Bond University

Australian Journal of Clinical Education

Volume 8 Issue 1

2021

Co-producing a Drug and Alcohol Nursing Subject With Experts by Experience

Mark Goodhew
University of Technology, Sydney

Yvonne Samuel
The University of Sydney

Candice Gilford
The University of Sydney

Jo River
The University of Sydney

Follow this and additional works at: https://ajce.scholasticahq.com/

This work is licensed under a Creative Commons Attribution-Noncommercial-No Derivative Works 4.0 Licence.

Co-producing a Drug and Alcohol Nursing Subject With Experts by Experience

Mark Goodhew*, Yvonne Samuel, Candice Gilford**, Jo River****

* School of Nursing, University of Technology, Sydney
** School of Nursing, The University of Sydney

Abstract

Nurses are frontline workers and have an important role to play in reducing the harms associated with alcohol and other drugs (AOD) dependence. AOD dependence is a major cause of preventable illness, particularly since the overprescribing of opioids has led to a worldwide overdose crisis. However, nurses receive little education in their undergraduate training about AOD or harm reduction strategies. Additionally, the 'war on drugs' and associations with criminality, often means that nurses hold negative attitudes towards people with AOD dependence. There is evidence that education can improve nurses' attitudes towards people with AOD use, especially when it includes narratives, knowledge and experiences of people with lived experience. In this paper, we outline how experts by experience (people with a lived experience of AOD dependence) and nurse educators developed a high-quality AOD undergraduate nursing subject using a co-production framework. We discuss how the co-production process allowed for the development of a unique and innovative nursing subject that provides students with a humanistic, realistic and pragmatic view of AOD dependence.

Nurses, as frontline workers, are likely to have considerable contact with people who experience alcohol and other drug (AOD) dependence (Smothers et al., 2018; Tierney et al., 2020; Watson et al., 2010). AOD dependence is defined as physiological, psychological and cognitive reliance on alcohol and/or drugs to the extent that substance use is prioritised over other activities and behaviours that were previously valued (World Health Organization, 2020). Although nurses are well positioned to care for people who use AOD, like other health professionals, they continue to hold stigmatising attitudes towards people with dependence (Lovi & Barr, 2009; van Boekel et al., 2013). This represents a significant barrier to people seeking treatment who already feel stigmatised within the broader society.

The lived experience narratives of people with AOD dependence can contribute to dispelling stigmatising myths about people who use ADO and foster equity in health care (Roussy et al.,2015; Valenti & Allred, 2020). In the context of AOD, lived experience is gained via experiences of dependence, including experiences of accessing health services and experiences of stigma and discrimination in the community. Some people with lived experience are also considered experts by experience by virtue of their expertise and activism in harm reduction approaches, as well as their support and advocacy for people with AOD dependence. To date, lived experience perspectives on AOD dependence have been included in nursing education (Roussy et al., 2015; Valenti & Allred, 2020). However, experts by experience have rarely been involved in the overall design, delivery and evaluation of nursing courses in tertiary settings. Involving experts by experience in all aspects of course design and delivery could arguably provide nursing students with a more accurate and empathic view of AOD dependence, and further contribute towards dispelling stigmatising attitudes.

This paper is co-authored by experts by experience and nurse educators who are involved in co-producing an AOD subject for undergraduate nursing students. The experts by experience have around forty years combined experience working as peer workers and harm reduction activists in the field of AOD dependence. The nurse educators have 25 years combined teaching experience, as well as expertise in co-production research. Clinical nurses and educational designers were also involved in the initial co-planning stages of the co-production process. The paper provides an overview of AOD dependence in the community and associated harms; nurses role in providing care; and educational initiatives incorporating lived experience perspectives. We then report on a co-production process that involved a partnership with experts by experience and nurse educators in the co-planning, co-designing, co-delivering and co-evaluating of the undergraduate AOD subject. Finally, we reflect on the value and challenges of coproducing the AOD course.

I BACKGROUND

AOD use is a significant public health issue, with over 2% of the world's population being diagnosed with AOD dependence (Ritchie, 2019). Globally, each year, 11.8 million people die from smoking, alcohol, and substance use, and 11.4 million people die prematurely (Ritchie, 2019). Over the past few decades, there has been a dramatic rise in opioid-related deaths, with 109,520 deaths in 2017 (Ritchie, 2019). This rise is largely attributed to the doubling of opioid prescriptions between 2001 -2013 in the United States, Canada, Australia and some Western European countries (Berterame et al., 2016). AOD use can also lead to hospitalisation for related harms such as overdose, injury, liver-related disease and mental distress (Australian Institute of Health and Welfare, 2018). Furthermore, people with dependence are at high risk of experiencing social issues such as domestic violence and homelessness (Australian Institute of Health and Welfare, 2018).

Australian statistics mirror international AOD rates. In 2011, 4.5% of all deaths in Australia were from AOD use, and the burden of disease from AOD was 6.7% (Australian Institute of Health and Welfare, 2018). Over the past decade, Australia's number and rate of opioid-induced deaths have also been increasing, and in 2017 there were 1,171 opioid related deaths (Chrzanowska et al., 2019). Around 200,000 Australians access AOD treatment each year (Ritter et al., 2014).

Counselling, case management, withdrawal management, rehabilitation and pharmacotherapy are the main therapies used in Australia to treat AOD dependence (AIHW, 2018).

Nurses play an essential role in reducing mortality rates and burden of disease associated with AOD use. There is evidence that some nurses, particularly those who specialise in AOD treatments, are providing effective care to people who experience dependence. Research indicates that specialised nurses have successfully supported prisoners, homeless people and pregnant women with AOD dependence (McKeever et al., 2014; Mistral & Hollingworth, 2001; Papaluca et al., 2019). Nurses also provide valuable care in needle and syringe programs and supervised injecting facilities (Gagnon & Hazlehurst, 2020). Nonetheless, the paucity of AOD content in undergraduate and postgraduate nursing programs means that most nurses do not feel confident in caring for individuals with substance dependence (Compton & Blacher, 2020; Ford, 2011; Lovi & Barr, 2009). Nurses also hold stigmatising views about drug use that centre around the notion that AOD patients are manipulative, violent and criminal drug seekers, who are undeserving of care (Copeland, 2020; Horner et al., 2019; Neville & Roan, 2014). Nurses' attitudes towards people who use AOD arguably stem from the 100 year global war on drugs. Drug dependence in this war, is predominantly depicted as criminal, and managed via the criminal justice system, rather than being viewed as a social and health issue (Hari, 2016).

Nurses who receive AOD education can significantly improve the support they provide to people with AOD dependence, particularly via brief screening and harm reduction interventions (Watson et al., 2010). Education can also positively impact on nurses' attitudes and empathy towards people with AOD dependence (Smothers et al., 2018), particularly if programs include a reflective component where nurses consider their attitudes towards people who use AOD (Rassool & Rawaf, 2008; Vadlamudi et al., 2008).

To improve AOD education, people with lived experience are beginning to co-deliver AOD courses with nurse educators (Roussy et al., 2015; Valenti & Allred, 2020). Interest in lived experience perspectives arguably arose in response to consumer movements of the '60s and '70s, when psychiatric patients began to speak out about inhumane care and fought for the rights to influence mental health service delivery (Tomes, 2006). Within Australia, most nursing curriculums now include illness and lived experience perspectives as a requirement of nursing registration standards for practice (Nursing and Midwifery Board of Australia, 2016). Patient narratives can provide nurses with insights into the lives of people they care for and enable them to be more responsive and person-centred in their approach (Benner et al., 2009). Nonetheless, involvement of people with lived experience is often tokenistic with people having little power and control to ensure that their 'perspectives and contributions' are valued (Roper et al., 2018, p. 4).

Although mostly tokenistic, important initiatives to more meaningfully include AOD lived experience perspectives in health service design and delivery have been undertaken in the context of AOD treatment facilities (Goodhew et al., 2019). AOD experts by experience have also been involved in co-delivering subjects with nurses, which has been linked to reducing nursing students' stigmatising attitudes towards people with dependence (Roussy et al., 2015; Valenti & Allred, 2020). However, to date, the full extent of lived experience contributions has not been realised. Despite their considerable expertise and advocacy work, AOD experts by experience have not been involved in the planning, design and evaluation of nursing programs.

II A CO-PRODUCTION FRAMEWORK

Co-production, which came out of social care and civil rights movements in the United States (Cahn, 2000; Ostrom & Ostrom, 1978), is gaining traction in academia and health services for improving the quality, relevance and evaluation of approaches to care (Lignou et al., 2019; Roper et al., 2018; Scholz et al., 2019). Unlike conventional approaches to involving people with lived experience, co-production includes people with lived experience from the outset as equal partners throughout the co-planning, co-design, co-delivery and co-evaluation stages (Horner, 2016; Roper et al., 2018). Co-planning relates to deciding what needs to be solved, who should be involved, and over what time frame; co-design refers to defining the problem and developing

potential solutions; co-delivery is the processes of deciding on task allocation; and co-evaluation refers to decisions about how to measure processes and outcomes (Roper et al., 2018). Overall, co-production provides a collaborative approach that engenders more genuine partnership and shared decision making between people with lived experience and key stakeholders (Horner, 2016; Roper et al., 2018). More than a method, co-production is also an 'ethos' where the perspectives of people with lived experience are honoured and entrenched hierarchies are disrupted (Horner, 2016). Additionally, via reciprocal and respectful partnerships collaborators build their collective capacity to effectively design, deliver and evaluate initiatives (Scholz et al., 2019).

III CO-PRODUCING AN AOD SUBJECT WITH EXPERTS OF LIVED EXPERIENCE

Between 2019 to 2020, our collaborative team of experts by experience and nurse educators commenced a co-production process to develop an AOD Bachelor of Nursing subject, which incorporates an 80-hour clinical placement, and will be offered as an elective subject to nursing students in 2021. Our aim was to co-produce a high-quality and clinically relevant program that would embed lived experience perspectives. Our broader aim was to transform nursing AOD education and positively impact nurses' attitudes towards people who experience AOD dependence. Below, we provide a brief description of the co-produced AOD nursing subject and evaluation, before reflecting on the co-production process.

A *A Co-Producing the Education Program*

The core co-production team included experts by experience and nurse educators. However, in the initial co-planning and co-design stages, the team also consulted with clinical nurses working in the AOD field and educational design experts. Although priorities of the various stakeholders differed, the perspectives of experts by experience was elevated to ensure that nursing voices did not dominate.

Initially, the core team and consultants considered key objectives for student learning outcomes. These were then discussed and prioritised. Nine learning objectives emerged from the co-planning and co-design stage. Experts by experience favoured student learning about the war on drugs, which has significantly shaped current approaches to AOD, as well as the impact of stigmatising attitudes towards people with lived experience of AOD use (Hari, 2016). Additionally, experts by experience favoured harm reduction approaches to care and emphasised the importance of language in nurse-patient interactions, which could be powerful in reinforcing stigma (NADA, 2020). Nurse educators and clinicians' expertise was also incorporated. For example, they favoured trauma informed approaches to care, that can underpin mental distress and AOD use (Mills, 2015). Table 1 outlines the nine learning objectives of the AOD undergraduate nursing subject.

Table 1
Nine learning objectives of the AOD undergraduate nursing subject

The AOD subject will enable students to:
i. examine the various social, biological, and genetic theories of AOD dependence including complex trauma;
ii. learn how the War on Drugs shapes societal attitudes about drug use and influences AOD care;
iii. consider the importance of language and its potential detrimental impact on service users;
iv. examine perspectives from experts by experience, ADO nurses and educators;
v. reflect on their attitudes about AOD use;
vi. explore AOD treatments and consider both harm reduction and abstinence-based options;
vii. consider the physical health needs of service users;
viii. develop interpersonal and counselling skills that will enable the creation of therapeutic relationships with service users;
ix. become proficient in conducting collaborative AOD assessments and AOD clinical skills.

Additionally, the collaborators determined that the learning objectives would be grouped into key themes, which could then be delivered via three core modules. The use of modules would allow the team to develop discrete content themes and related assessment tasks. Table 2 outlines the three modules of the AOD undergraduate nursing subject.

Table 2
Three Modules of the AOD undergraduate nursing subject

Module	Description
Module One	Concentrates on the various types of AOD use, dependency and treatments. The module also considers causation theories (e.g. social determinants, trauma, biochemical and genetic) of drug dependency, and would explain how the war on drugs shaped treatment and care and public health consequences
Module Two	Concentrates on evidence-based harm reduction interventions such as supervised injecting centres, needle and syringe programmes, community naloxone programs and pill testing, and how they can be used to reduce the risks associated with drug use.
Module Three	Concentrates on the students learning skills including collaborative comprehensive AOD assessments, monitoring and intervening in AOD withdrawals, dispensing opioid replacement therapy, observing the physical and behavioural signs of AOD intoxication, communication skills and motivational interviewing skills.

Finally, drawing on active and flipped classroom approaches to teaching and learning (Berrett, 2012; Kaufmann, 2003) introduced by the educational designer consultants, the collaborators determined how teaching would be delivered. Active learning and flipped classroom methods are a means of generating higher order thinking: application, analysis and evaluation (Anderson & Krathwohl, 2001; Bloom et al., 1956). They typically include online pre-learning, face-to-face small group interactions and problem-solving activities that also promote critical

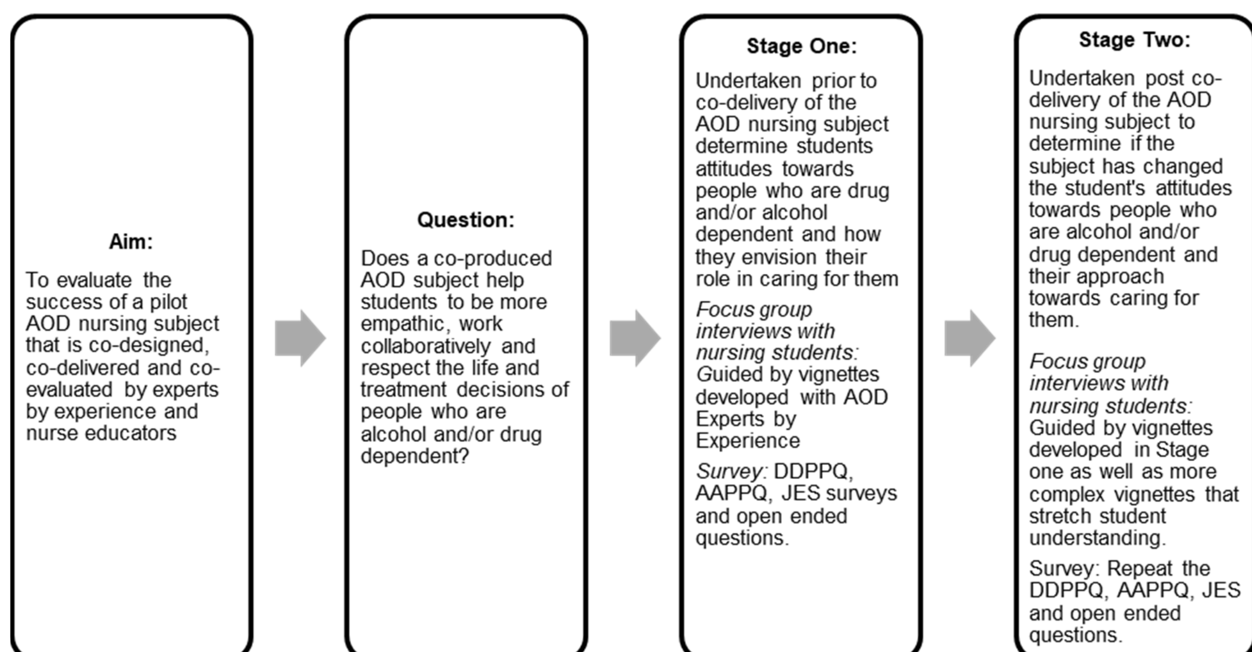
thinking and reflection via peer-to-peer learning (Kaufmann, 2003). Additionally, experts by experience also determined that some classes needed to be taught outside of the university to ensure real-world experiential learning opportunities (e.g. in AOD harm reduction services). Furthermore, clinical nurses recommended drawing on clinical stimulations to assist students in developing essential skills, such as collaborative AOD assessments and managing an opioid-related overdose. All collaborators determined that the course should be co-delivered with experts by experience and senior AOD registered nurses in order to provide students with real-world examples of service user experiences and AOD nursing.

B *Co-Producing the Course Evaluation*

In addition to co-planning and co-designing the education program, experts by experience and nurse educators also collaboratively planned the evaluation of the AOD nursing subject, which relates to the co-evaluation stage of co-production (Roper et al., 2018). Experts by experience and nurse educators discussed multiple approaches to evaluation including measuring changes in student empathy. Importantly, experts by experience drew attention to the limits of empathy measures, arguing that students could score high on empathy but might be less empathic if a patient refused treatment and continued using drugs. Therefore, it was decided that the evaluation tools should measure nurses' attitudes and empathy towards people with AOD dependence regardless of their treatment decisions. The team settled on using pre and post measures of student empathy and attitudes via validated survey tools including: Drug and Drug Problems Perceptions Questionnaire (DDPPQ); Alcohol and Alcohol Problems Perceptions Questionnaire (AAPPQ); and Jefferson Empathy Scale (Hojat et al., 2001; Watson et al., 2003).

Furthermore, it was determined that qualitative research methods would allow a more detailed picture of students' attitudes towards AOD use and treatment decisions when triangulated with survey data. Mixed methods have been used previously in nursing research (Williamson, 2005). The team therefore included qualitative survey questions and focus group interviews as part of the evaluation. The experts by experience developed a series of 'real-world' vignettes of typical interactions between people with AOD dependence and nurses that nursing students could discuss in focus groups, as well as more complex vignettes that centred on a patient presenting for non-related AOD health condition. Figure 1 outlines the co-evaluation plan for the AOD undergraduate nursing subject.

Figure 1
Co-evaluation plan for the AOD undergraduate nursing subject



IV REFLECTING ON THE CO-PRODUCTION PROCESS

The co-production framework proved to be important in providing a systematic approach to collaboration, with distinct phases of co-planning, co-design, co-delivery and co-evaluation (Roper et al., 2018). We have completed the first round of the co-planning and co-design phase and have engaged in co-evaluation planning. We are now preparing a second co-design workshop to brainstorm the subject's assessments and to determine who will co-deliver the teaching modules.

To date, through discussions and debates, our team has been able to generate and prioritise nursing subject objectives, modules, teaching methods and evaluation. We were supported by the ethos of co-production, which seeks to prioritise the perspectives of those with lived experience in order to level power dynamics with other stakeholders (Horner, 2016). The nursing educators were mindful of their privileged positions and willing to engage in conversations about power as required in co-production processes (Roper et al., 2018).

Importantly, co-production emphasises reciprocity and mutual capacity building (Roper et al., 2018), which enabled the team to remain open to mutual learning. Being active in movements to decriminalise drug use and increase access to harm reduction interventions, experts by experience had considerable knowledge and experience of approaches to AOD recovery that favoured harm reduction over abstinence. Additionally, they had a more nuanced understanding of how stigma impacted on people with lived experience. This knowledge and experience shaped both the design of the subject content and evaluation. For example, it led to a unique emphasis on the history of the war on drugs and harm reduction principles in the subject content, which has frequently been overlooked in nursing education. However, as Ford (2011) argues, we need more knowledge about harm reduction interventions because most people who are AOD dependent are not ready to embrace abstinence. Knowledge of historical processes that lead to stigma can also help nurses interact better with people with AOD dependence and provide more pragmatic and less stigmatising care.

Expert by experience input, and their awareness of stigmatising nursing practices, also led to more nuanced measures of nursing students' empathy and attitudes towards people with AOD dependence being chosen for the co-evaluation of the nursing subject. Therefore, the experts by experience not only built the capacity of nurse educators to understand lived experience perspectives, and pragmatic harm-reduction solutions to complex AOD issues, the evaluation process will arguably allow the team to better determine whether the subject has influenced the student's attitudes.

The nurse educators in the team had considerable teaching and research experience, including in co-production approaches. Therefore, they were able to support experts by experience to understand nursing education within tertiary settings, as well as co-production strategies and research methodologies that could be used within the co-production framework. The nursing educators were also able to secure educational resources, including funding to pay the experts by experience for engaging in the co-production phases. Experts by experience were motivated to increase their own capacity to engage in co-producing health professional education and have taken up further opportunities to be involved in the project, including engaging in a research training and mentoring program with established lived experience researchers.

At times, the co-production process did not run smooth. For example, it is ideal that equal numbers of people with lived experience co-produce initiatives to ensure equal voice in the process (Roper et al., 2018). However, initially, nursing educators struggled to recruit people to the co-planning stages of the project due to a lack of funds. As noted by Nathan (2004), lack of funds to pay people with lived experience limits collaborative processes, particularly among socioeconomically disadvantaged populations. This is particularly relevant as the association between drug dependence and social and economic hardship is strong (Shaw et al., 2007). Later, funding was secured to support the co-produced initiative, which resulted in equal numbers of experts by experience being involved.

V CONCLUSION

Co-production is an imperfect process that requires adequate time and resources. However, the systemic and collaborative framework allows collaborators to come together and pool their combined knowledge, experience and expertise. In this initiative, the co-production framework allowed collaborators to create an innovative and unique nursing subject that embeds lived experience perspectives. As such, it could potentially improve nursing students' understanding of the lives and needs of people with AOD dependence. Although we cannot determine the efficacy of our collaborative approach at this point, findings from our planned co-evaluation will arguably allow us to better determine whether our innovative approach positively influenced nursing students' empathy and attitudes towards people with lived experience of AOD dependence.

References

AIHW. (2018). *Alcohol and other drug treatment services in Australia: 2016-2017*. https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2016-17/contents/table-of-contents

Anderson, L. W., & Krathwohl, D. (2001). *A taxonomy for learning, teaching, and assessing: a revision of Bloom's taxonomy of educational objectives*. Longman.

Australian Institute of Health and Welfare. (2018). *Impact of alcohol and illicit drug use on the burden of disease and injury in Australia: Australian Burden of Disease Study 2011* (Australian Burden of Disease Study series no. 17. Cat. no. BOD 19, Issue. https://www.aihw.gov.au/reports/burden-of-disease/impact-alcohol-illicit-drug-use-on-burden-disease/contents/table-of-contents

Benner, P., Tanner, C. A., & Chesla, C. A. (2009). *Expertise in Nursing Practice, Second Edition: Caring, Clinical Judgement and Ethics*. Springer Publishing Company.

Berrett, D. (2012). How 'Flipping' the Classroom Can Improve the Traditional Lecture *The Chronicle of Higher Education; Washington, Feb, 19, 2012*.

Berterame, S., Erthal, J., Thomas, J., Fellner, S., Vosse, B., Clare, P., Hao, W., Johnson, D. T., Mohar, A., Pavadia, J., Samak, A. K. E., Sipp, W., Sumyai, V., Suryawati, S., Toufiq, J., Yans, R., & Mattick, R. P. (2016). Use of and barriers to access to opioid analgesics: a worldwide, regional, and national study. *The Lancet, 387*(10028), 1644-1656. https://doi.org/10.1016/s0140-6736(16)00161-6

Bloom, B. S., Engelhart, M. D., Furst, E. J., Hill, W., & Krathwohl, D. R. (1956). *Taxonomy of educational objectives: The classification of educational goals. Handbook I: Cognitive domain.* David McKay.

Cahn, E. (2000). *No more throw-away people: The coproduction Imperative*. Essential Books.

Chrzanowska, A., Dobbins, T., Degenhardt, L., & Peacock, A. (2019). *Trends in drug-induced deaths in Australia,1997-2017. Drug Trends Bulleting Series*. https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/Drug%20Induced%20Deaths%20July%202019%20Drug%20Trends%20Bulletin_Final_0.pdf

Compton, P., & Blacher, S. (2020). Nursing Education in the Midst of the Opioid Crisis. *Pain Management Nursing, 21*(1), 35-42. https://doi.org/10.1016/j.pmn.2019.06.006

Copeland, D. (2020). Drug-seeking: A literature review (and an exemplar of stigmatization in nursing). *Nurs Inquiry, 27*(1), e12329. https://doi.org/10.1111/nin.12329

Ford, R. (2011). Interpersonal challenges as a constraint on care: the experience of nurses' care of patients who use illicit drugs. *Contemporary Nurse, 37*(2), 241-252. https://doi.org/10.5172/conu.2011.37.2.241

Gagnon, M., & Hazlehurst, E. (2020). How Do Nursing Organizations Measure Up on Harm Reduction? An Environmental Scan. *Canadian Journal of Nursing Research*, 844562120914425. https://doi.org/10.1177/0844562120914425

Goodhew, M., Stein-Parbury, J., & Dawson, A. (2019). Consumer participation in drug treatment: a systematic review. *Drugs and Alcohol Today, 19*(2), 97-112. https://doi.org/10.1108/dat-05-2018-0023

Hari, J. (2016). *Chasing The Scream: The First And Last Days Of The War On Drugs*. Bloomsbury.

Hojat, M., Mangione, S., Nasca, T. J., Cohen, M. J. M., Gonnella, J. S., Erdmann, J. B., & Veloski, J. (2001). The Jefferson scale of physician empathy: development and preliminary psychometric dataJ. *Educational and Psychological Measurement, 61*(2), 349-365.

Horner, G., Daddona, J., Burke, D. J., Cullinane, J., Skeer, M., & Wurcel, A. G. (2019). "You're kind of at war with yourself as a nurse": Perspectives of inpatient nurses on treating people who present with a comorbid opioid use disorder. *PLoS One, 14*(10), e0224335. https://doi.org/10.1371/journal.pone.0224335

Horner, L. (2016). *Co-constructing research: A critical literature review. Arts and Humanities Research Council, Bristol, UK.* https://connected-communities.org/index.php/project_resources/co-constructing-research-a-critical-literature-review

Kaufmann, D. M. (2003). Applying educational theory in practice. *BMJ, 326*, 213-216.

Lignou, S., Capitao, L., Hamer-Hunt, J. M., & Singh, I. (2019). Co-Production: An Ethical Model for Mental Health Research? *American Journal of Bioethics, 19*(8), 49-51. https://doi.org/10.1080/15265161.2019.1619877

Lovi, R., & Barr, J. (2009). Stimga reported by nurses related to those experiencing drug and alcohol dependency: A phenomenologicla Giorgi study. *Contemporary Nurse, 33*(2), 168-178.

McKeever, A. E., Spaeth-Brayton, S., & Sheerin, S. (2014). The role of nurses in comprehensive care management of pregnant women with drug addiction. *Nursing for Women's Health, 18*(4), 284-293. https://doi.org/10.1111/1751-486X.12134

Mills, K. L. (2015). The importance of providing trauma-informed care in alcohol and other drug services. *Drug Alcohol Review, 34*(3), 231-233. https://doi.org/10.1111/dar.12273

Mistral, W., & Hollingworth, M. (2001). The Supervised Methadone and Resettlement Team nurse: an effective approach with opiate-dependent, homeless people. *International Nursing Review, 48*, 122-128.

NADA. (2020). *Language matters.* (2020, 26th August) https://nadaweb.azurewebsites.net/wp-content/uploads/2018/03/language_matters_-_online_-_final.pdf

Nathan, S. (2004). Consumer participation: The challenges to achieving influence and equity. *Australian Journal of Primary Health, Vol. 10*(3), 15-20.

Neville, K., & Roan, N. (2014). Challenges in nursing practice: nurses' perceptions in caring for hospitalized medical-surgical patients with substance abuse/dependence.*The Journal of Nursing Administration, 44*(6), 339-346. https://doi.org/10.1097/NNA.0000000000000079

Nursing and Midwifery Board of Australia. (2016). *Registered Nurses Standards For Practice*. https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards/registered-nurse-standards-for-practice.aspx

Ostrom, V., & Ostrom, E. (1978). Public goods and public choices. In E. Savas (Ed.), *Alternatives for delivering public services: Toward improved performance*. Westview Press.

Papaluca, T., McDonald, L., Craigie, A., Gibson, A., Desmond, P., Wong, D., Winter, R., Scott, N., Howell, J., Doyle, J., Pedrana, A., Lloyd, A., Stoove, M., Hellard, M., Iser, D., & Thompson, A. (2019). Outcomes of treatment for hepatitis C in prisoners using a nurse-led, statewide model of care. *Journal of Hepatology, 70*(5), 839-846. https://doi.org/10.1016/j.jhep.2019.01.012

Rassool, G. H., & Rawaf, S. (2008). Predictors of educational outcomes of undergraduate nursing students in alcohol and drug education. *Nurse Education Today, 28*(6), 691-701. https://doi.org/10.1016/j.nedt.2007.11.005

Ritchie, H. (2019). *'Drug Use'* OurWorldInData.org. https://ourworldindata.org/drug-use

Ritter, A., Berends, L., Chalmers, J., Hull, P., Lancaster, K., & Gomez, M. (2014). *New Horizons:The review of alcohol and other drug treatment services in Australia Final Report*.

Roper, C., Grey, F., & Cadogan, E. (2018). *Co-production: Putting principles into practice in mental health contexts*. University of Melbourne. https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0007/3392215/Coproduction_putting-principles-into-practice.pdf

Roussy, V., Thomacos, N., Rudd, A., & Crockett, B. (2015). Enhancing health-care workers' understanding and thinking about people living with co-occurring mental health and substance use issues through consumer-led training. *Health Expectations, 18*(5), 1567-1581. https://doi.org/10.1111/hex.12146

Scholz, B., Gordon, S., Bocking, J., Liggins, J., Ellis, P., Roper, C., Platania-Phung, C., & Happell, B. (2019). 'There's just no flexibility': How space and time impact mental health consumer research. *International Journal of Mental Health Nursing, 28*(4), 899-908. https://doi.org/10.1111/inm.12589

Shaw, A., Egan, J., & Gillespie, M. (2007). *Drugs and poverty: A literature review*. Scottish Drugs Forum. http://www.sdf.org.uk/wpcontent/uploads/2017/03/Drugs__Poverty_Literature_Review_2007.pdf

Smothers, Z., Reynolds, V., McEachern, M., Derouin, A. L., Carter, B. M., & Muzyk, A. (2018, May/Jun). Substance Use Education in Schools of Nursing: A Systematic Review of the Literature. *Nurse Educator, 43*(3), 136-139. https://doi.org/10.1097/NNE.0000000000000449

Tierney, M., Finnell, D. S., Naegle, M., Mitchell, A. M., & Pace, E. M. (2020). “The Future of Nursing: Accelerating gains made to address the continuum of substance use”. *Archives of Psychiatric Nursing*. https://doi.org/10.1016/j.apnu.2020.07.010

Tomes, N. (2006). The patient as a policy factor: a historical case study of the consumer/survivor movement in mental health. *Health Affairs, 25*(3), 720-729. https://doi.org/10.1377/hlthaff.25.3.720

Vadlamudi, R. S., Adams, S., Hogan, B., Wu, T., & Wahid, Z. (2008). Nurses' attitudes, beliefs and confidence levels regarding care for those who abuse alcohol: impact of educational intervention. *Nurse Education in Practice, 8*(4), 290-298. https://doi.org/10.1016/j.nepr.2007.10.003

Valenti, M., & Allred, K. (2020). Using Peer Recovery Specialists to Educate Nursing Students. *Nurse Educator, 45*(4), 179-180. https://doi.org/10.1097/NNE.0000000000000738

van Boekel, L. C., Brouwers, E. P. M., van Weeghel, J., & Garretsen, H. F. L. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence, 131*(1-2), 23-35. https://doi.org/10.1016/j.drugalcdep.2013.02.018

Watson, H., Maclaren, W., Shaw, F., & Nolan, A. (2003). *Measuring staff attitudes to people with drug problems: The development of a tool*. https://www.webarchive.org.uk/wayback/archive/20180517065944/http://www.gov.scot/Publications/2003/08/17735/23454

Watson, H., Munro, A., Wilson, M., Kerr, S., & Godwin, J. (2010). The involvement of nurses and midwifes in screening and brief interventions for hazardous and harmful use of alcohol and other psychoactive substances: *WHO/HRH/10-6*. https://apps.who.int/iris/handle/10665/70480

Williamson, G. R. (2005). Illustrating triangulation in mixed-methods nursing research. *Nurse Researcher, 12*(4), 7-18.

World Health Organization. (2020). *Management of substance abuse*. https://www.who.int/substance_abuse/terminology/definition1/en/