of change and Motivational Interviewing (MI), and harm reduction.

Biopsychosocial Model and Concurrent Disorder Approach

Participant 2 discussed using a holistic approach that targets the biological, psychological, and social aspects of an individual. Two participants discussed that nurses "wear a lot of hats" and Participant 3 explained the following:

> Yeah, we are there all the time, if they need, we manage their medical needs, their mental health needs as well. We are just there all the time. That's what I mean by we wear many hats. Sometimes, we are even your rec(reational) therapist when we take you out for passes. Maybe a little bit of SW when you have issues with your housing, or you know people want to talk about their money and what not. They tell us their medical concerns that we can relay to the hospitalist or their mental health issue to their psychiatrist. I think

> in that sense we wear a lot of hats, and other disciplines are a bit more narrow compared to what we do.

Coinciding with the biopsychosocial model, Participant 4 discussed utilizing a concurrent disorder approach when working with ISUD. Participant 4 provided their view on this:

> Well by definition concurrent disorders is that they often coexist together and I don't think the connection is really fully understood but it's kind of like theorized that either the symptoms of the mental health condition can cause the person to seek refuge in using substances as a way of coping. But also, that people who use substances can sometimes develop mental health challenges as a result. It's not really teased out yet the exact relationship.

De-stigmatizing Approach and Lived Experience

Participant 4 also discussed a de-stigmatizing approach and engages in de-moralizing substance use within their work setting. Interestingly, Participant 4 also discussed their lived experience with a mental health disorder, although it was not a substance use disorder. Participant 4 outlined that some of the skills that they learned in the outpatient program are similar interventions that they may utilize with ISUD and their lived experience may make providing education easier.

Trauma-Informed Approach

Participant 2 further discussed that the concept of gender as it intertwines with trauma. Additionally, Participant 2 discussed utilizing a trauma informed approach:

> So, trauma informed is recognizing that trauma is kind of...recognizing and appreciating that...(unintelligible) walks through our door has some kind of trauma that is going to

> influence the way that they receive care...so it's about respecting patient's wishes, being a safe space for them to come and talk and seek treatment.

Stages of Change and Motivational Interviewing (MI)

Although it doesn't guide their practice, Participant 2 also spoke about the utilization of stages of change, a commonly used concept when caring for ISUD. Additionally, participants (Participants 2, 3, 4) discussed utilizing MI, although this is not an approach that they have been certified in or would consider themselves proficient.

Harm Reduction

Lastly, three participants spoke about the utilization of harm reduction within their practice. Although Participant 3 didn't discuss harm reduction as a concept, they discussed how harm reduction influenced them to pursue a career in psychiatry and work with ISUD. Participant 4 outlined harm reduction as a philosophy:

> Harm reduction is like, I guess it's a philosophy where instead of taking hardline approach, to what we believe clients' recovery should look like, we're doing things that minimize harm for the client and accomplishes their goals. So like, for one client, and that could be different from one client to client, for one person it might be like instead of using uhm... meth every day, I'm gonna use it like only on the weekends. For another client, it might look like – I'm just gonna have a naloxone kit and that's what I am ok with.

The participants discussed the overall goal of minimizing the harm of substance use and its consequences by providing interventions such as safe alternatives like opioid agonist treatment, monitoring use in safe consumption sites, and preventing complications and death by providing naloxone kits and harm reduction supplies. Overall, participants discussed multiple approaches,

theories, and perspectives that impact their nursing interventions. The following section discusses the themes and subthemes that reflected the identified effective nursing interventions that supported the recovery of ISUD.

Effective Nursing Intervention Themes

Person-Centred Care

All participants outlined that ISUD become a focal point of the caring interaction and it was very important for nurses to be person-centred. Recurrent subthemes were focused on the development of a therapeutic relationship and the co-creation of a care plan (See Table 4).

Establishing a Therapeutic Relationship. An essential component in the beginning of the inpatient stay is to establish a relationship with the individual receiving care. This is fundamental in order for further interventions to occur. Not establishing a relationship can lead to consequences to the inpatient stay. Participant 1 explained the following:

> So I think what really helped is first, establishing relationship with the client. And once you establish relationship with the client, you eventually get to have a meaningful discussion with the client. Some of the clients may even engage and talk to you about their past history, their addiction, the substance, how much they are taking, I noticed that some clients as well in my past experience, if you don't establish a good rapport or good relationship with the client, the client may not engage with you in a conversational or meaningful discussion. And it's hard to identify what their goals are, or what kind of substances they're coming off, or how much they're taking, it makes it harder for the nurses and as well for the team as well.

Although the nurse attempts to establish the relationship when the patient gets admitted, participants discussed that this happens throughout the inpatient stay which can lead to a stronger

Table 4

The Theme and Subthemes Within Person-Centred Care

Person-Centred Care		
Establishing a therapeutic relationship	General Nursing Approaches	Welcoming and friendly
		Introduction
		Avoid medical jargon
		Avoid wearing uniform
		Notice the small things
		Acknowledge and applaud decision to come
		Validate hardship
		Ensure confidentiality, privacy, honesty, transparency, empathy, and nonjudgmental approach
		Being available
		Dedicate time
	Talking to the Person	Establishes rapport, further interventions, reflection, motivates
		Open ended, probing, answering questions
		Focus on experience
		Validate experience
		Gently persuade
		Subtle rather than direct approach
		Provide feedback
		Gauge when the person is ready
		Maintain open communication when guarded
Co-creation of a care plan	Goal Identification	Do not enforce treatment or goals they're not seeking
		Allow patient to set goals

Person-Centred Care		
		Set a plan for admission Identify goals – substance related Focus on life goals Post admission goals Support goal attainment
	Collaboration	Offering information Asking feedback about care plan

therapeutic connection. To establish a therapeutic relationship, participants discussed interventions that were considered general nursing approaches including talking to the person.

General Nursing Approaches. All participants discussed standard nursing approaches that they apply. First, participants outlined that it can be helpful to be welcoming and being friendly. Nurses can introduce themselves, not use uniforms but dress in street clothes, and avoid using medical jargon. Sometimes it can be noticing the small things that the client appreciates and using that as a starting point for conversations. Participant 2 provided an example:

> …kind of therapeutic sharing, whether they come in wearing a Raptors hat...talk about the Raptors a little bit, talk to them as a person and not as a patient or whatever number is on their ID band.

By focusing on the interests of the person, they can feel as if they're an individual not so different from the care provider (Participant 2). It was also helpful to acknowledge and applaud the client's decision to come in to get help (Participant 2). Doing so encourages them and allows the person to believe that staff want the best for them (Participant 2). Validating hardships that previously took place can also be helpful (Participant 2).

When caring for ISUD, they intentionally ensure confidentiality (Participant 1), privacy (Participants 1 and 3), honesty and transparency (Participants 2 and 4), and utilize empathy

(Participants 1 and 2) and a non-judgemental attitude (Participants 4). Participants 2 and 4 outlined that these approaches can be helpful to lessen the power imbalance existing within the nurse-client therapeutic relationship. A prominent intervention that all the participants discussed is being available throughout the 24-hour day to individuals for which they provide care. Participant 2 outlined the following:

> So, uhm...like the allied health is there 8 hours a day, and nurses are there 24 hours a day so...you know problems don't only happen in the 8 hours the doctors are there, or the SW is there. We are the first contact for everything, every hour of the day. So even if they want to talk to a SW, they talk to a nurse first, if they want to talk to doctor, they talk to nurse first. We are always that go between. We are available 24/7.

Being available and accessible means that the nurse is generally the first person ISUD access throughout their inpatient stay (Participants 2 and 3). This allows nurses to build rapport, understand the contextual background of the inpatient admission, and discuss the individual's needs (all participants). Additionally, Participant 3 discussed that nurses are the "eyes and ears" of the care team due to increased availability and presence. This allows nurses to notice more medical, social, and psychological concerns than other interdisciplinary care team members (Participant 3). However, being available is not enough and nurse should intentionally create space and time for interaction. Participants 1, 2, and 4 discussed that they dedicate specific time to spend with the individual, to ensure that they see ISUD frequently throughout their shift. When spending time with the patient, talking to the person about various topics can help advance the therapeutic relationship.

Talking to the Person. The subtheme of talking to the person is the act of dedicating the time and space to have ongoing conversations with the person. All participants outlined that this

is an effective intervention when working with ISUD. Talking to the person is helpful to continue establishing rapport, allowing for further interventions to be implemented, encouraging self-reflection, and can help motivate the person in their recovery journey (Participant 1). Interventions can focus on common techniques such as using open-ended questions, probing questions (Participant 4), and answering questions (Participant 3). Participants discussed that it can be helpful to focus the conversation on various things. One strategy is to let the person verbalize their experience (Participants 1 and 3). Initial discussions can be solely focused on substances and individual experiences can be neglected. Thus, it is vital to let the individual have space to speak about aspects that they may want to speak about and let them verbalize their needs. When discussing experiences, it can be helpful to validate challenging situations (Participants 1 and 2). When talking to ISUD, participants discussed having specific intentions for the conversation. For example, discussions can focus on gently persuading ISUD to think about and make healthier choices. Participant 3 discussed meeting individuals where they are at:

> So I think meeting people where they are, you know providing the support make some healthy choices, little bit safer, and kind of use that gentle persuasion, maybe planting seed of abstinence later on – that's probably more effective than cold turkey or if you know what I'm saying?

Another example would be to use conversations to have a subtle rather than a direct approach when speaking about options. A way that this can be done is to discuss consequences of options (Participants 2 and 4). Another focus can be on providing feedback to the patient (Participants 1, 2, and 3). Feedback can emphasize various aspects such as the individual's negative self-talk or their progress.

Individuals may have varying mental or emotional states when they come into the inpatient unit. These can be based on potential intoxication or withdrawal states. Although nurses may need to conduct specific assessments, they must gauge if the person is ready to engage in the conversation and delay assessments or interventions as needed (Participants 2, 3, and 4). Participant 4 outlined a helpful approach when individuals present with altered mental states:

> So, you can kind of give people reasonable expectations if I can guess what they're gonna feel like the next few days. If they're using opioids, the first time they're coming off opioids, I'll let them know that you won't be feeling well for the next few days. Maybe during that time, you don't want to do goal setting until they feel a bit better. But at the beginning, I try to ask, every time I do an admission, I try to ask about the goal, what would you like to see at the end of your stay.

Lastly, Participant 4 noted that individuals may also not trust the healthcare system and care providers. Although they might be at optimal physical and emotional states to discuss their goals and wants, previous stigmatizing experiences may impact their current responses. Participant 4 offered the following:

> I tell them, if they're guarded, you know, I am here if you want to talk but if you don't want to talk, that's okay too. I find that, that kind of sometimes, occasionally will break down that barrier. Well okay now there's no pressure.

After establishing a relationship, another way for nurses maintain person-centredness is through the co-creation of care plans with ISUD.

Co-Creation of a Care Plan. The subtheme of co-creation of a care plan centres on interventions that aim to understand and highlight specific goals of the person receiving care. To establish a care plan, participants highlighted interventions rooted in goal identification and

collaborating with the person.

Goal Identification. All participants discussed how vital it is to focus on the goals of the person receiving care. To do so, participants discussed not enforcing treatment approaches or goals that the person was not seeking, especially when they are not ready (Participants 3 and 4). Participant 3 considered this in detail:

> Yeah so, I guess for everybody abstinence isn't the goal, maybe some people want to reduce how much they use or use a method that will be a bit safer. I guess you can't really force people who aren't ready. If you really want someone to abstain for the rest of their life, they have to be ready for that, right? So I think meeting people where they are, you know providing the support (to) make some healthy choices, little bit safer, and kind of use that gentle persuasion, maybe planting seed of abstinence later on – that's probably more effective than cold turkey or if you know what I'm saying? Forcing people into abstinence.

Based on the perspective of ISUD, the nurse supports what the person may want or need. For example, some ISUD present with multiple substance use challenges and may only want to focus on one substance during the admission. When this is the case, the nurse allows the client to set the goals. Participant 2 outlined this practice:

> If they're polysubstance and they...you ask them...what is their goal here...and their goal might be to stop using opiates but continue using cocaine at parties or whatever...As long as that cocaine is...It's one substance at a time for me...So, the patient makes the goal of what they see long term. They're living their best life at...their most functional life and if it includes using a substance...occasionally or a harm reduction, reducing the amount then uh...that's what their recovery means to me.

All participants outlined that it is imperative to set out a plan for the admission. This can be achieved by trying to understand what recovery means for the individual with SUD and trying to understand what their goals are (Participants 2, 3, and 4). However, nurses can purposefully ask about the substance(s) of concern which can help establish history (what type of substance is the person consuming and the amount) and context for the admission (Participants 1 and 2). Nurses can further co-create the care plan by trying to understand what the client's goals are. All participants overwhelmingly discussed interventions rooted in trying to identify the goals of ISUD during the admission.

Generally, it can be helpful to ask the client what they would like to achieve at the end of their admission (Participants 3 and 4). Nurses can focus on substance use specific goals. To extract these goals, nurses can ask if there is a preference for abstinence or harm reduction and if there is a focus on one substance or multiple substances (all participants). Cessation or reduction of substance use can also introduce issues that individuals may have challenges with. For example, clients may have cravings to use substances after admission. Thus, clients may have goals around increasing their tools or coping skills. Alternatively, participants outlined that nurses could discuss future possible situations and highlight some goals that could be helpful. Participant 3 spoke about it below:

> They have to try to give people the idea that you're gonna have these feelings, they're inevitable, you're gonna be at a point - I wanna have a drink. You have to figure out what you're gonna do about that. That's part of goal planning, if your goal is abstinent, you have to do some kind of intervention to stop you from drinking. That's definitely part of the nursing role during their stay.

Goals can focus on other aspects of the person's life such as education, vocation, and life goals. Participant 3 outlined the following:

> So, if they're dissatisfied with the way their life is going. If they have an idea of where they're like to be, maybe they don't like their work, maybe they don't have any hobbies, things that make their life enjoyable, that's something that's always a good idea to explore, and try to understand you know - what they would like out of life?
>
> Uhm, I think it's a good idea to understand, if it's not even about just life goals, like what else they want to do, it's definitely about your goal for substance use, where do you want to go from here. In a few weeks, when you're gonna be done withdrawing, do you wanna go back, what do you want to do afterwards?

As such, goals do not always have to be focus on the admission stay but can also focus on post-admission (Participants 1, 3, and 4). Participant 4 offers another way this can be asked:

> It depends on how, on my relationship with the client. I think this client specifically, I approached it like asking him...in your best-case scenario of how things are gonna go for you when you are discharged, what would that look like for you?

After general goals have been identified, participants outlined that it is vital to support clients attain their goals. Nurses can ask clients to write down their goals. This intervention encourages ISUD to reflect on themselves and their goals; this can be helpful for those that may have not set goals (Participant 1). Nurses can also ask clients to further break down their goals to smaller and attainable goals (Participants 1 and 3). For example, clients can identify daily or weekly goals that progress toward their major goal. After goal setting, nurses can support clients identify next steps that are essential to their goals (Participants 1, 3, and 4). Another helpful intervention would be to remind individuals about the goals they have set in the beginning of the

admission (Participant 3). In some instances, the challenges with substances can lead to resigning from their treatment. Participant 3 explicates how nurses play a role in this:

> They told us what they'd like to do, they told us what their goals are for the admission, we are just kind of helping them stay on track. Sometimes, I find that people that they're about to leave and they wanna sign out Against Medical Advice (AMA). You can sit with them and remind them why they're here, what they wanted out of this admission, and why they should stay. Sometimes that does work.

When such opportunities present, nurses can attempt to have further discussion about their goals, highlight their goals, and reasons they should continue the admission. Overall, all participants outlined that it is effective to support ISUD identify goals, next steps, and support their goal attainment. Throughout the care interaction, participants highlighted that nurses collaborate with the individual.

Collaborating with the Person. During the inpatient admission, the nurse responds to the client as much as the client responds to the nurse. In some instances, nurses may recognize that they can impart something that maybe beneficial to the person and attempt to offer it. Participant 3 discussed what one can do when ISUD feel "stuck":

> Maybe the client's kind of stuck at a point in their recovery. Advocating for themselves...we can give them some pointers and some tips what might help them along with their recovery. If they're agreeable we can advocate for that...Sometimes some clients are reluctant to change or uh you know don't like the plans set forward by the team.

Nurses can also encourage collaboration by asking feedback from the person regarding their treatment plan. For example, nurses can ask if there could be something else the team could do to

change or improve the care. Clients can also present with challenges that they are struggling with and with which the nurses can work. For example, Participant 4 supported a client's decision regarding Methadone and Suboxone:

> I have this client who was dependent on opioids. He had been on Methadone for quite some time. He was admitted for mental health and but also has concurrent substance use ...and he was trying to decide whether Suboxone versus Methadone was right for him. Whether he was ready to make the change...uhm from Methadone which he had been on for years to Suboxone which is more like, more recent medication and could've helped him in his recovery. Um, and so I helped him explore his feelings around what his goals were for himself and his recovery and like what each of those choices would look like for him in terms of matching up with those goals.

In this instance, the client presented an issue they were grappling with, and the nurse responded with specific interventions to allow for better decision-making. Depending on what the ISUD brings to the care encounter, the nurse responds to support the person's wishes and goals. Overall, it is important to be person-centred throughout the inpatient admission. Participants outlined that this can be achieved by establishing a therapeutic relationship and co-creating a care plan, allowing the person to set goals for the admission and guide their care.

Empowering the Person in Their Recovery Journey and Fostering Hope

All participants discussed that effective interventions were focused on empowering ISUD and fostering hope. Subthemes that recurred were education, ensuring that ISUD have options and choice, and providing encouragement and advocating on their behalf (See Table 5).

Education. ISUD may often feel disempowered through the challenges they have faced. This can make them feel that they are unable to achieve their goals and continue with the way

their life has been going. Thus, all participants found that it was helpful to increase the patients'

Table 5

The Theme and Subthemes Within Empowerment and Hope

Empowering the Person in Their Recovery Journey and Fostering Hope		
Education	Provide education on substance(s)	Withdrawal process Pharmacotherapy IV issues – infection, BBV Harm reduction approaches How to use needles Supplies Overdose prevention and intervention Naloxone kit The law Safe consumption site
	Tools	SMART Recovery DBT
Options and choice	Made aware of available options Discuss positive and negative impacts of options Give choice and clarify preference	
Providing encouragement and advocating on their behalf	Act as their cheerleader Explore life and positive aspects	Social supports Future plans
	Advocacy within hospital	Advocate for best interest Medical or mental health needs Safety Longer admission Advocate against stigma Speak up and confront Sets tone-stigma will not be tolerated Role model
	Advocacy external to hospital	Housing Waitlist

belief in themselves to achieve goals they have set. To increase their ability, participants outlined that it is beneficial to educate and provide tools to ISUD (all participants). Education tends to focus on substances, their impact, and potential interventions. For example, nurses can provide education on the withdrawal process (Participants 2, 3, and 4) and potential pharmacotherapy that can be used to alleviate withdrawal symptoms (Participant 2). Another education focus can be on the route the substances are taken. For example, for those that consume substances intravenously through injection, nurses can provide education on blood borne viruses (BBV) that transmit via blood (Participant 1). Thus, education also focuses on harm reduction. For example, nurses can provide education on safe use of needles, the benefits of having harm reduction supplies, interventions to take in case of an overdose, the use of a naloxone kit, the law (Good Samaritan Overdose Act), and the utilization of a safe consumption site (Participants 1, 2, 3, and 4). Lastly, education can focus on providing ISUD tools such as Self-Management and Recovery Training (SMART) recovery and Dialectical Behavioural Therapy (DBT) skills. By providing ISUD with education, they can become informed regarding their substance use and corresponding treatment, which can support choice.

Discussion of Options and Providing Choice. After the person's goals have been identified, Participants 2, 3, and 4 outlined that ISUD should be made aware of the available options. It is helpful to do this in instances whereby individuals are unsure of the next steps and potential options open to them (Participants 2 and 3). It is also important to discuss the positive and negative impacts of each option and potential outcome of that option. Participant 3 spoke about how this can be done:

> I try to get people to walk through the choices of the options available to them and what would happen with each. Um, because I find that a lot of people don't think that through,

> really even though it seems like a really basic thing to explore. So, I would say if you made this choice, what's the best-case scenario of what would happen? What's the worst-case scenario of what would happen? If you made this other choice, what's the best-case scenario, what's the worst-case scenario? Once you run through those things, you feel, a lot of the time people feel more prepared to make a decision.

After their options are identified, all participants discussed that ISUD should be given the choice regarding what they would like to do. Potential interventions can be for nurses to ask about the individual's preferences and clarify their preferences if there are inconsistencies with the team and care plan (Participants 1 and 2). By providing choice, individuals can learn that treatment will not be forced on them (Participants 2 and 3). For example, Participant 2 spoke about allowing individuals to leave their inpatient admission and come back when they are ready. Or, some ISUD may want to continue their admission although their goals may not quite fit the purpose of the treatment. Participant 2 spoke about not discharging individuals when this occurs:

> Yeah, so even if like somebody just wants harm reduction and want to come in and just get some clean time to give their body a rest in MWS...fine. But just know that there is a loss of tolerance at the end of admission and don't use the same amount (of substance). I can see a patient coming in for two days if that's what they want...Okay. That's what we will call recovery in this moment...and of course we don't...If a patient says that (that's) their recovery... they don't get discharge from the service right away. We continue to work with them because it can be...it's fluid, it can change all the time.

By incorporating the discussion of options and choice, ISUD can feel involved with their care.

Encouragement and Advocacy. ISUD need to have hope that they can attain their goals

and that they have a future. Interventions to increase their belief in themselves would be to act as their cheerleader. Participant 2 explained why it is essential to do this:

> Well, I think that uhm...the decision to stop using substances is huge...they don't know a life without it, so its really scary. Like it's scary and it's brave and acknowledging that gives them some...gives them some self-esteem, some self-worth, have some, know that they do have power in this and that they can change and can get better. So, don't give up...cause I think probably there's a lot of negative self-talk that's been happening for a long time. So, we could be their cheerleader – is a huge thing. Maybe they don't have social support in the community or wherever they came from, and this is the first time they are realizing, yes life can be different, it can be better, without substances. Or with less substances, or whatever it is their goal is.

Other interventions that Participants 1, 2, and 3 outlined were to explore what the individual would like in their life and discussing positive aspects of their life. For example, speaking about social supports such as their partner, children, and friends that care about them can help increase hope (Participant 3). Asking about future plans and how they envision their life without substances can also be beneficial (Participants 1, 2, and 3). By doing so, clients refocus on their goals, start thinking about their next moves, and identify skills they possess or require to address their challenges (Participant 3).

To empower ISUD, all participants highlighted advocacy as an effective intervention. Advocacy focuses on nurses promoting the person's best interest (Participants 2 and 3). Advocacy can occur within the hospital. Participants highlighted that nurses can advocate for medical or mental health issues that arise which require further support. Examples Participant 3 used to highlight this included, a person's safety, room changes when unit issues occur, or as

Participant 2 shared to advocate for a longer admission. Nurses can also advocate against stigma by speaking up and confronting individuals who may be demonstrating stigma (Participant 4). Participant 4 discussed their experience:

> Yea, I speak up. I was actually in an overnight shift once with two other nurses who were talking about as if it was a purely theoretical academic subject whether people who have been in treatment for substance use more than twice and have gone out and used substances again, are deserving of treatment a third time. And they were talking about, how they were not, and that it was a waste of healthcare dollars. Um, and I was furious and I spoke up. And I'm really happy that I did because I actually changed the viewpoint of one of the two and I felt like I did my job.

By speaking up, individuals who may possess stigma can learn that they cannot speak about ISUD derogatorily and opposing stigma sets the tone that it will not be tolerated (Participant 4). Alternatively, there are stigmatizing events where judgment is passed which can be difficult to deal with. Participant 4 explains the following:

> Mostly what I am talking about is like snide, comments, where you can't quite speak up because nothing really negative was actually said but it was communicated, some judgment. And it's just like in passing, unless you get right on it, you cannot really address it on the moment.

In instances like that, nurses can role model behaviours that are mindful of stigma such as by using language that diminishes judgment towards ISUD; this can help change the stigmatizing environment (Participant 4). Advocacy can also occur external to the hospital setting. Participants 2 and 3 discussed advocating for housing or shorter waitlists for community supports. Overall, interventions that ensure patients are well informed to make choices within a

non-stigmatizing, encouraging environment empowers ISUD through their recovery and can foster hope.

Holistic Approach

Participants highlighted multifaceted interventions that focused on many components in the lives of ISUD. Effective interventions were those that targeted the biological, psychological, social domains, spirituality and culture, and recreation (See Table 6).

Table 6

The Theme and Subthemes Within Holistic Interventions

Holistic Approach		
Biological	Wound care, pain, sleep	
	Withdrawal management	Assess
		Pharmacotherapy
		Non-pharmacotherapy
Psychological	Monitoring	
	Crisis intervention	
	Identify and manage triggers	
	Manage cravings	Reassurance
		Medications
		Distraction
		Riding out the cravings
		Encourage to stay
	Manage feelings	Identification and labelling of feelings
		Anxiety Sit with the patient Ice packs Grounding
		DBT Distress tolerance Opposite to emotion action

Holistic Approach			
	Guilt	Reframe or challenge negative thoughts Coach ISUD work through negative self-talk Problem-solve	
Social	Assess Participate in care discussion		
	Connect with formal supports	Inpatient nurse can role model social skills Community outpatient medical programs	
	Connect with peers	Encourage to attend groups in inpatient setting Connect with AA or self-help groups	
Spirituality and Culture	Assess to understand Provide information about services Support spiritual and cultural practices		
Recreation	TV, movies, music Nature walk Exercise	Ping pong Card or board games Massage chairs	Art Puzzles Meditation

Biological. Participants discussed interventions rooted in the biological component of the individual. Given that each person presents with varying issues related to substances, complications can arise. ISUD can discuss their medical concerns with nurses who can provide interventions. For example, participants discussed that some individuals may present with wounds. Nurses can provide wound care and manage infection related to the wound (Participants 2 and 3). Other biological issues that nurses manage are pain and sleep hygiene (Participant 3). Nurses can also respond to medical emergencies such as overdoses within the inpatient setting. Participant 3 spoke about this**:**

Well, we have Naloxone in our crash carts, you'd also have to call code blue, do VS

> (vital signs), hopefully you wouldn't do a chest compression. The naloxone would work and you'd call ambulance. We are capable of managing those kinds of medical emergencies.

Moreover, participants highlighted that a major aspect that needs to be addressed is the person's withdrawal.

Withdrawal Management. All the participants discussed how essential it is to manage the withdrawal symptoms that clients present with. When withdrawal symptoms are not managed, clients can have increased cravings, feel the need to use substances (Participant 1), and may abruptly discontinue their admission stay (Participant 3). As previously discussed, participants outlined that providing education about withdrawal symptoms may be needed for some that are seeking treatment for the first time (Participant 3). All participants spoke about the use of pharmacotherapy to manage withdrawal symptoms. For example, Participant 3 discussed the use of standardized tools to assess withdrawal symptoms:

> So, there's different approaches for different substances. There's alcohol, there's CIWA, which is the Clinical Institute for Withdrawal for Alcohol, and you just score their withdrawal and it's like a protocol to make, not foolproof, but like to standardize the administration of medications to counter the withdrawal. Or like, for opioids, it would be COWS, the Clinical Opioid Withdrawal Scale, I think is what it stands for.

After the withdrawal symptoms are assessed, medications are offered and provided to the client. However, Participants 2 and 3 also spoke about being mindful of the effects of the medication used for withdrawal management. Medications may have anticipated effects such as sedation or euphoria that the person may still be seeking. Thus, being vigilant of the person's overall presentation and using clinical judgment to not provide further medications can be warranted

(Participant 2). For those that use nicotine, nicotine replacement therapy can be offered (Participant 1). Participants also discussed the use of non-pharmacotherapy interventions to manage withdrawal. For example, nausea can be managed with ginger, ginger ale, and crackers (Participant 2). Participant 3 spoke about the use of hot packs to manage pain and muscle aches. Overall, participants outlined that the management of withdrawal is essential to support the recovery of ISUD. After providing effective interventions during the first few days of admission, additional vital interventions can be completed during the inpatient stay.

Psychological. All the participants highlighted the effectiveness of interventions rooted in the psychological component of individuals. Within the inpatient setting, nurses can support the management of co-occurring mental health issues and can also focus on providing tools that individuals can use after the inpatient admission. Patients can have accompanying mental health issues in addition to their substance use which should be managed at the same time (Participant 3). Participant 3 spoke about on-going monitoring of the individual's mental health state and providing emotional support. Despite the support, individuals may have a crisis within the inpatient setting. When patients start having increased emotional distress, nurses can dedicate time to provide emotional support, engage in therapeutic communication, participate in safety planning, encourage the use of coping skills, and provide medications as needed (Participants 2 and 3). However, some individuals may not have coping strategies to utilize; all participants highlighted how essential it is to support ISUD to gain such skills. Participants discussed that the focus should be on supporting ISUD to independently manage triggers (Participant 4) and cravings, especially prior to discharge to the community (Participants 2 and 3). As a first step, nurses can support the identification of "triggers" to the substance use, such as emotional states like sadness, as explained by Participant 4:

> You'd also help them identify some of the triggers for them. Uhm, that are either triggering emotions that cause them to want to use substances if that's how it works for them, or sometimes it's just a trigger directly to use the substance. I say ok like is there something that like usually leads you to reach out to that or do you have a general feeling before that kind of thing happens that makes you want to use the substance? Depending on how they brought it up, the question will be phrased differently. Most importantly, non-judgmental and straight to the point.

Identification of triggers can help pre-emptively identify how they can cope when such occasions reoccur in the future (Participant 2). Additionally, nurses support the management of "cravings" related to the substance. Individuals may be tempted to use substances as cravings may start to increase as they work towards their goal.

Nurses can provide reassurance (Participant 1), pharmacotherapy, encourage the use of distraction (watching TV, listening to music, taking a bath) (Participants 1 and 3), encourage "riding out" the cravings, and encourage the individual to continue their inpatient stay (Participant 3). Role playing or practicing of skills can also be effective. Tools can focus on managing feelings. Feelings may start to arise as this is the first-time individuals considered stopping or reducing their substance use; as such, labelling and identification of feelings can be helpful (Participant 2). Anxiety can be very common (all Participants) and helpful interventions can be to sit with the patient (Participant 2), providing ice packs, and grounding (Participant 1). Participants also spoke about the utilization of interventions (such as distress tolerance and opposite action) connected with DBT (Participants 2 and 4). ISUD can also feel guilty for how they have "acted" in the past and about the consequences of their substance use (Participant 3). It

can be effective for nurses to help reframe or help challenge negative thoughts which was discussed by Participant 3:

> But I think, there's quite a few people that I talk to that just have incredible feelings of guilt. They feel guilty for the things that they've done in the past; they feel guilty with the way they have acted towards family members or friends. Or they have some kind of interpersonal fight going on and they can't manage it because they're in the hospital. I'll let them vent about their issue, I like to remind people that the way they view themselves in such a negative light isn't necessarily true to what their loved ones, or what we think as your staff. A lot of people struggle with comorbid addiction and mental health issues have a lot of trouble with their own self-worth, reminding them sometimes, sometimes your brain is your own worst enemy, that's effective in making feel better, at least in the short term.

Nurses can coach individuals to challenge and work through their negative self-talk and introduce a new skill they can utilize when this reoccurs (Participant 3). Supporting a patient to problem-solve a myriad of issues can also support their recovery (Participants 2 and 3). Overall, the nurse supports the patient's psychological self-management and encourages the acquisition of tools.

Social. A majority of the participants discussed how beneficial it is for the nurse to focus on the person's social support (Participants 1, 2, and 3). Initially, the patient's supports should be assessed (Participants 2 and 3). Assessment focuses on current supports especially upon discharge (Participant 2). If supports are identified, such as family, they can be encouraged to participate in care discussions (Participant 2). However, individuals may struggle with identifying supports; for these individuals, connection with formal, community, and peer

supports is vital. Within the inpatient setting, nurses can act as the formal support (Participant 2). Nurses can boost social skills that individuals may have struggled with (Participant 2). For example, nurses enforce rules, set boundaries, and practice interpersonal communication such as saying "no" (Participants 2 and 4). Inpatient nurses can also organize and connect ISUD to outpatient medical programs (Participant 2). Another beneficial intervention is to connect ISUD with peers. Within the inpatient setting, patients can be encouraged to attend groups (Participants 1, 3, and 4). In the community, patients can be referred to peer-led groups such as Alcoholics Anonymous (AA) and other self-help groups (Participant 1). Peer support is helpful as peers can provide strategies based on experiences and increases the person's social network (Participants 1 and 3). Participant 1 shared:

> So it helps them understand other people situation as well, in comparison to theirs. And they can share some of their experiences. Some of the things that they learn throughout their life that they can provide to other people. It's something I find with clients...They like to share something that may work/ worked for them in the past as well.

This was further validated by Participant 3:

> I've seen people when they take the 12-step program, they have a confidante that they can call. I've been told from patients that seems to work really well. Someone who has a similar experience, someone who can tell you it's not worth it.

Overall, assessing supports, re-establishing social connection, and connection to formal and peer social supports are effective nursing interventions that support recovery.

Spirituality and Culture. Only one participant (Participant 2) discussed how beneficial it is for nurses to provide interventions focused on spirituality and culture. During the admission assessment, nurses can conduct assessments focused on understanding the person's spirituality

practices and ask how the team can support these practices in the inpatient unit. Participant 2 discussed supporting Indigenous people and their practices, providing scriptures as requested, providing information about non-denominational services, and other non-religious based activities such as nature walks. Participant 2 also spoke about supporting individuals of Muslim faith:

> Certainly like, things like for Muslim clients who have a, you know someone's fasting for Ramadan, connecting with dietary services to have their, to respect their wishes for meals uhm if they need to pray a certain of number times per day. Getting them a space, a quiet space that they pray.

Participant 2 also spoke about culture as it intertwined with spirituality. Participant 2 spoke about supporting people of Caribbean background by connecting ISUD with services that are culture specific (i.e., Substance Abuse Program for African Canadian and Caribbean Youth [SAPACCY]). Additionally, individuals of Indigenous background can be supported with smudging and be referred to Aboriginal services. Lastly, Participant 2 spoke about being mindful of those who may identify as Lesbian, Gay, Bisexual, Transexual, Queer + (LGBTQ+) as there might be complex trauma or substance use concerns.

Recreation Therapy. Lastly, Participants 1, 2, and 3 discussed that nursing interventions focused on recreation therapy effectively promoted recovery. Focusing on recreation is helpful as it reintroduces hobbies that ISUD may have neglected (Participants 2 and 3) and the reintroduction of hobbies can help disassociate activities (such as going outside) from substance use (Participant 2). Nurses proposed activities such as watching television, movies (Participants 1 and 3), listening to and playing music (Participant 2), and utilizing a pass for a nature walk (Participants 1 and 2). Participant 2 outlined the following:

> Yeah, fresh air is helpful, not being locked in a kind of a stale environment of the hospital. Like I know that our Aboriginal service does a great job of doing like earth-based, nature-based interventions. Grounding, so I think it's a good thing when they ask to go outside because so many people with substance use issues are you know, spending most of their time, seeking their next drug, or their next bottle of booze, if they could just spend some time outside looking at the sky, feeling the earth under their feet, it helps them ground themselves. It's a missing part I think, in our treatment. There's not enough nature.

Recreation also focused on physical exercise such as playing ping pong (Participant 1), playing card or board games (Participants 1 and 3), the use of massage chairs (Participant 1), doing art, puzzles, and engaging in meditation (Participants 2 and 3). Overall, interventions that focused on various aspects of an individual supported the recovery of ISUD.

In summary, this chapter highlighted that participants viewed recovery as a process with general goals of abstinence or harm reduction which is determined by the client. When caring for ISUD, participants highlighted that they were mindful of theories or concepts such as biopsychosocial model and concurrent disorder approach, destigmatizing approach, trauma-informed approach, stages of change and Motivational Interviewing (MI), and harm reduction. Lastly, effective nursing interventions that promoted recovery were those that were rooted in the themes of being person-centred, empowerment and promotion of hope, and a holistic approach.

Chapter 5: Discussion

This study explored effective nursing recovery-oriented interventions that promoted the recovery of ISUD within an inpatient psychiatric setting. The goal was to illuminate the diverse interventions that nurses implement in practice. As previously discussed, effective nursing interventions were those that were person-centred, focused on empowering and instilling hope, and holistically focused. In this chapter, I discuss how the participants' view of recovery falls alongside personal recovery (as discussed in Chapter 2), the utilization of diverse theories and approaches, how the findings compare to the literature review (including the perspectives of ISUD compared to nurse participants, and infrequently mentioned interventions). Lastly, I highlight the significance of the findings, limitations, and future directions.

View of Recovery

Due to the diverse definitions of recovery, a sub question of the study was to illuminate how nurses caring for ISUD view recovery. Based on the findings, participants' view of recovery fits personal recovery. This is also evident in the interventions that participants discussed such as utilizing a person-centred approach, empowerment, instillation of hope, focusing on goals beyond substance use, and social support. Thus, the study demonstrates that psychiatric nurses in the academic teaching hospital are utilizing personal recovery and are employing interventions rooted in the CHIME framework. This is a promising finding as it means that nurses look at ISUD as the experts, rather than viewing themselves as the experts who hold the key to recipients' recovery.

The Application of Theory, Models, and Approaches

As there are identified and usable theories, models, and guidelines (i.e., Tidal Model, the Guidelines for Recovery-Oriented Practice, CHIME framework), nurses supporting ISUD may

be utilizing such concepts in practice and not be aware of this. This study may help illuminate that theories, models and guidelines underly practice even if the nurse does not acknowledge it in their discussion of the practice. This is important as nurses should recognize what theories and concepts support their practice, be able to articulate what they do and why they do it, as theory-guided practice has been shown to be beneficial (Younas & Quennell, 2019). As per the study, participants did not discuss the Tidal model, Guidelines for Recovery-oriented Practice, and the CHIME framework. An explanation could be that there is insufficient education regarding such approaches. For example, Participants 3 and 4 discussed not being trained or being proficient in using MI. This could mean that further education on theories, models, and approaches is needed.

Exposing nurses who provide care to ISUD to a foundational theory or model in teaching sessions might help them make the connection between theory and practice. For example, the interventions that participants highlighted within person-centredness are evident in many of the commitments within the Tidal Model (such as value the voice, respect the language, become the apprentice, craft the step beyond, give the gift of time, develop genuine curiosity, etc.) (Barker & Buchanan-Barker, 2005). Similarly, interventions rooted in empowerment and social support resonate with connectedness and empowerment within CHIME framework (Slade et al., 2012). Thus, as theory-guided practice has been shown to be beneficial (Younas & Quennell, 2019) teaching these are two existing models and frameworks as baseline education may enhance the work of nurses caring for ISUD.

Participants most frequently discussed theories of harm reduction and MI that guide their practice. The use of harm reduction when caring for ISUD is an interesting finding as this was not revealed in the literature review. The utilization of harm reduction can be beneficial as this would mean that nurses are still supporting the person in their goal, staying person-centred, even

if they may continue to use substances and not pursue abstinence (Danda, 2021). It would also mean that psychiatric nurses are not pushing a specific agenda or goal when working with ISUD. However, this can be context specific. For example, forensic patients may have a specific order that they must abstain from alcohol or drug use within their disposition (Bettridge & Barbaree, 2008). Nurses practicing in such settings may have a different and challenging therapeutic relationship when working with ISUD as the nursing role may become focused on rule adherence. Thus, harm reduction may not always be applicable within psychiatric settings and can be difficult to utilize. MI was also discussed frequently by participants; this is not surprising as MI has been noted to be effective in stopping or preventing binge drinking, reducing the amount and frequency of alcohol use, and substance abuse (Frost et al., 2018). Although two participants either did not receive education in MI or did not consider themselves proficient in MI, they spoke about the benefits of MI and trying to implement this. Thus, standardized education (of some approaches like harm reduction and MI) for nurses who work with ISUD is important in helping nurses directly tie theory to clinical practice, thus strengthening their practice (Parks et al., 2013).

Although only one participant brought up the biopsychosocial model and only Participant 4 addressed concurrent disorder approach, the utilization and incorporation of both were evident within the work of all participants. For example, the interventions rooted in the theme of holistic care, underpins the biopsychosocial model and interventions within the biological and psychological domains underline concurrent disorder approach. Incorporation of these concepts in nursing care is crucial as 20% (Rush et al., 2008) to 50% (Buckley et al., 2009) of individuals with a psychiatric illness have a co-occurring SUD. ISUD are three times more likely to have a mental illness (Rush et al., 2008), and people with mental illness are two times more likely to

have a SUD when compared to the general population (Buckley et al., 2009). The utilization of both a biopsychosocial and concurrent disorder approach is a promising finding as it would mean that nurses provide care to ISUD holistically rather than providing interventions within segregated domains.

Less frequent theories, approaches, and models within the study were trauma-informed and de-stigmatizing approaches. As one participant explained, being trauma-informed is the assumption that individuals that come through the healthcare system may have experienced a traumatic event in their personal lives that impacts the way they receive care. Being trauma-informed is important as it is estimated that about 76% of Canadians have experienced a traumatic event in their lifetime (Ameringen et al., 2008) and the prevalence of current PTSD among ISUD varies between 15-42% (Roberts et al., 2015). Moreover, individuals with trauma may have increased utilization of healthcare services (Sansone et al., 2014) and this may indicate that psychiatric nurses will have increased exposure to individuals with trauma. Thus, there may be merit in pursuing and illuminating the intersection of nursing recovery-oriented interventions and trauma-informed approaches when caring for ISUD who have trauma. Only one participant discussed interventions that focused on tackling stigma within their work environment. It was interesting as only this participant worked in a general psychiatric inpatient unit. Not advocating against stigma could mean that addiction specific units already have a common goal of supporting ISUD and understanding the stigma ISUD experience; thus, advocating within their teams was not something required as stigma was minimal or non-existent. This finding may mean that substance use was moralized within general psychiatric settings and stigma is still present there. This is consistent with the findings of Dikobe et al. (2016) whereby inpatient psychiatric nurses outlined feeling unsafe as individuals with concurrent disorders have

increased physical aggression, are uncooperative, misinterpret behaviours, and act on impulses to attack. Nurses can also label ISUD as manipulative and outlined needing to be vigilant about their reactions (Johansson & Wiklund-Gustin, 2016). It corroborates the stigmatizing stories I received from individuals I worked with and previous study findings that nurses (Russell et al., 2017) and other care providers possess stigma towards ISUD (van Boekel et al., 2013). Thus, exploration of nurses working within general psychiatric settings and stigma (and interventions that counteract stigma) should be considered. Overall, participants draw from many theoretical standpoints which is beneficial when caring for ISUD, however, there might be a benefit in incorporating education about a specific theory or framework which provides a similar lens when providing nursing care.

Comparing the Literature Review and the Findings of the Study

Given that the literature review provided the background information to initiate the study, it would be helpful to review how the findings of the study compare to the findings of the literature review.

Within the literature review, effective interventions that were unique from the perspective of ISUD were those that focused on social support, education, and system navigation. As per the study findings, all nurse participants discussed interventions rooted in supporting the social domain and making sure that ISUD have all the necessary information through education. The findings of the study are parallel to the literature review findings about ISUD noting the importance of social support. Since psychiatric nurses are applying these effective interventions, they are promoting the recovery of ISUD. Nurse participants did not discuss system navigation within the study. The omission of system navigation could be related to the focus being on ISUD rather than individuals with severe mental illness. In individuals with severe mental illness, case

management which includes coordination and system navigation, has been shown to be effective (Dieterick et al., 2010). Additionally, it might be a difficult intervention to implement within inpatient settings as nurses usually cannot leave the unit for an extended trip with a patient.

Within the literature review, interventions rooted in withdrawal management, harm reduction, spirituality, culture, advocacy, and disclosure were not frequently raised as effective nursing interventions that promoted the recovery of ISUD. Contrary to this, the study findings reveal that all nurse participants are utilizing interventions that support withdrawal management, harm reduction, and advocacy. All participants discussed that withdrawal management is an essential primary intervention that nurses must utilize in the earlier part of the admission to support the recovery of ISUD. It would make sense that participants highlighted this as unmanaged withdrawal can lead to uncomfortable withdrawal symptoms and can lead to life threatening complications (Gupta et al., 2021). Moreover, withdrawal management is an expected competency for addiction nurses as per the Addiction Nursing Certification Board (Wason et al., 2021) and when withdrawal has been managed, further interventions can be implemented.

Regarding harm reduction, all participants also discussed that promoting harm reduction is an essential intervention to promote the recovery of ISUD. As participants highlighted, there are diverse goals that ISUD discuss with care providers. It is vital that nurses support the goals that the individual would like to achieve and not promote a specific goal which contradicts their identified goal (Bartlett et al., 2013; Imkome, 2017). Harm reduction allows for a flexible approach that encompasses many interventions which supports ISUD in many aspects (Danda, 2021). Additionally, such a flexible approach can support nurses to maintain a therapeutic

relationship with ISUD and continue providing support and interventions throughout their recovery journey.

Lastly, advocacy was highlighted by all participants as an effective intervention within the study. This is a new finding as advocacy was minimally discussed within the literature review. Although all participants spoke about advocacy, there was a difference in how participants from addiction specific units and from the general psychiatric unit discussed advocacy. Participants from the addiction unit spoke about advocating for ISUD within the hospital system and focused on the person's care plan such as longer admission or change in medication, whereas the participant from the general psychiatric unit discussed advocating for ISUD within the hospital system to decrease stigma. This highlights that units within the psychiatric hospital that do not specialize in supporting ISUD may possess stigma towards ISUD. Further exploration of stigma towards ISUD within these units or various other units within the hospital should be considered. Overall, the study reveals that nurses are utilizing withdrawal management, harm reduction, and advocacy to promote the recovery of ISUD.

The study illuminates some areas that are regrettably consistent with findings within the literature review. As per the literature review, spirituality, culture, and disclosure were not frequently mentioned. Unfortunately, the findings of the study coincide with this finding as only one participant discussed spirituality and culture. Nurses may underestimate the importance and the role of spirituality in the patient's recovery (McDowell et al., 1996). Yet, spirituality may be beneficial in the lives of ISUD as it fosters hope, reassures that life will improve, and improves the person's state of mind (DiReda & Gonsalvez, 2016; Grim & Grim, 2019; Heinz et al., 2010). In terms of culture, African, Caribbean, and Black Canadians have challenges with substance use (Nguemo et al., 2019), like Cannabis (Tuck et al., 2017). Additionally, on-reserve First Nations

youth have a higher prevalence for alcohol abuse when compared to other youth (Lemstra et al., 2013). Some First Nations communities may have up to 85% of their population experience a problem with opioid use (Health Canada, 2011), although in the general population, opioid related hospitalizations have been increasing in the past 5 years with youth aged 15-24 and 25% of youth between grade 7-12 engaged in high-risk drinking behaviour (Public Health Agency Canada, 2018). Even though such problems exist, a barrier that continues to exist is a lack of culturally relevant and appropriate services (Gainsbury, 2017), even though culture is a protective factor that fosters resilience (Henson et al., 2017).

Perhaps the lack of mentioning interventions rooted in spirituality or culture can be explained by having too broad general questions as the purpose was to include as many effective interventions as possible that nurses used to promote recovery; the questions did not focus on any specific intervention. Knowing the organization within which this study took place, I know that there are multiple supports available to recognize and bolster spirituality and culture. For example, the hospital has access to spiritual care providers, spiritual spaces and services, and also has culture specific services such as SAPACCY, Aboriginal services, Rainbow services, and Youth, Women's, and Geriatric units. Thus, participants may actually utilize such services which were not highlighted, perhaps due to the way the questions were phrased. As such, how nurses utilize interventions rooted in spirituality and culture when working with ISUD should be further reviewed.

Lastly, disclosure was not discussed in the literature review and within the study. Interestingly, one participant discussed their lived experience and its impact on their practice. However, the participant's lived experience was related to a mental health disorder rather than a SUD. Lived experience can be helpful and there are peer recovery support services that have

beneficial outcomes such as improved relationships with care providers, increased treatment retention, and greater satisfaction with their treatment (Eddie et al., 2019). Peer recovery services are those delivered by ISUD (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). Although specifically hired peer workers may not disclose their own experiences, being employed as a peer, makes known that they have a SUD. ISUD outline that care providers with lived experience, promotes the idea that recovery is possible and increases hope (Munro et al., 2017). Additionally, lived experience roles reduce coercion, increases the rights of care recipients (Deegan, 2007), and do not have the same power imbalance such as traditional care providers and care recipient relationships (Mendoza et al., 2013). Therefore, exploration of the experiences of nurses with lived experience related to SUD and self-disclosure (or non-disclosure), who work within addiction settings might be beneficial. This would probably be difficult to achieve as there might be issues with disclosure and having a smaller sample size. The utilization of self-disclosure when caring for ISUD should still be explored. Overall, interventions based on spirituality, culture, and disclosure should be explored as they were minimally highlighted within the literature review and the study.

Significance of the Findings

As previously highlighted in the literature review, only one study was conducted in Canada, and it focused on the examination of hope (Koehn & Cutcliffe, 2012), and previous studies did not focus on effective nursing interventions that promoted the recovery of ISUD. This study furthers nursing science as it highlighted effective recovery-oriented interventions that inpatient Canadian nurses use when working with ISUD within an academic institution. Completion of the study contributes to the improvement of the care received by ISUD as it offers nurses a list of successful interventions that can be implemented. Nurses may consider a range of

interventions, from those most used to those rarely used, and decide what might be most effective for their patients. Moreover, the study underscores that theories and concepts (such as harm reduction, CHIME framework, Tidal model, and MI) should be an educational focus. The study also highlights some strengths (being person-centred, collaborative, developing care plans through goal identification and discharge planning, promotion of choice, empowerment, education, and providing holistic care) and weaknesses (deficits in culturally competent and spiritually focused care) of psychiatric nurses when caring for ISUD. Finally, this study indicated that ISUD are still experiencing stigma even within specialized psychiatric settings.

Limitations

A limitation of the study is that the sample size is small (N=4). Due to the smaller sample size, there could have been interventions that were not discussed. Although nurses may consider the findings transferrable, these may not apply to some settings. Furthermore, the study highlighted the perspective of nurses, and ISUD may have a different perception; that is, that the interventions nurses may believe are effective, those with SUD may not view these as effective for *their* recovery.

Additionally, the literature search described in Chapter 2, was specifically narrow in order to examine perceptions of effective nursing interventions when working with individuals experiencing SUD. If search terms had been expanded to include terms such as approaches, terms such as recovery capital, may have surfaced.

Finally, the interview tool contained questions that may have been too broad which may have resulted in the omission of such interventions such as spirituality and culture.

Future Directions

Due to the limited discussion of interventions rooted in spirituality and culture, future studies could highlight how nurses implement such interventions to support the recovery of ISUD. Additionally, the nurses' use of self-disclosure and lived experience when caring for ISUD can be studied. Another area to explore would be the nurses' role and effective interventions that promote recovery of ISUD and trauma. Lastly, stigma towards ISUD and interventions to counteract stigma should be explored within general psychiatric units.

Conclusion

This study evolved from my attempts to understand and explicate nurses' unique role and positive contributions toward the experiences and recovery of ISUD. The study utilized QD to explore effective nursing recovery-oriented interventions when working with ISUD. Effective nursing interventions were rooted in the themes of being person-centred, and the importance of empowerment and fostering hope, and holistic care. Although the study offered such effective interventions, nurses should be careful that these interventions will not fit all individuals or situations, thus, emphasizing the need to be person-centred. Although this study counters such unfortunate stigmatizing experiences that ISUD continue to face, there are additional organizational, systemic, and national strategies that could be implemented to improve the care and experiences of ISUD.

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Footnotes

[1] Within the thesis, the term Substance Use Disorder may sometimes be used singularly (Substance Use Disorder) or plurally (Substance Use Disorders). Likewise, the term ISUD may be used singularly (Individuals with Substance Use Disorder) or plurally (Individuals with Substance Abuse Disorders).

Appendix A: Athabasca University Research Ethics Board Approval

Athabasca University
RESEARCH CENTRE

CERTIFICATION OF ETHICAL APPROVAL

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

Ethics File No.: **24195**

Principal Investigator:
Mr. Niall Tamayo, Graduate Student
Faculty of Health Disciplines\Master of Nursing

Supervisor:
Dr. Annette Lane (Supervisor)
Dr. Rola Moghabghab (Co-Supervisor)

Project Title:
Effective Nursing Recovery-Oriented Interventions for Individuals with Substance Use Disorder: A Qualitative Descriptive Study

Effective Date: February 16, 2021 **Expiry Date**: February 15, 2022

Restrictions:

Any modification or amendment to the approved research must be submitted to the AUREB for approval.

Ethical approval is valid *for a period of one year*. An annual request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

A Project Completion (Final) Report must be submitted when the research is complete *(i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable))* or the research is terminated.

Approved by: **Date: February 16, 2021**

Barbara Wilson-Keates, Chair
Faculty of Health Disciplines, Departmental Ethics Review Committee

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Athabasca University Research Ethics Board
University Research Services, Research Centre
1 University Drive, Athabasca AB Canada T9S 3A3
E-mail rebsec@athabascau.ca
Telephone: 780.213.2033

Appendix B: Centre for Addiction and Mental Health Research Ethics Board Approval

camh

June 4, 2021

Study Title: Effective Descriptive Nursing Study Recovery-Oriented Interventions for Individuals with Substance Use Disorder: A Qualitative Descriptive Study

Principal Investigator: Rola Moghabghab, Centre for Addiction and Mental Health
Co-Investigators: Niall Tamayo, Annette Lane

REB #: 031/2021
Review Type: Delegated

Expiry Date: June 4, 2022

Study Approval Letter

The Centre for Addiction and Mental Health Research Ethics Board has reviewed this study and has granted approval until the expiry date noted above.

Documents Approved:

- Protocol (Version 3 dated 2021JUN03)
- REDCap e-Consent Form (Version 4 dated 2021JUN03)
- Participant Master List (Version 1 dated Feb 11, 2021)
- Interview Protocol (Version 1 dated Feb 11, 2021)
- Invitation to Participate (Version 3 dated 2021MAY01)
- Recruitment Poster (Version 3 dated 2021JUN04)
- Initial Email Contact Script (Version 1 dated 2021MAY01)
- Initial Telephone Contact Script (Version 1 dated 2021MAY01)
- List of Organizational Supports for Staff (Version 1 dated 2021MAY01)
- Informed Consent Process Checklist & Note (Version 1 dated 2021MAY01)
- Webex Email Script (Version 1 dated 2021MAY01)

Please note the following:

- This study must be conducted as outlined in the REB approved materials, and in accordance with CAMH policies and procedures, the TCPS2 (2nd edition of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans), the provisions of the Ontario Personal Health Information Protection Act and its applicable Regulations, and with all other applicable laws, regulations or guidelines
- No deviations from, or changes to, the protocol should be initiated without prior written approval from the CAMH REB, except when necessary to eliminate immediate hazard(s) to study participants

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Toronto, ON
M5S 2S1

camh

- Ethics approval must be renewed prior to the expiry noted above - failure to do so will result in an immediate suspension of ethics approval

REB members with a conflict of interest on a study do not participate in the discussion, deliberation or decision on such studies.

The Centre For Addiction and Mental Health Research Ethics Board (CAMH REB) operates in compliance with, and is constituted in accordance with, the requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2), the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP), Part C, Division 5 of the Food and Drug Regulations, Part 4 of the Natural Health Products Regulations, Part 3 of the Medical Devices Regulations, and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The CAMH REB is qualified through the CTO REB Qualification Program and is registered with the U.S. Department of Health and Human Services (DHHS) Office for Human Research Protection (OHRP).

Yours sincerely,

Dr. Robert Levitan
Chair
Research Ethics Board
Centre for Addiction and Mental Health
E-mail: Robert.levitan@camh.ca
Telephone: 416-535-8501 x 34020

33 Ursula Franklin Street
Toronto, ON
M5S 2S1

Appendix C: Centre for Addiction and Mental Health Research Ethics Board Amendment Approval

camh

August 16, 2021

Study Title: Effective Descriptive Nursing Study Recovery-Oriented Interventions for Individuals with Substance Use Disorder: A Qualitative Descriptive Study

Principal Investigator: Rola Moghabghab, Centre for Addiction and Mental Health
Co-Investigators: Niall Tamayo, Annette Lane

REB #: 031/2021-01

Amendment #1 Approval Letter

The Centre for Addiction and Mental Health Research Ethics Board has reviewed this study and has granted approval until the expiry date noted above.

Documents Approved:

- Protocol (Version 5 dated 2021AUG12)
- Initial Telephone Contact Script (Version 2 dated 2021JUL13)
- Email Reminder Script (Version 1 dated 2021JUL13)

Please note the following:

- This study must be conducted as outlined in the REB approved materials, and in accordance with CAMH policies and procedures, the TCPS2 (2nd edition of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans), the provisions of the Ontario Personal Health Information Protection Act and its applicable Regulations, and with all other applicable laws, regulations or guidelines
- No deviations from, or changes to, the protocol should be initiated without prior written approval from the CAMH REB, except when necessary to eliminate immediate hazard(s) to study participants
- Ethics approval must be renewed prior to the expiry noted above - failure to do so will result in an immediate suspension of ethics approval

REB members with a conflict of interest on a study do not participate in the discussion, deliberation or decision on such studies.

The Centre For Addiction and Mental Health Research Ethics Board (CAMH REB) operates in compliance with, and is constituted in accordance with, the requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2), the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP), Part C, Division 5 of the Food and Drug Regulations, Part 4 of the Natural Health Products Regulations, Part 3 of the Medical Devices Regulations, and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The CAMH REB is qualified through the CTO REB Qualification Program and is registered with the U.S. Department of Health and Human Services (DHHS) Office for Human Research Protection (OHRP).

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camh

Yours sincerely,

Dr. Robert Levitan
Chair
Research Ethics Board
Centre for Addiction and Mental Health
E-mail: Robert.levitan@camh.ca
Telephone: 416-535-8501 x 34020

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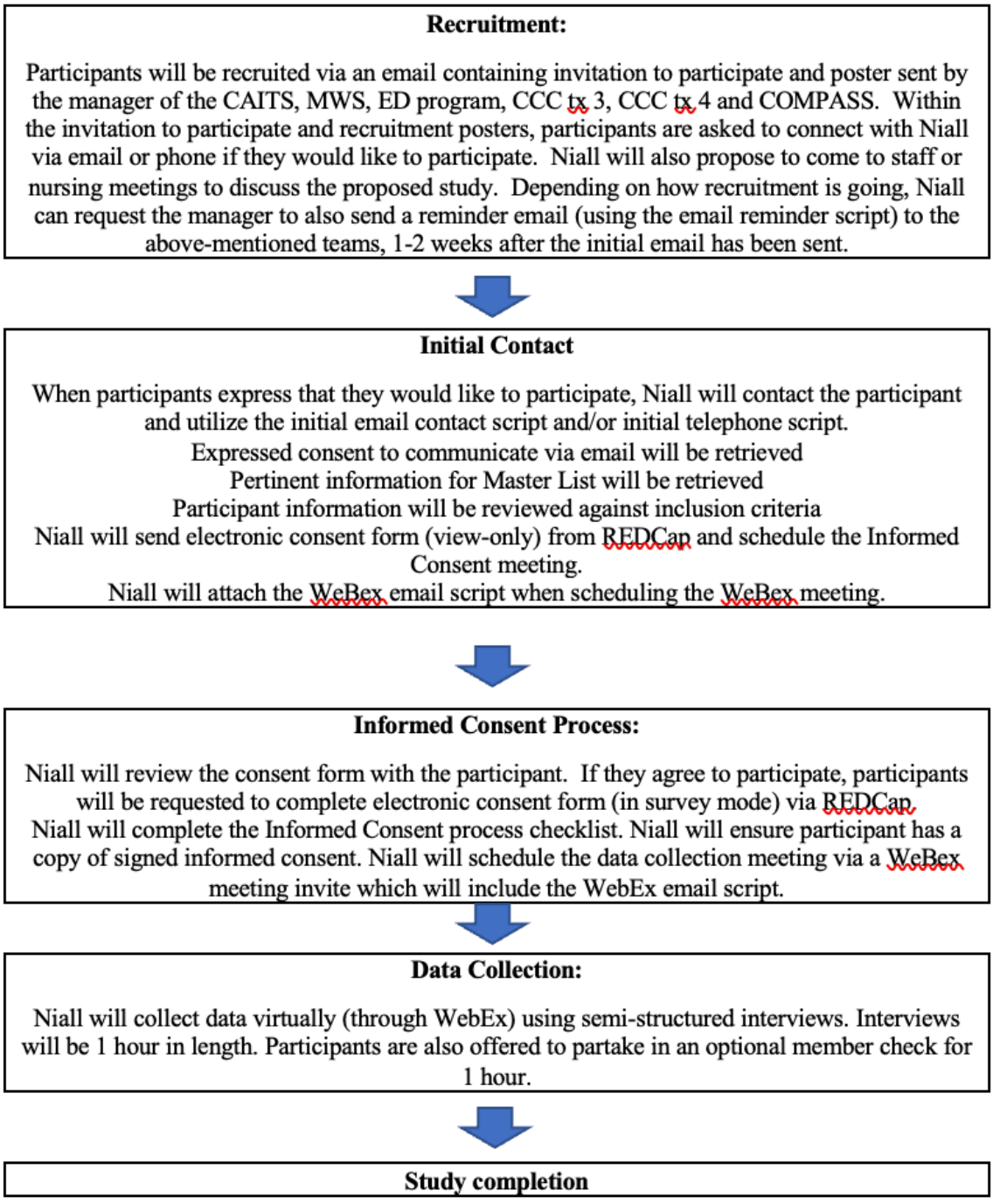
Toronto, ON
M5S 2S1

Appendix D: Study Flow Chart

6.0 Flow chart



Appendix E: Recruitment Poster

camh
mental health is health

Athabasca University

PARTICIPANTS NEEDED FOR RESEARCH IN ADDICTION NURSING

We are ***looking for Nurses*** to take part in a study to describe effective nursing recovery-oriented interventions when working with individuals with substance use disorder.

As a participant in this study, you would be asked to participate in a ***one-time virtual interview***.

Your participation is ***entirely voluntary*** and would take up approximately ***one-two hours*** of your time. By participating in this study, you will help identify effective nursing recovery-oriented interventions which can improve the care received by individuals who strugglewith substance use.

In appreciation for your time, you will be entered into a draw for a $20 gift card to Starbucks.

To learn more about this study, or to participate in this study, please contact:

Graduate Student:
Niall Tamayo, Master of Nursing Student
Athabasca University
Email: ntamayo1@athabasca.edu
Cell:(416) 558-4758

This study is supervised by:
Rola Moghabghab Email: rola.moghabghab@camh.ca
Dr Annette Lane Email: alane@athabascau.ca

This study has been reviewed by the Athabasca University Research Ethics Board.
Version 3 dated 2021JUN04 CAMH REB # 031/2021

Appendix F: Letter of Information/ Informed Consent Form

LETTER OF INFORMATION / INFORMED CONSENT FORM

Effective Nursing Recovery-Oriented Interventions for Individuals with Substance Use Disorder

June 3, 2021

Principal Investigator:
Rola Moghabghab, Director
rola.moghabghab@camh.ca

Co-Investigator:
Dr. Annette Lane, Associate Professor
alane@athabascau.ca

Graduate Student:
Niall Tamayo
niall.tamayo@camh.ca

You are invited to take part in a research project entitled 'Effective Nursing Recovery-Oriented Interventions for Individuals with Substance Use Disorder'.

This form is part of the process of informed consent. The information presented should give you the basic idea of what this research is about and what your participation will involve, should you choose to participate. It also describes your right to withdraw from the project. In order to decide whether you wish to participate in this research project, you should understand enough about its risks, benefits and what it requires of you to be able to make an informed decision. This is the informed consent process. Take time to read this carefully as it is important that you understand the information given to you. Please contact *Niall Tamayo* if you have any questions about the project or would like more information before you consent to participate.

It is entirely up to you whether or not you take part in this research. If you choose not to take part, or if you decide to withdraw from the research once it has started, there will be no negative consequences for you now, or in the future.

Introduction
My name is Niall Tamayo and I am a Master of Nursing Student at Athabasca University. As a requirement to complete my degree, I am conducting a research project about effective nursing interventions that facilitated the recovery of individuals who struggle with substance use. I am conducting this project under the supervision of Rola Moghabghab and Dr. Annette Lane.

Why are you being asked to take part in this research project?
You are being invited to participate in this project because you have provided care to individuals who struggle with substance use and are currently working at an academic teaching psychiatric hospital in Toronto.

What is the purpose of this research project?
The purpose of this qualitative descriptive study will be to describe the effective recovery-oriented nursing interventions that nurses apply in an academic teaching psychiatric hospital in Toronto. We are trying to highlight the nursing perspective regarding interventions that effectively facilitate the recovery of individuals who struggle with substance use. The information gained from this study can provide nurses with a variety of effective nursing interventions they can draw from when providing care to individuals who struggle with substance use.

What will you be asked to do?
You will be asked to participate in a one-time, 1-hour virtual interview, scheduled at your convenience. You will be asked to provide consent to communicate over email. You will be invited to answer some questions regarding effective nursing interventions that facilitated the recovery of individuals who struggle with substance use. The questions are focused on understanding what these interventions are and how they can facilitate recovery. The audio and video will be recorded for transcription purposes.

You will be invited to review the findings prior to the dissemination.

What are the risks and benefits?
There should be minimal physical, social, and economic risks involved by participating in the study. However, there can be psychological and spiritual risks. The risks are due to the author requesting you to think about your experiences and the past. These can include traumatizing and non-positive experiences which can alter your state. If any psychological or spiritual risk arises, Niall will immediately connect you to the principal investigator (Rola Moghabghab), who is a licensed Nurse Practitioner with extensive clinical experience, who will conduct an assessment and implement interventions. Interventions may include providing you a list of organizational supports for employees or crisis resources. In extreme risk, interventions may include research staff contacting emergency services to support you.

If WebEx is used, videoconferencing technology possesses privacy and security risks. It is possible that information could be intercepted by unauthorized people (hacked) or otherwise shared by accident. This risk can't be completely eliminated.

You or the research team can stop the session at any time, including if there are technical difficulties. If there are technical issues, one of our technical staff may join the call to provide support.

Additionally, the security of information sent by e-mail cannot be guaranteed. Please do not communicate personal sensitive information by e-mail. Email is not monitored outside of work hours. Please do not use email to communicate emergency or urgent health matters – please contact your clinician or, in case of a medical emergency, call 911.

Benefits

By participating, it might help highlight the beneficial work you are providing in your nursing practice.

The study can help increase awareness on effective recovery-oriented interventions that inpatient nurses at CAMH utilize when working with individuals who struggle with substance use. The study may produce knowledge which can better facilitate the recovery and improve the care of individuals who struggle with substance use.

Compensation
You will have a chance to be financially gifted for their time. You will be entered into a draw for a $20 gift card to Starbucks to be drawn on Aug 31, 2021.

Do you have to take part in this project?
As stated earlier in this letter, involvement in this project is entirely voluntary. You may stop your participation at any point; this can also be done partway through the interview. You would have

to inform the research team if you wish to withdraw. Prior to data analysis, any data collected until that point may be removed from the study.

Withdrawal from the study will result in the removal of your name from the gift card draw.

How will your privacy and confidentiality be protected?
The ethical duty of confidentiality includes safeguarding participants' identities, personal information, and data from unauthorized access, use or disclosure.

We will not be sharing information about you to anyone outside of the research team. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is, and we will store that information in a password protected document.

Members of the research team and authorized representatives of CAMH, including the CAMH Research Ethics Board and Research Quality Assurance Office, will have access to your study records for use in connection with this study.

All information will be held confidential, except when legislation or a professional code of conduct requires that it be reported.

How will my anonymity be protected?
Anonymity refers to protecting participants' identifying characteristics, such as name or description of physical appearance.

Each participant will be provided with a participant code. No identifying information such as names will be on any data collection tools. Demographics of the participant and description of the unit will be utilized. Only the researchers will have the information regarding personal identifiers.

Every reasonable effort will be made to ensure your anonymity. All participant names and identifying information will be disguised through pseudonyms in the research report and any publications that occur from this research.

How will the data collected be stored?
- Data will be stored in a password-protected file on the principal investigator's computer. Any recording will also be password-protected. The computer is password protected and will be safely stored at all times. Data will be retained for 5 years, and then destroyed.
- The principal investigator, supervisor will have access to the data collected.
- Depending on the participants recruited, the data may be compared to the results of another study in the future. Further Research Ethics Board approval would have to be sought if a later project is designed.

Who will receive the results of the research project?
- The existence of the research will be listed in an abstract posted online at the Athabasca University Library's Digital Thesis and Project Room and the final research paper(s) will be publicly available.
- Given the descriptive nature of the study, direct quotations will be reported.
- The initial results will be reviewed with the participants. Aspects of the research project may be submitted for publication to research journal(s) (to be determined). The author may also present the findings during grand rounds at the academic teaching hospital and at

conferences. If published, the author will send the participants the paper and associated findings through email. Participants will also be able to retrieve the thesis paper from the Athabasca digital thesis room: https://dt.athabascau.ca/jspui/

Who can you contact for more information or to indicate your interest in participating in the research project?

Thank you for considering this invitation. If you have any questions or would like more information, please contact me by e-mail niall.tamayo@camh.ca or phone:4165584758, the principal investigator by e-mail rola.moghabghab@camh.ca or my supervisor by e-mail alane@athabascau.ca. If you are ready to participate in this project, please complete the participant e-consent form (survey-mode) via REDCap.

Thank you,

Niall Tamayo

Please note that the survey data may be initially collected and housed on servers located in the continental USA and is subject to USA privacy legislation.

This project has been reviewed by the Athabasca University Research Ethics Board. Should you have any comments or concerns regarding your treatment as a participant in this project, please contact the Research Ethics Office by e-mail at rebsec@athabascau.ca or by telephone at 1-800-788-9041, ext. 6718.

If you have questions about your rights as a participant or about ethical issues related to this study, you can talk to someone who is not involved in the study at all. That person is the Chair of the Research Ethics Board (REB). The REB is a group of people responsible for the ethical oversight of this study. The Chair of the REB can be reached by telephone at 416-535-8501 ext. 34020.

Participant Code

PARTICIPANT CONSENT FORM

Effective Nursing Recovery-Oriented Interventions for Individuals with Substance Use Disorder

Graduate Student: Niall Tamayo **Phone: (416)558-4758**
Email: niall.tamayo@camh.ca

Your signature on this form means that:

- You have read the information about the research project.
- You have been able to ask questions about this project.
- You are satisfied with the answers to any questions you may have had.
- You understand what the research project is about and what you will be asked to do.
- You understand that you are free to withdraw your participation in the research project without having to give a reason, and that doing so will not affect you now, or in the future.
- You agree to be audio and video recorded.
- You agree to the use of direct quotation.
- You allow data collected to be archived in the Athabasca University Library's Digital Thesis and Project Room.

Your signature confirms:

- You have read what this research project is about and understood the risks and benefits. You have had time to think about participating in the project and had the opportunity to ask questions and have those questions answered to your satisfaction.
- You understand that participating in the project is entirely voluntary and that you may end your participation at any time without any penalty or negative consequences.
- You have not waived any legal rights/rights to legal recourse in the event of research-related harm
- You have been given a copy of this Informed Consent form for your records; and
- You agree to participate in this research project.

_____ _____
Signature of Participant Date

Person conducting consent discussion signature:
I have explained this project to the best of my ability. I invited questions and responded to any that were asked. I believe that the participant fully understands what is involved in participating in the research project, any potential risks and that he or she has freely chosen to participate.

_____ _____
Signature of person conducting consent discussion Date

If you have questions about your rights as a participant or about ethical issues related to this study, you can talk to someone who is not involved in the study at all. That person is the Chair of the Research Ethics Board (REB). The REB is a group of people responsible for the ethical oversight of this study. The Chair of the REB can be reached by telephone at 416-535-8501 ext. 34020.

Appendix G: Interview Protocol

Participant Code: **Date:**

INTERVIEW PROTOCOL

Effective Nursing Recovery-Oriented Interventions for Individuals with Substance Use Disorder

	Memos
Introduction Thank you for accepting the invitation to participate in this research interview about your nursing interventions that were effective in facilitating the recovery of individuals with substance use disorder. I would like to confirm that you have read and signed the Letter of Information and Informed Consent Form. Your participation is voluntary, and you may choose to withdraw from the interview at any time. You may also choose to not answer any of the questions. The interview will take up to one hour. Before we begin, I want to acknowledge my position within the institution as APCL. However, I will guarantee confidentiality and I will have a researcher lens on rather than an educator lens. What is said and by whom during the interview will not be shared with the institution.	
Questions Do you have any questions before we begin? Let's get started.	
Recording Ask Permission. I will begin recording our interview.	
Demographics Age: Gender:	

Education: Additional certification (i.e. CNA psychiatric): Length of time in addictions: Length of time in current position:	
Interview Questions	**Memos**
How did you come to work in addictions?	
How do you view recovery? Are there theories, best practices that you utilize when caring for people who have substance use disorders?	
How do nurses facilitate the recovery of ISUD?	

What makes the role of a nurse unique? Are there interventions that nurses do which is different from other interprofessional team members?	
What are nurses doing well to support the recovery of ISUD? During admission? During their stay? During Discharge?	
What are interventions that you found effective for the recovery of ISUD? Are there interventions that you seem to do more of? Are there interventions that patients seem to seek more of?	

Do you have any other questions before we end the interview?	
Thank you Again, I want to thank you for your time. I will include your name for a draw for a $20 Starbucks gift card. You will be informed via email if you get this. Lastly, would you be ok if we contact you for a future meeting to double check our findings?	