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## Exploring the experiences of staff working at an opiate assisted treatment clinic: An interpretive descriptive study

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## ABSTRACT

There have been many advances in harm reduction over the past three decades. One of the newest approaches is the provision of medical grade heroin to people with opiate addiction, known as opiate assisted treatment (OAT). There is one clinic in North America which provides this service. The goal of this study was to uncover how clinic staff provide care to those who attend this clinic, their perspectives on how the clinic program impacted them and their patients, and their opinions about the program itself. This was a qualitative study with an interpretive descriptive methodology underpinned by critical social theory. Convenience sampling yielded 22 participants – 18 nurses, two social workers and two peer support workers. Thematic analysis was undertaken to identify recurring, converging and contradictory patterns of interaction, key concepts and emerging themes. The study location was the OAT clinic located in the downtown eastside of Vancouver, BC. The findings were organized around the following six themes: from chaos to stability, it's not all roses, a little preparation would be good, putting the patient at the centre, the stigma hasn't gone away, and the clinic is life transforming. Taken together, these themes indicate the complexities of working in this environment. The findings can guide clinic staff, including nurses, in how they provide care to patients with addiction problems and also provide direction for policy makers on harm reduction planning.

*Contribution of the paper:* What is already known about the topic?

- Opiate Assisted Treatment is an effective harm reduction approach to care and there is only one clinic offering this treatment approach in North America.
- There is limited research on opiate assisted treatment clinics; research is primarily conducted in Europe.
- Staff working in clinics that provide opiate assisted treatment are primarily concerned about overdoses and the diversion of heroin.  
What does this paper add?
- Staff working in clinics that offer opiate assisted treatment engage in complex and challenging care, which is also very rewarding.
- Patient outcomes in opiate assisted treatment clinics are positively impacted by the approach of staff.
- This novel work establishes the importance of attending to the effects of educational preparation, power dynamics, and physical space on staff working at opiate assisted treatment clinics, for developing successful harm reduction programs.

There is a long history of addiction in human culture. Humans have had a taste for psychoactive substances for as long as there have been written records; abnormal patterns of substance use have been described since antiquity (Crocq, 2007). Illicit substance use is associated with harm, including the harm that occurs as a result of intoxication

and violence (Miller et al., 2015) and the harm that occurs as a direct result of using illicit drugs. The harm associated with illicit substance use includes higher rates of HIV and hepatitis C, as well as injection related infections such as endocarditis, cellulitis and osteomyelitis. It is in consideration of these harms, as well as the long term, enduring

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nature of substance use that the concept of harm reduction has arisen over the past three decades. Harm reduction refers to the policies, programs and practices that aim to reduce the harm associated with the use of illicit substances by people who are either unwilling or unable to stop substance use (Harm Reduction International, 2018). Initially, harm reduction consisted of needle and syringe exchange and the provision of methadone, but it has come to embrace a variety of interventions, including supervised injection sites and opiate assisted treatment (OAT).

There have been significant advances in the provision of harm reduction in British Columbia, Canada. A notable example is the establishment of a clinic that provides OAT. This clinic was created to conduct a study called NAOMI or North American Opiate Maintenance Initiative. The NAOMI study was a quantitative study that compared the benefits to patients of providing injectable heroin to optimized methadone. The results of that study showed that heroin was clearly superior to methadone as a treatment intervention (Oviedo-Joekes et al., 2009). A follow-up study called SALOME or Study to Assess Longer Term Opioid Medication Effectiveness, determined that there was no difference between patients receiving injectable heroin and patients receiving injectable hydromorphone (Oviedo-Joekes et al., 2016).

One issue with these studies was that patients were unable to access heroin after the study was completed. Given how well they were doing this became an ethical problem. Providence Health Care took the Canadian federal government to the Supreme Court of British Columbia and won a ruling that essentially stated that denying patients access to heroin was denying them access to health care (Lupick, 2014). As a result of that court decision, the ongoing OAT program was born. The OAT clinic operates out of an aging building on the downtown eastside of Vancouver, which is considered by many to be the epicenter of the drug epidemic in British Columbia (Jozaghi, 2014). This is a neighborhood with an extremely marginalized population and the patients that attend the clinic reflect this demographic.

Although OAT programs have been well established in Europe for a number of years, there is a dearth of qualitative research that explores the experiences of both staff and patients. Qualitative research allows researchers to study the social interactions of humans in naturally occurring settings. The researcher is able to gather data and make sense of the phenomena that are observed and revealed. Qualitative research considers questions that involve the “what” and “why” of human behaviour (Lichtman, 2014). As such, qualitative research can deepen understanding of the complexity of social interactions and the meanings that participants themselves attribute to those interactions (Marshall & Rossman, 1999).

## 1. Overview of the study

The objectives that guided this exploratory, descriptive study were to explicate the experiences, observations and perspectives of the staff who work at the clinic. Specifically, the goal was to uncover how the staff provide care to what is generally considered a challenging population (Dodge, Brady, & Maguire, 2006; Press, Zornberg, Geller, Carrese, & Fingerhood, 2016), their perspectives on how the clinic program has impacted them and their patients, and their opinions about the program itself.

There is a lack of qualitative research about the experiences of staff in OAT centers. Only one study that used a qualitative approach to talk to OAT clinic staff was located (Demaret, Lemaitre, & Anseau, 2012). Interpretive description was selected as the approach to this inquiry because it calls attention to human experience in both its constructed and contextual nature, whilst allowing for shared realities (Thorne, 2008). Interpretive description captures themes and patterns and allows the development of broader understandings that can inform practice. Interpretive description is a non-categorical, inductive method that is driven by a clinical problem that is approached thematically. It allows

the researcher's interpretive lens to be accessible and visible throughout the research process (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). Thematic analysis was undertaken to identify recurring, converging and contradictory patterns of interaction, key concepts, and emerging themes.

Critical social theory (CST) served as a theoretical perspective to this research because it allowed us to understand the political and social agendas that influence people's lives. CST is an important tool for uncovering the complexities of the social world and how its discourses affect people. CST is about power – who has it and who does not. Power is not a neutral term. Power encompasses racism, marginalization, micro-aggressions and stigma. From a nursing perspective, CST is important because it allows nurses to question what is taken for granted, what norms are unchallenged, what works and what does not (Sumner & Danielson, 2007). CST focuses on transforming the world rather than simply explaining it. The goal of CST is to intentionally attend to and disrupt oppressive sociopolitical contexts and processes (D'Arrigo-Patrick, Hoff, Knudsen-Martin, & Tuttle, 2017).

In the case of this study CST was chosen because it reflects the first author's worldview (the individual's knowledge and point of view). Embracing a social justice perspective about the world, means that we believe in an equitable distribution of resources and opportunities. The patients in this study are highly marginalized. A social justice perspective is congruent with CST and often arises when understanding processes of marginalization. Taking a social justice perspective informed the analysis, which was attentive to issues of marginalization and powerlessness that are experienced by front line staff in the OAT clinic.

The OAT clinic staff is composed of nurses, social workers, pharmacists, peer support workers and physicians. Frontline staff, including nurses and social workers, do not generally perceive of themselves as having power. Nursing is an oppressed group (Fulton, 1997). In a study by Katriina et al. (2014) nurses rated themselves as having little power in relation to environmental forces, resources and communication competency. Social and structural factors in both the activities and organization of nursing work implicitly communicates to nurses that they have less value than other members of the health care team (Hart, 2015). Social workers also experienced a sense of powerlessness when dealing with team members who are perceived to have more power. Power inequities affect the voice and contributions of social workers. They feel that they get talked over and lost by more powerful members of the health care team (Ambrose-Miller & Ashcroft, 2016).

When a CST lens is employed, people have an opportunity to question, understand and come to terms with their position. In doing so they have the opportunity to reflect on power and how to access it (Mooney & Nolen, 2006). When nurses use a CST lens to engage in critical reflection, they can develop insights into the central values of nursing. A CST approach allows nurses to probe the historical assumptions of professional nursing and how those assumptions influence practices (Sumner & Danielson, 2007). It also allows them to understand power, how it is distributed and how they can access and utilize it.

Data analysis in interpretive descriptive study involves moving beyond the theoretical framework towards an abstracted interpretation that will illuminate the phenomenon that is being investigated in a novel and meaningful fashion (Thorne et al., 2004). In qualitative work, such as this, the stages of analysis are non-linear, with data collection and analysis occurring concurrently. Data analysis in the interpretive descriptive tradition requires an immersion in the accounts of the participants to develop themes within each account and through constant comparison, a description of the patterns between and among the narratives (Irwin, Thorne, & Varcoe, 2002). The two main tasks in data analysis utilizing interpretive description are the identification of themes within coding categories and identification of themes across coding categories (Gillespie, 2002). The aim is to work upwards towards broader levels of abstractions and to connect the themes to

generate a theoretical or conceptual model (Ganapathy, 2016).

Ethical approval was obtained from the University of Alberta and Providence Health Care. Convenience sampling was utilized to recruit participants. All of the staff received an email communication about the study with an invitation to participate. The staff were excited about the project and independently approached the researcher asking to be included. Informed consent was obtained and an honorarium – a \$20 gift card – was provided. Identities were protected by the use of initials in the transcripts and pseudonyms in all reports of the findings.

The clinic is a small, rather congested site in an aging building. There are approximately 140 patients involved in the program. They attend the clinic three times a day to inject either heroin or hydromorphone. Their drugs are provided by the nurses, who supervise their injections.

Twenty-two staff members at the clinic participated in interviews for this study. This is considered a reasonable number for a qualitative study where the focus is on sample adequacy as opposed to sample size (O'Reilly & Parker, 2012). The participants ranged in age and experience. Four of the participants had worked at the clinic for less than a year whilst three of them had been with the clinic since the beginning of the first study. Eighteen of the participants were nurses, two were social workers and two were peer support workers.

Data were collected using in-depth, semi-structured individual interviews lasting 30 to 45 min. Interviews were audiotaped and transcribed verbatim. The interview guide consisted of open-ended questions that allowed for broad and unstructured responses. Interviews started with a discussion of the participant's work and life experiences and then turned to focus on their experiences, perceptions and observations about their working life at the clinic. Two follow-up focus groups were held at the clinic to obtain staff feedback on the preliminary findings.

## 2. Findings

Analysis of the participants' stories revealed that their experiences at the clinic were multifaceted and provided both challenges and opportunities. It became apparent that their work life provided many occasions for pleasure but also some frustrations. The findings were organized around six themes reflected in the interview data: from chaos to stability, it's not all roses, a little preparation would be good, putting the patient at the centre, the stigma hasn't gone away, and the clinic is life transforming. Taken together, these themes indicate the complexities of working in this environment. Unlike the qualitative study cited above (Demaret et al., 2012) concerns about diversion and overdose were not the primary issues raised by the staff who participated in this study.

### 2.1. From chaos to stability

The participants in this study told many stories about how the clinic had changed their patient's lives for the better. Having access to medically prescribed heroin took away one of the challenges of living with addiction which is having to search for access to illicit substances several times a day. Elizabeth talked about how "people are reconnecting with their family that they haven't talked to for years." Michael related that it was impressive:

seeing people get unionized jobs as front desk workers... It's pretty amazing because you look at these people, they were having to sell their bodies, you know, crime, whatever to get their next fix. And now they're able to have some stability, they've got, you know, a routine going on in their life.

Vanessa mentioned that "I've seen a few that like some of them have taken classes. And there's a young man who's gotten to like cooking school and he's got a job." Julie brought up something more basic, but still important: "I think the biggest thing for me is I always love, we've

had so many patients lately that have, have gotten dentures."

David summed it up by saying:

not having stability in their addiction, not having to search for their next drug, lower amount of crime. Being able to do other things like live a life whether it be to find a place to sleep permanently like housing, having food, like they spend their money on food, clothes, entertainment, going back to school some of them. Being able to maintain part time work because a lot of them have employers that can work around or they work part time right so shorter hours so they can work around their hours.

The staff observations are directly supported by the findings of the various quantitative studies that have been conducted. According to Blanken, Hendriks, van Ree, and van den Brink (2009), OAT is associated with stable physical, mental and social health. Verthain et al. (2008) also noted that physical and mental health improved and street heroin use declined. Another study by Verthain, Schafer, and Degkwitz (2013) showed that social integration improved. A Vancouver study by Oviedo-Jokes et al. (2010) showed that OAT participants had a significant reduction in drug-related HIV transmission risk behaviour. It was apparent that the stability achieved by the patients was important and significant for the staff. David noted that "...it makes everything worthwhile." It was clear that patients' outcomes validated the staffs' work at the clinic.

### 2.2. It's not all roses

It would be easy to assume that a clinic such as this, which is providing a unique service in the North American context, is doing everything right. The clinic is very busy. It is treating around 140 patients, which is the most it can handle given the physical constraints of the location. However, the staff indicated that there are a number of challenges related to working at the clinic. The most significant of these is space or the lack thereof. The staff repeatedly brought up this issue. Rebecca noted that "...it's a very small space with a lot of big personalities." Tabitha talked about how:

the biggest challenge I would say with [the] clinic is ... the facility itself, it's very old, it's very run down. There's exposure to asbestos, to mold, the roof is leaking, many things like that. I think a lot of that is around the fact that we are in a very small space. And people don't have the space they need pre- and post-injection.

Alison talked about how she

...would love to have a new space, a larger space so we could actually fit more people comfortably so that half the people don't have to stand and like hang out. Or that there's enough chairs for everybody if people want to stay and do activities. It's like a space that would accommodate like more time and more people so I think that would be good.

These comments bring up a lot of issues around the idea of space. It is in fact, place, not space, which frames our behavior. Place isn't just about space. It is about human experience and interpretation (Stedman, 2003). Place is not just physical, it is socially constructed. Place has an impact on people, materially, cognitively and in terms of their social interactions (Fletcher, 2006).

One of the most significant impacts of place constraints was the potential for conflict. A number of the staff members mentioned this. Stuart talked about how the lack of space contributes to instances of conflict. "We have all these people crammed into this little space right? And some of our patients are high on crystal or whatever. The lack of space really contributes to the potential for conflict." Natasha noted that "...a bigger part of it is because of the space right?"

Lack of space also contributes to the staffs' inability to provide comprehensive care for their patients. Many of the staff felt that the clinic should provide more comprehensive care, including primary care

but the lack of space precludes this. Melissa talked about.

funding, more money because with more money we could get a bigger space, cleaner space – do more for the clients – take on primary care. We could take on more clients, help more people. I mean even if out of the two thousand some people in two years have died from fentanyl if we could have even taken on fifty more.

Melanie mentioned that it is difficult to provide basic care because, “We have a very small space here and we don’t have all of the space that we would like in terms of being able to treat the clients with their wound care and those sorts of things.”

### 2.3. A little preparation would be good

There have been numerous publications examining the issue of staff preparation in caring for people who have an addiction. A publication by Marcellus (2007) noted that healthcare professionals continue to lack education about substance misuse. Murphy-Parker (2013) noted that the nursing literature indicates that there is a negligible amount of substance misuse education within schools of nursing in more developed countries.

The registered nurses in particular verified these findings. Marcelle stated “It’s not part of it at all...when I was in nursing school we didn’t even really talk about mental health and substance use at all.” The nurses all felt that what they had learned about addiction and mental health they had learned as a result of working at the clinic. Paul said “It’s more on the job...there were a lot of things I had to learn on the go...I’d make a lot of mistakes.” The registered psychiatric nurses and social workers seem to be better prepared for the work in the clinic. Julia indicated that “as a psychiatric nurse...mental health and substance use is a big component of our education.” What seems to be critical to increasing the understanding of health care workers about issues of addiction is ensuring they have access to and understand the latest research on addiction. Treatment, education and policy decisions need to be implemented using facts instead of anecdotal or prejudicial information (Erickson, Wilcox, Miller, Littlefield, & Lawson, 2003).

An issue that the staff identified was that the lack of educational preparation had an impact on staff turnover. They noted that at times a newly hired person would only last a short time before they left. Paul stated that “you see people coming that, that just don’t fit and they just don’t last because it, it’s too hard and people that get uptight and take it personally...” Jane indicated that “...it wasn’t what they expected and they leave the clinic fairly soon.” It is difficult to know without speaking to them why the staff left, but lack of educational preparation could be a contributing factor.

### 2.4. Putting the patient at the center

Patient centered care is an often cited value in nursing, but there is some evidence that practitioners only pay lip service to the concept. Paterson (2001) noted that practitioners frequently discount the experiential knowledge of their patients. Knowing the patient or understanding the patient’s reality, is an important component of patient centered care (Mantzorou & Mastrogianis, 2011). Incorporating shared decision making into clinical practice continues to be a challenge (Legare & Thompson-Leduc, 2014).

The staff at the clinic, however, have embraced the concept of patient centered care. They spoke in a way that made evident that they consider this an important strategy in caring for their patients. Alison spoke about how it is important to “...give [patients] that respect and make sure to treat them like they’re, they’re an adult and they can make educated decisions.” Jody talked about “...getting to know the kind of stories, finding out where they came from and how they ended up where they are. Building close relationships with them and having breakthrough and seeing improvements in their lives.” And Peter spoke of how you need to “...make sure the patients feel heard and make sure

their concerns are validated.” Melinda spoke about how it was “...extremely rewarding...” to gain the trust of the patients and watch them grow. A number of the staff spoke about how the relationships with the patients were the reason that they kept working at the clinic. Alison said “That’s a definite reason for me staying as long as I have.” Interestingly, although the term client is generally preferred by community, public health and mental health nurses, the staff at the clinic preferred to use the term “patient”.

### 2.5. The stigma hasn’t gone away

Addiction is highly stigmatized. There is a plethora of literature and an ongoing social conversation that supports this. Stigma is not just an experience for the patient with the addiction issue, it is also an experience for the staff. A number of the staff members talked about how their choice of job impacted their interactions with family and friends. Natasha noted that “...from friends and family there’s always – it’s always very – it’s never fully embraced.” Peter talked about how “You’re always having to back that statement up with evidence.” Melissa spoke about how you are “...being constantly questioned like why are you working there – when are you going back to the hospital as if I should be doing something different and something better in their terms.” The experience of stigma made the staff cautious about who they talked to about their work. It also made them much more sensitive to the stigma their patients experienced. Melanie noted that “it’s something we need to be aware of. I feel like I need to protect them.”

Nurses who cared for patients with HIV infection experienced stigma, which resulted in mental health issues and a loss of job satisfaction (Phillips, 2009) and mental health nurses are stigmatized “by association” (Harrison, Hauck, & Ashby, 2017). Caseworkers who deal with incontinence feel stigmatized by other members of the team and the public (Ostaszkievicz, O’Connell, & Dunning, 2016). No literature was located that dealt specifically with the stigma experienced by health care workers who care for people with addiction issues but it was clearly an issue in this study.

### 2.6. The clinic is life transforming

Happily, despite all the challenges, the staff related that working at the clinic has been life transforming for them. Melanie said:

Working at [the clinic] has given me a lot more patience and understanding in the sense that – how do I – I mean people come here with a lot of issues and, you know, you’ve really got to be understanding and give time to, you know, hear people out and their frustrations... made me think more about advocacy and things that we need to do for our communities.

Melanie talked about how she was compelled to talk about her work with her friends, family and acquaintances in an effort to increase their understanding of her patients and their intrinsic value to society. Jody related that:

I think having a more personal understanding of the level of trauma that these folks have experienced in their life and how that has contributed to their addicted lifestyle. It’s just allowed me to be more compassionate about it, that, that’s the biggest thing.

Peter stated that “my work gives me hope.” Natalie spoke about how “...every day I cherish what I have and who I have in my life...” And Natasha spoke about how “I get paid to actively practice compassion on a daily basis.” For Natasha, the opportunity to pursue active compassion means not just talking about it, but doing something. The staff often talked about the things they did for patients, from listening to building relationships to providing them opportunities for accomplishment and change.

Life changing experiences for nurses often seem to occur in the face of adversity, whether it is the experience of nurses working at ground

zero in New York after the terrorist attacks on September 11, 2001 (Fruiterman, 2006) or nurses who work in impoverished areas in some countries in Africa (Daniels & Servonsky, 2005). Adversity is also a common element in the addictions field, where workers constantly battle public perceptions about people who have an addiction issue. It is apparent from the participant's stories that adversity is a common experience at the clinic. Overcoming this adversity contributes to the staff's sense of achievement.

### 3. Discussion

The intersecting issues that the staff experienced as a result of working at the clinic clearly had an impact on their working lives and their perceptions of the work that they do. This study revealed a number of issues that have implications for the staff at the clinic. On the challenging side, the clinic's physical environment is clearly an issue for the staff. The built environment has an impact on the social determinants of health and health inequities (Gelormino, Melis, Marietta, & Costa, 2015). Space confers power (Gieryn, 2000) and lack of space can be seen as a symbol for the staff's lack of power to obtain the space they need to work in. Space is socially produced and constructed and it could be said that space "...keeps people in their place" (Kitchin, 1998, p. 343). From a critical realist perspective, space impacts agency. As Putnam (1999, p. 76) suggested, "...our words and our life are constrained by a reality not of our own invention..."

A number of researchers (Lancman, Mangia, & Muramoto, 2013; Makinde, Bjorkqvist, & Osterman, 2016) support the concept that lack of space leads to conflict, Kilcoyne and Dowling (2007) also observed that the lack of space leads to moral distress and burnout for staff, who are unable to provide the care that they believed patients deserve. Space can also be seen to have a causal relationship on institutional effectiveness (Fugazotto, 2009). Fugazotto contends that it is important to be strategic about space because it has an impact on how well the program operates. Space also has communicative value, lending validity to the program that operates within it.

The staff indicated that they felt powerless to change their working environment, one person stated "we can't do anything about it." Neglecting the material forces that impact on clinical practice is to neglect the potential for clinical learning and practice (Fenwick, 2014). Space is central to the production, organization and distribution of cultural power. An appropriately resourced workplace is not only functional, but it also confers power and status (Paliedelis, 2013). The difficult environment that the staff had to work in (and the patients had to be in) is illuminated by the philosophical approach of critical social theory, which highlights the complex social and political agendas that are inherent in the environment. Poor working conditions in the clinic reveal a lack of concern and lack of priority from decision makers. It is difficult to understand where this lack of priority comes from although it could just be an issue of addiction not being considered a priority in the health care system. Stigma is pervasive at all levels. There is research that reveals that people with addiction issues feel unworthy, different, excluded and powerless when accessing health care (Brondani, Alan, & Donnelly, 2017). The clinic design reflects this.

The lack of educational preparation is also an issue. There is some evidence that educational preparation can change the attitudes and skills of nurses and other staff who are working with addicted patients. Gerace, Hughes, and Spunt (1995) observed that educational interventions were influential in improving nurses' confidence in caring for substance misusing patients. On the other hand, Ford, Bammer, and Becker (2009) revealed that workplace education was not enough on its own but needed to be accompanied by role support in the field to provide advice and assistance.

Addictions education can play a pivotal role in preparing health care providers to care for populations with substance use issues but a focus on attitudes is also important (Warren, Cisler, Weatherford, & Zakaria, 2013). Addiction is a problem that cannot be addressed with

education alone (Vandermause & Townsend, 2010). Education needs to be combined with a problem-based learning approach and site specific support. Workplace experience was found to be an important factor in addiction competence (Krokmyrdal & Andenaes, 2015). For this reason, in addition to pre-licensure educational programs, staff need ongoing education and support in the work setting.

It is important for nurses to take a CST perspective to their work, because it will make visible the complexities of the social world and the discourses that impact those who seek care (Sumner & Danielson, 2007). This in turn will help them understand the strategies they need to utilize to better care for their patients and, hopefully, have a better connection with them. This will help them create therapeutic relationships and potentially leave them happier in their work. Therapeutic alliances are important for patients with addiction issues. There is evidence that therapeutic alliances are a predictor of engagement and retention in treatment (Meier, Barrowclough, & Donmall, 2005).

The experience of stigma is well documented in relation to people who use substances but there is virtually no literature that discusses the stigma experience of health care workers who work with this population. However, as this study revealed, stigma is an issue for care providers who work in addictions. Stigma is generally seen to have negative social, political, economic and psychological consequences (Crocker & Major, 1989) for groups who are marginalized and oppressed. This is not necessarily the case for health care workers. However, health care workers may choose to remove themselves from social situations where they think stigma is likely. For this reason, ongoing public education and the implementation of interventions that address stigma around addiction is an important strategy to minimize this issue. For many members of the public, including nurses, addiction remains a moral rather than a public health issue. Yet, there is some evidence that when the public sees addiction as treatable and people with addiction as having positive attributes they are more likely to view addiction in a positive light (Barry, McGinty, Pescosolido, & Goldman, 2014; Livingston, Milne, Fang, & Amari, 2011).

The finding that the staff routinely put patients at the center of their care is encouraging. Patient centered care is a goal that is not always realized but in the case of this clinic it seems to be the norm. It is clear that a majority of the staff take a critical perspective to their work and understand the social and political challenges that their patients face. Some research suggests that patients want their practitioners to provide patient centered care (Little et al., 2001). Patient centered care should incorporate the following principles: getting to know the patient as a person, enabling the patient to make decisions based on informed choices, shared decision making, providing tailored information, supporting the patient to assert their choices and ensuring that care and services are appropriate for each individual patient (Manley, Hills, & Marriott, 2011). It is clear from the stories that the staff shared that they embrace these principles.

It is important for patients to feel safe when they are accessing care and patient centered care is an important strategy for achieving this. Culturally safe care focuses attention on power imbalances, institutional discrimination and inequity (Pauly, McCall, Browne, Parker, & Mollison, 2015). As a result of their effort to provide patient centered care, the staff ensured that the patients had power and a more equitable relationship with their providers.

The life changing aspects of the clinic program, for both the patients and the staff, were remarkable. The staff descriptions of the changes they saw in their patients were compelling and the staff's own experiences were also noteworthy. The staff were excited when they talked about the changes they observed in the patients. It was clear that this was a central reason that they continued to work at the clinic. A number of them mentioned that they found the positive changes in their patients inspirational.

There is evidence that experiencing life changing events "...opens hearts and minds" (Callister & Cox, 2006, p. 95), which is reflected in the experiences of the staff. Given the positive way the staff talked

about the patients it was evident that their hearts and minds were open to their patients at the clinic. Another study by Johansson and Lindhal (2012) revealed that when nurses feel that they are part of something momentous it increases their commitment to the patients. Being immersed in work at the clinic meant that the staff were immersed in the culture of their patients, which is different from their own. Being immersed in this way led to a change in thinking, including increased compassion, accepting differences and recognizing societal ills. It also changed the way the staff engaged in care. The staff were committed to providing the patients with holistic, patient centered and supportive care. The experiences of the participants highlighted the art of caring, which is particularly important in nursing (Levine, 2009).

There is evidence that many nurses are reluctant to embrace harm reduction (Ford, 2010). Ford's research revealed that while many nurses are supportive of needle exchange, they are less supportive of other forms of harm reduction, being mistakenly optimistic about the efficacy of abstinence based programs. Given the overwhelming evidence in support of harm reduction measures (Bell, Belackova, & Lintzeris, 2018; Enns et al., 2016; Fernandes et al., 2017; Kim, Pulkki-Brannstrom, & Skordis-Worrall, 2014), it is important that nurses embrace these strategies. This highlights the need for more education at both the undergraduate level and for practicing nurses.

#### 4. Conclusion

The findings from this study are intended to highlight and make visible the work of staff at this OAT clinic. It is clear that the work that the staff engaged in is complex and challenging but provides many instances of achievement and satisfaction. Future qualitative research in OAT clinics should include patients' perspectives. Future research should also examine staff experiences more thoroughly, including the issue of stigma and how it impacts on practice. This OAT clinic is the first of its kind in North America, but it is clear from this study that careful attention needs to be paid to issues of physical space, stigmatization, and the educational preparation of staff. This study also revealed the importance of patient centered care, which should be central to any caregiver who works in this field.

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#### Disclosures

The authors report no real or perceived interests that relate to this article that could be construed as a conflict of interest.

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