Part I: Working with patients

Introduction

A strong therapeutic alliance is integral to helping patients recover from a substance use disorder. Talking to patients about their substance use can be challenging for clinicians. This section briefly outlines some general guidelines for working with patients with substance use disorders and some therapeutic techniques that have been shown to be useful in treating patients; clinicians are encouraged to incorporate these techniques when treating patients for addiction.

General guidelines

- Be aware of patients' possible guilt/shame about addiction.
  - Reframe addiction as **biomedical problem** ("You have a substance use disorder") rather than **moral failing** ("You are an addict").
  - Be **non-judgmental** in your approach.
- Encourage patient to take responsibility for getting help for addiction **without blame**.
- Understand difficult patient behaviours as manifestations of illness.
  - Patients with substance use disorders tend to be disorganized, late for appointments, miss appointments, request urgent appointments, etc.
  - Substance use disorders make patients' lives much more difficult to control.

- Use **brief intervention** techniques to engage patient in treatment (1):
    1. Give feedback from assessment.
    2. Inform patient about health risks and offer help.
    3. Assess patient's readiness to change.
    4. Negotiate strategies for change.
    5. Arrange follow-up.
- Refer patients to psychosocial treatment when indicated.
    - Many options for patients to choose from: residential vs. outpatient, individual vs. group, religious vs. secular, etc.
    - Effective psychosocial treatment models for patients with substance use disorders include Seeking Safety (2), structured relapse prevention (3), and cognitive behavioural therapy (4, 5).

Encouraging behavioural change

When talking to patients about problematic substance use, the role of the care provider is to inform patients of their options and express willingness to help in order to enhance the patient's motivation. The approach taken for each individual patient depends on the patient's current stage of change.

Stages of change

The transtheoretical model of behaviour change (6) recognizes six stages of change:

1. Precontemplation
    - Not ready to change pattern of substance use.
    - May be unaware that their substance use is problematic.

2. Contemplation
    - Becoming aware that substance use is problematic.
    - Beginning to see some advantages to change.
    - Considering making a change in the next six months.
3. Preparation
    - Commitment to change.
    - Planning, decision-making, goal-setting.
4. Action
    - Change in progress.
    - Encountering consequences of changing substance use, both positive (e.g., more energy, improved relationships) and negative (e.g., withdrawal, boredom).
    - Establishing new habits and new lifestyle.
5. Maintenance
    - Working to sustain new habits.
    - Learning to deal with challenges and setbacks.
6. Relapse
    - Return to old behaviours.
    - Normal part of change process.
    - Opportunity to learn what caused the relapse and recommit to goal with a renewed motivation towards behaviour change.

Enhancing motivation

The Center for Substance Abuse Treatment recommends using different strategies to enhance motivation depending on the patient's stage of change (7):

Precontemplation	Work to establish **trusting relationship** Open the door to conversations about substance use • Present facts • Express concern • Ask how patient sees their substance use • Offer help without pressure
Contemplation	Acknowledge **difficulty** of change Normalize **ambivalence** Explore patient's reasons **for** and **against** making a change Explore patient's **values** and **strengths** Emphasize patient's free choice Reiterate **help** and **support**
Preparation	Work together to create a **concrete plan** • What is the goal? • What are the strategies/tools (e.g., medication, counselling)? • What is the timeline? • What supports will patient use? • How will patient address barriers/setbacks?
Action	See patient frequently to check in and support engagement Acknowledge **successes** and address **setbacks** Support change through **small steps**
Maintenance	Acknowledge **success** Support healthy lifestyle changes Maintain **contact**
Relapse	Help patient **re-enter** change cycle Explore **reason** for relapse Look for **alternative strategies** Maintain **contact**

Trauma-informed care

Trauma occurs when an individual is in a frightening situation that overwhelms their ability to cope. As a result, the individual is left with feelings of fear, horror, and helplessness that can last for the rest of their life. Many patients with a substance use disorder have a trauma history; care providers should keep this in mind in their interactions with patients.

Roots and effect of trauma

- Adverse childhood events (8):
  - Strong correlation between adverse childhood events (ACEs) and development of risk factors for disease, including substance use disorders.
  - Risk increases with number of ACEs.
- Multigenerational trauma: Trauma experienced by parents affects children.
  - E.g., children of Holocaust survivors, children of survivors of Canadian residential school system.
  - Effect on individuals, families, and communities.
- Trauma can have a profound effect on people's lives:
  - Loss of stability
  - Abnormal neurodevelopment
  - Mental health problems (e.g., PTSD)
  - Substance use as a **coping mechanism**

Principles of trauma-informed care

Acknowledgment	Listen, empathize, normalize, validate.
Trust	Be honest about your knowledge, skills, and limitations as a care provider. Provide **transparency** and **shared power** in decision making. Enforce consistent **boundaries**.
Collaboration	Emphasize patient's **choice** and **control**
Compassion	Not "What's wrong with you?" but "What happened to you?" Identify the patient's needs and explore implications for care.
Strength-based	Acknowledge **resilience**. Acknowledge that coping mechanisms (e.g., substance use) are **understandable** and **logical**.
Safety	Physical safety: Well-lit office, safe building, comfortable environment. Emotional safety: Avoid re-traumatizing patient.

Asking about trauma

- Spend some time developing initial rapport before asking about trauma.
- Be prepared to define trauma:
  - "Sometimes we see or experience things that are very violent, frightening, or overwhelming, and those things can stay with us for many years if we don't get help dealing with them. There is lots of research to show that experiences like these can have an impact on our physical and mental health."
- Explain link between trauma and substance use:
  - "Memories of traumatic experiences can cause a lot of overwhelming emotions, and a lot of people use drugs or alcohol as a way to cope with those emotions."

- How to ask:
  - "Have you ever experienced any difficult life events, either in childhood or as an adult, that you think might be related to some of the things you are struggling with now?"
  - "Is that something you would be able to talk to me about?"
  - "I know it can be really difficult to talk about these things. We know that childhood histories of abuse are much more common than once reported, and that a history of trauma can have an effect on an individual's physical and mental health. You don't have to tell me the details, and we will work together to find supports for you."
- Responding to disclosure:
  - Acknowledge **disclosure**: "I appreciate you sharing this with me. I know it's not easy to do."
  - Acknowledge **impact**: "That sounds like a really difficult experience. It must have been really hard for you."
  - Express **compassion**: "What happened wasn't your fault." "Nobody deserves to be treated that way." "I'm so sorry that happened to you."
  - **Normalize** reactions: "It makes a lot of sense that you would have difficulty trusting people; you're trying to protect yourself." "I can understand how drinking keeps you from having to think about such a frightening memory."
- Develop a set of resources (handouts, useful websites, etc.) to provide to patients.

Assessing effect of trauma

- Who has patient disclosed to?
- Is patient experiencing ongoing effects (e.g., anxiety, flashbacks)?
- Is patient using harmful coping strategies (e.g., substance use, self-harm)?
- Has patient had any therapy in regards to their trauma?
- If trauma is unresolved, refer patient to specialized treatment:
  - Trauma-focused cognitive behavioural therapy (TF-CBT)
  - Eye movement desensitization and reprocessing (EMDR)
  - Seeking Safety
  - Dialectical behavioural therapy (DBT)
- Publicly funded programs often have long waiting lists; offer patient ongoing support while they are awaiting treatment.