SUBSTANCE USE DISORDERS: CAUSES, TYPES AND RECOVERY

by © Lindsay D. Maxwell

A report submitted to the School of Graduate Studies in partial fulfillment of the requirements for the degree of

Master of Nursing

Faculty of Nursing

Memorial University of Newfoundland

October 2021

St. John's Newfoundland and Labrador

Abstract

Background and Purpose: This practicum project was inspired by a need to improve patient education on the inpatient withdrawal management unit in the Central Zone of the Nova Scotia Health Authority. As a result of the COVID-19 pandemic, many changes were implemented on the inpatient unit including elimination of group programming. These changes resulted in an increase in the number patients leaving treatment against medical advice, as well as the number of re-admissions to the unit. The purpose of this project was to develop an interactive education session and associated resources that provided information on substance use disorders (SUDs) (the causes and types) and the recovery journey. Two educational handouts were developed as take-home resources for the patient and their support person(s).

Methods: The practicum project consisted of an integrative literature review, consultations with key stakeholders and an environmental scan.

Results: The literature review and consultations supported the implementation of a patient education session to be delivered by nurses on the withdrawal management unit. Additionally, due to the lack of resources available to support persons and the evidence in the literature for including families in a patient's care plan, a support person resource was created to fill this gap.

Conclusion: The practicum project was designed to enhance and improve patient care offered on the inpatient withdrawal management unit. Its implementation is warranted, particularly with the COVID-19 driven changes, and is a much-needed resources as identified by both patients and staff members. Continued implementation of the patient and family education has the potential to have a positive influence on the rate of individuals who discontinue inpatient treatment prematurely as well as the number of re-admissions.

Key Words: *substance use disorders, patient education, education session, inpatient withdrawal management, addiction*

Acknowledgements

First, I would like to thank my practicum supervisor, Dr. Joy Maddigan, for her unwavering support. Her guidance, feedback and willingness to work through semesters to enable me to complete this project prior to the arrival of my baby was more than I could have asked for and none of this would have been possible without her. Dr. Maddigan's compassion for mental health nursing is nothing short of inspirational and that same compassion translates into her encounters with students.

I would also like to acknowledge my husband, my children and my parents. My husband, Matt, has given me the encouragement and support I have needed every step of the way over the last three years. I truly would not have been able to do this without him. To my daughter, Halle, you motivate me in ways I could never explain. To my son, Remi, who is watching from above, you have taught me that I truly can get through the seemingly impossible. To my newest son who is still on the inside, I thank you for staying where you are for me to finish this degree! Finally, thank you to my parents who remain just as proud when I tell them my semester marks in my Master's degree as they were when I received my kindergarten report card.

Last but certainly not least, I need to thank the staff and patients of the inpatient withdrawal management unit in the Central Zone of the Nova Scotia Health Authority. You have been the backbone of this project and I can only hope I have done you all justice.

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Substance Use Disorders: Causes, Types and Recovery

A nurse's role goes far beyond doing assessments and administering medications. One of the biggest, and often overlooked, roles of a registered nurse (RN) is the provision of education to patients (Arkansas State University, 2018). Providing education allows patients to make informed decisions about their health and encourages them to be more equal partners on the health care team (Heath, 2016). While patient education is a standard part of care in medical nursing, its role in mental health and addictions nursing is often unclear. However, providing education to this patient population is equally as important. Much like education provided to a patient with a medical illness, educating patients with substance use disorder about their illness has been proven to play a positive role in influencing their choice to use substances (Yoast et al., 2008).

The importance of educating individuals with substance use disorder (SUD) was the catalyst for this practicum project. After years of employment as a registered nurse on an inpatient withdrawal management unit coupled with witnessing the changes initiated by the COVID-19 pandemic, it was clear that a significant gap in therapeutic services existed for this inpatient population. As a result of the COVID-19 pandemic, many changes were implemented on the inpatient withdrawal management unit where this project was intended to be implemented. The usual 21-day withdrawal management program, that included two weeks of group programming, was eliminated. This program was replaced with a medical withdrawal only program which resulted in a patient's average length of stay going from 21 days to less than one week. Due to this significant change and the elimination of the group focused portion of the program, patients were receiving minimal education during their stay. While some optional groups remained, these were primarily leisure related groups.

Since these changes have been implemented on the withdrawal management unit, there has been an increase in the number of patients who leave treatment against medical advice (i.e., prior to their planned discharge date) as well as a significant increase in readmission rates. With these factors taken into consideration, it was clear that an improvement to the current service offered was necessary. Therefore, the purpose of this practicum project was to develop an education session and associated resource that discussed SUDs (the causes and types treated on the inpatient unit) and the recovery journey. To achieve this, a patient education session with a take home summary was developed. Additionally, due to the lack of support and information available for the support persons of those with substance use disorder, a support person resource was also developed. The details of these resources will be discussed in depth in the following sections.

Practicum Objectives

The overall goal of the practicum project was to provide both the patients of the inpatient withdrawal management unit and their support person(s) with education on substance use disorders as well as increase their awareness of available community resources to support their recovery.

The key practicum objectives were:

1. Describe importance of patient education as it relates to individuals with substance use disorder, through a thorough review of the literature;
2. Identify the necessary components and delivery methods for a patient education session as determined by inpatients, front line staff and leadership on the inpatient withdrawal management unit;

3. Improve patients' knowledge on substance use disorders and recovery through the delivery of a patient education session;
4. Increase support persons' knowledge on substance use disorders as well as inform them of resources that are available for them, through the distribution of a pamphlet; and
5. To demonstrate advanced nursing practice competencies through optimizing the health system, research and leadership competencies.

Overview of Methods

To achieve the practicum objectives three key methods were used. These three methods were: an integrative literature review, consultations with key stakeholders and an environmental scan. First, a comprehensive literature review was conducted to explore existing research on the provision of education to patients admitted to inpatient mental health and addictions units. The results obtained from the literature review determined the direction of the consultations and the environmental scan. Upon completion of the literature review, consultations were conducted with twelve different individuals. These interviews served to gather the perspectives of the individuals who would be directly and indirectly involved in the resources developed. A thorough environmental scan was also completed. For this process, two individuals were interviewed and both telephone and internet resources were explored. The details of these three methods will be provided in the subsequent sections.

Summary of the Integrative Literature Review

An integrative literature review was conducted to explore the best practices and methods of delivery for providing education to individuals and their support person(s) on inpatient mental health and addictions units. The information gleaned from this literature review, along with the other methods used, was the basis for the resources that were developed. A short summary of the

review will be provided in this section, but the full integrative literature review with literature summary tables is presented in Appendix A.

Methods

For the integrative review, a search of the literature was conducted using the CINAHL and PubMed online databases. A combination of the search terms “addiction”, “substance abuse”, “patient and family education”, “planning education session”, “addictions”, “inpatient”, “addiction education”, and “patient education” was used in four separate searches. The inclusion criteria for the selection of the studies for the review were: i) any relevant study published in the English language, ii) study populations were adults aged 18 and above, and iii) the education intervention was provided in either inpatient or outpatient settings. Studies that explored addiction education in the pediatric population were excluded from the review. The primary studies of interest were those that were completed in inpatient settings. However, by including studies that were conducted in outpatient settings, additional information pertinent to the education session was uncovered and proved valuable to the overall concept explored in this review. Additionally, in an effort to uncover as many studies as possible, no date limit was placed on the search but preference was given to the most recent studies. Quantitative and qualitative studies, as well as mixed methods designs were sought.

The four searches combined resulted in a combined total of 220 journal articles, with the inclusion and exclusion criteria applied. The abstracts of each of these articles were examined and considered for inclusion in the review. Those that were deemed appropriate to help achieve the goal of the integrative review were then evaluated for quality. Only studies of medium and high quality were included in the final review. The decision to exclude low quality studies was influenced by Mi (2017) who argued that the inclusion of low-quality studies in a literature

review had the potential to result in inaccurate conclusions. Based on the quality ratings, fourteen studies were included in this literature review. The studies that were included were a combination of quantitative, qualitative, and mixed methods studies, with the majority being quantitative.

Results

Upon analysis of the fourteen studies, six common themes emerged. These were: curriculum for the education session, effective approaches to support addiction education, benefits of a patient education session, the need for a non-judgmental environment, the importance of a therapeutic relationship, and the inclusion of family in addictions education.

Curriculum for the Education Session. The first theme explored the content that should be included in an education session provided to individuals on an inpatient addictions unit. The importance of delivering factual information that included discussion of the psychological, physiological, and sociological effects of drug and alcohol use was illustrated across the literature (Bair, 2017; Chilton et al., 2020; Havnes et al., 2019; Khazaal et al., 2008; Kirby et al., 2021; Roy-Byrne et al., 2014; Stalonas et al., 1979; Sussman et al., 2005; Zhang et al., 2017). Including information about refusal skills and how to cope with sobriety when a trigger for substance use is mental/emotional pain was also referenced throughout the literature (Chilton et al., 2020; Havnes et al., 2019; Roy-Byrne et al., 2014; Stalonas et al., 1979; Sussman et al., 2005; Zhang et al., 2017). Additionally, ways to promote recovery including identifying triggers, acknowledging available resources and developing recovery plans was recommended as important to include in the education session (Chilton et al., 2020; Kirby et al., 2021; Stalonas et al., 1979; Sussman et al., 2005; Zhang et al., 2017).

Effective Approaches to Support Addiction Education. The second theme discussed the most effective approaches and delivery methods to support the education session. Keeping the education session within a maximum 90-minute time frame and integrating a variety of delivery methods was identified as the most effective way to gain and maintain participants' attention (Bair, 2017; Ghouchani et al., 2017; Hero et al., 2016; Khazaal et al., 2008; Kirby et al., 2021; Roy-Byrne et al., 2014; Silverman, 2016; Stalonas et al., 1979; Vederhus et al., 2014; Zhang et al., 2019). Additionally, incorporating psychotherapy approaches such as motivational interviewing and cognitive behavioural therapy has been shown to have added benefit (Chilton et al., 2020; Ghouchani et al., 2017; Khazaal et al., 2008; Kirby et al., 2021; Roy-Byrne et al., 2014; Vederhus et al., 2014).

Benefits of Addiction Education. The third theme illustrated the potential benefits that have been observed as a result of providing education specific to SUDs. These benefits included: increased health knowledge, positive behaviour change, increased peer support and decreased substance abuse related emergency department visits and admissions (Bair, 2017; Chilton et al., 2020; Ghouchani et al., 2017; Havnes et al., 2019; Hero et al., 2016; Khazaal et al., 2008; Kirby et al., 2021; Roy-Byrne et al., 2014; Stalonas et al., 1979; Sussman et al., 2005; Vederhus et al., 2014; Zhang et al., 2017; Zhang et al., 2019).

The Need for a Non-Judgmental Educational Environment. Providing the education session in a way that eliminates stigma, promotes acceptance, and ensures participants do not feel guilt or shame for their substance use was the premise of the fourth theme. Participants should feel acceptance from both their peers in the group as well as the group facilitator (Chilton et al., 2020; Havnes et al., 2019; Khazaal et al., 2008; Silverman, 2016).

The Importance of the Therapeutic Relationship. Building upon the previous theme, the fifth theme present in the literature described the correlation of the relationship between the person providing the education and the participants, with the success of the education session. It was identified as critical that the individual providing the education session possessed the characteristics of trust, honesty, knowledge and good rapport with participants (Chilton et al., 2020; Havnes et al., 2019; Silverman, 2016).

The Inclusion of Family in Addictions Education. The final theme highlighted the importance of family/friend support in an individuals' recovery journey. Educating support persons allows them to better understand SUDs and ways that they can best support both their loved ones and themselves (Bair, 2017; Ghouchani et al., 2017; Havnes et al., 2019).

Summary of the Consultations and Environmental Scan

Consultations

Consultations were conducted with twelve key individuals. This included five nurses (four RNs and one LPN), one social worker, two individuals in a leadership role, three patients and one support person. The consultations allowed these individuals to provide their input on the details of the practicum project. The inclusion of patient consultations was of particular importance as, rarely is the type of education that a patient receives influenced by the patients themselves.

Following organizational approval, participants were recruited from the inpatient withdrawal management unit where the education session was to be provided. The direct care providers as well as those in leadership roles were recruited through email whereas the patients were recruited through direct face-to-face contact. After patient consent was obtained, the

support person was recruited by telephone. Data was collected in the format of one-on-one interviews conducted in person, via "Zoom for healthcare" and over the telephone.

The consultations revealed what the participants believed to be the most important information to include in the education session as well as what should be avoided. The interviews also shed light on the most appropriate delivery methods and session length. Finally, different resources available to both patients and their support persons were discussed.

Environmental Scan

A thorough environmental scan was also completed. The purpose of the environmental scan was to examine the variety of resources available to support a patient's recovery after discharge from the withdrawal management unit as well as the resources that are available for their support person(s). The environmental scan included two interviews as well as an internet search.

Two participants were interviewed: one community outreach worker and an individual working for the 211-information telephone line. The interview with the 211-information line took place over the phone while "Zoom for Healthcare" was used for the other. The same interview guide was used for both of these interactions. A thorough internet search was also conducted in an effort to uncover as many resources as possible.

The combination of the two interviews, as well as the internet search revealed a significant number of available resources. These included resources available within and outside of the Nova Scotia Health Authority, as well as a variety of mediums such as in person and virtual resources. This included resources within Nova Scotia as well as those available nationally. The full consultation and environmental scan report can be found in Appendix B.

Summary of the Resource Developed

Based on the information gleaned from the literature review, the consultations, and the environmental scan, three separate resources were developed. The first was a patient education session on SUDs and recovery from substance use. To supplement this education session, a take home resource was developed for patients that summarized the information in the session and presented a comprehensive list of resources available to patients after discharge from the inpatient withdrawal management unit. Finally, a resource intended specifically for the support persons was developed.

Patient Education Session

The biggest component of the practicum project was the patient education session. This session was developed to provide patients with information on the causes and types of SUDs as well as recovery from substance use. Upon recommendations from the literature review and consultations, the education session was developed to be delivered within an hour and a variety of delivery methods were incorporated. A combination of text, videos, pictures, games, open discussion and handouts were used to ensure participant engagement. First, the causes of SUDs were presented with a focus on the biopsychosocial model. The second component explored the three types of SUDs most commonly treated on the inpatient withdrawal management unit. This section discussed both withdrawal from and treatment for the three different types of SUDs. The final component of the education session discussed recovery and the importance of developing relapse prevention plans. The education session was developed in the format of a PowerPoint presentation as suggested in the consultations with patients.

To best support the individuals who will be responsible to deliver the education session, a facilitator's guide was developed. This guide highlights each slide of the PowerPoint with

detailed speaking notes for the facilitator to follow. The full detailed facilitator's guide is presented in Appendix C. Additionally, to complement the section on recovery, a recovery plan template was also developed to be distributed to all patients who attend the education session. This template serves a guide for patients to create their own recovery plan prior to their discharge from the inpatient withdrawal management unit. The recovery plan can be found in Appendix D.

Patient Take Home Resource

To reinforce the education session, print material was created for patients to take home with them after discharge from the inpatient unit. This resource was inspired by the consultations as both patients and staff highlighted the importance of having something that can be referenced after discharge. The first section of the take home resource contains a brief summary of the information that was presented in the education session. It provides on overview on SUD, how SUD affects the brain, the three types of SUDs discussed and tips on recovery from SUD. In addition, a comprehensive list of resources that are available within and outside of the community are presented. The list of resources is broken down into general resources available for everyone, 2SLGBTQIA+ specific resources, gender specific resources and BIPOC resources. The take home resource was developed in the format of a booklet but a template of the booklet is presented in Appendix E.

Support Person Resource

The final resource developed was one intended for the support persons of individuals with SUD. This resource was developed as a result of gaps identified in the literature review, consultations and the environmental scan. As specific information about SUDs for support persons is significantly lacking, this resource was developed to help fill that gap. Similar to the take home resource for patients, this resource provides an overview on SUD, presenting facts as

well as causes from the perspective of the biopsychosocial model. It also contains two sections on support. The first section outlines ways that a support person can support their loved one. The second section provides a list of resources that are available within the community as well as online, dedicated specifically to support persons. This list included both information specific resources as well as support groups. The resource will be available on the inpatient withdrawal management unit for patients to take home to their support persons and also for staff to provide to support persons as requested. The resource was developed in the format of a pamphlet but a template is presented in Appendix F.

Advanced Nursing Practice (ANP) Competencies

The Canadian Nurses Association (CNA) (2019) defines advanced practice nursing as "registered nurses (RNs) and nurse practitioners (NPs) who integrate graduate nursing educational preparation with in-depth, specialized clinical nursing knowledge and expertise in complex decision-making to meet the health needs of individuals, families, groups communities and populations" (p. 13). In addition to RN competencies, the CNA has identified several competencies specific to the advanced practice nurse (CNA, 2019). The completion of this practicum project led to demonstration of three ANP competencies. These were: optimizing health system, research and leadership.

Optimizing Health System Competencies

By practicing "advocacy, promoting innovative client care and facilitating equitable, client-centred health care", advanced practice nurses are optimizing the health system by contributing to its effective functioning (CNA, 2019, p. 30). This competency was demonstrated in the practicum project in three key ways. First, through consultations, staff and patients were engaged in resolving the issues present at the health system level. Second, the development of all

three resources (the education session, the patient take home resource and the support person resource) helped to contribute to the system level change that was identified as necessary throughout the consultations. Finally, gaps were identified and resources were developed to address these gaps. The first gap was the lack of education provided to the patients on the inpatient withdrawal management unit. This gap was filled with both the education session as well as the patient take home resource. The second identified gap was the lack of information and resources available to the support persons of individuals with SUD. This gap was filled with the development of the support person resource.

Research Competencies

In an ANP role, advanced practice nurses are "committed to generating, synthesizing, critiquing and applying research evidence" (CNA, 2019, p. 32). The practicum project encouraged demonstration of this competency in four different areas. First, appraising available research and completing an integrative review of the literature contributed to the development best practice guidelines in the form of the patient education session and take-home resource. Secondly, engaging in this process facilitated evidence-informed practice and the knowledge gleaned throughout the process was passed on to the direct care providers on the inpatient withdrawal management unit through the staff training that took place. Additionally, through an analysis of the literature, research-based innovations to improve patient care were identified, developed and implemented. Finally, through consultations with members of the health care team and patients, nursing practice, patient outcomes and health care delivery was enhanced.

Leadership Competencies

To be leaders in the organizations and communities where they work, advanced practice nurses are "agents of change, consistently seeking effective new ways to practice, improve care

and promote APN" (CNA, 2019, p. 33). This competency was demonstrated in two ways throughout the practicum project. This occurred through evaluation and identification of problems at both the community and clinical level and initiating change to address these challenges. At the community level, it was clear that information for support persons was lacking. Therefore, an innovative approach was developed, in the format of an information resource, to address this issue. Secondly, at the clinical level, the current programs on the inpatient withdrawal management unit were evaluated and determined to be inadequate for comprehensive patient care. Therefore, with this problem identified, change was initiated to address this challenge. This included the development of a patient education session as well as a take home resource for patients.

Implementation and Evaluation of the Resource

With the development of the resources completed, the next steps for the project are implementation on the inpatient withdrawal management unit and evaluation of its effectiveness.

Implementation

The implementation of the patient education session will occur in two steps. First, the session will be presented to the direct care providers and leadership on the inpatient withdrawal management unit. The staff who will be responsible for continued implementation of the education session on an ongoing basis will undergo a training session to familiarize themselves with the content and gain confidence in presenting the material themselves. After this is completed, the education session will be piloted to the patients on the unit. Staff members will be provided with the opportunity to attend the pilot session.

After completion of the pilot session, any necessary revisions to the education session will be made. Assuming that the education session is ready for ongoing implementation after this point, the RNs on the inpatient withdrawal management unit will be responsible for conducting

the education session once weekly, on Saturdays, for any patients interested in attending. Attending this education session will be an optional part of treatment for the patients on the inpatient unit but they will be strongly encouraged to attend. Additionally, it is encouraged that the responsibility of conducting the education session is shared among the RNs so everyone has equal opportunity for involvement. The full details of the implantation plan, along with helpful advice for the staff involved, is presented in the facilitator's guide which can be found in Appendix C.

Implementation of the patient take home resource and the support person resource will occur in two simple steps. First, these two resources will be presented to the health services manager of the inpatient withdrawal management unit for approval. After this is completed, the patient take-home resource will be distributed to any patients who attend the education session. The support person resource will be placed on the inpatient unit for any interested patients to take home to their support person and it will also be made available in the main lobby of the hospital for anyone who is interested in receiving their own copy.

Evaluation

To monitor the effectiveness of the resource an evaluation process needs to occur. First, at the end of the staff training session staff will be given the opportunity to provide feedback in the form of an open discussion. This feedback will be taken into consideration and any necessary changes made prior to the pilot session. Second, patients will be given the opportunity to evaluate the education session after they attend. All patients will be provided with an evaluation form at the end of the education session. Taking into consideration the range of literacy levels of the patient population, the evaluation forms will not be collected immediately after the session as patients will have the opportunity to request support from their assigned nurse in completing the

form if required. The evaluation forms that will be distributed are included in the facilitator's guide that is presented in Appendix C.

Conclusion

As described above, three methods led to the development of this practicum project. This included a thorough review of the literature, consultations with key stakeholders and a comprehensive environmental scan. These three methods highlighted gaps that existed within the addictions program and identified ways in which these gaps could be addressed. Together, this resulted in the development of three resources: a patient education session, a patient take-home resource and resource specifically for support persons.

The three resources have the potential to enhance the care delivered on the inpatient withdrawal management unit. This unit has been impacted significantly as a result of the COVID-19 pandemic with the biggest change being the discontinuation of the group programming once offered to patients. Re-implementing a group education session that focuses specifically on educating patients about the causes and types of SUDs as well as recovery from SUDs will greatly benefit patients. Implementation of this resource also has the potential to influence current re-admission rates and rates of patients leaving against medical advice. Additionally, the provision of a resource specifically for support persons is something that, to date, has not been offered. Therefore, this addresses a significant gap that has been present for years. The hope is, the addition of these resources will result in patients and their support persons becoming more knowledgeable about SUDs and empowered to be fully engaged in their recovery journey.

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Appendix A

Integrative Literature Review

Person-Centered Addiction Education: An Integrative Literature Review

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N6660: Practicum I

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July 21, 2021

Abstract

Objective: An integrative literature review was conducted to explore the best practices and methods of delivery for providing addiction specific education to patients and their families on addiction inpatient units.

Methods: A literature search was conducted using two different databases, CINAHL and PubMed. Studies that explored addiction education sessions were sought. Using the Public Health Agency of Canada Critical Appraisal Toolkit and Critical Appraisal Skills Programme, studies were appraised for quality. Only studies of medium and high quality were included in this review. In total, fourteen studies were chosen.

Results: Common findings from each of the studies were organized into six themes. These were: what is included in the education session, the most effect approach, benefits of the education session, non-judgemental environment, importance of the therapeutic relationship, and importance of family.

Conclusions: Findings from this review can be used to develop future education sessions. However, limitations of the review as well as gaps in the literature were acknowledged. Future research is required to address the identified gaps.

Keywords: Addiction, education, patient and family education

Person-Centered Addiction Education: An Integrative Literature Review

Greater than 2% of the world's population lives with a substance use disorder (Ritchie & Roser, 2019). That is over 156,000,000 individuals worldwide who abuse alcohol and/or illicit drugs. Substance abuse results in more deaths, illnesses, disabilities, and societal disruptions than any other preventable condition (Yoast et al., 2008). In Canada, between 2015 and 2016, there were more individuals hospitalized for alcohol related problems than for cardiac arrest. Approximately 77,000 hospital beds are needed to treat the number of individuals who require hospital admission for alcohol use disorder in Canada over a one-year period. (Addiction Center, 2021). Of note, this data does not take into account the number of hospital admissions that occurred as a result of drug abuse. These statistics alone illustrate the importance of ensuring that the individuals who enter into treatment for substance abuse are provided with the best evidence-based treatment to prevent relapse after discharge and to promote personal recovery.

One of the most important elements of addictions treatment is group education (Pollack & Stuebben, 1998). Education has been shown to increase knowledge on the disease process, understand the skills needed for recovery from substance abuse, and the effects of drugs and alcohol on a person's body and mind (Friedrich & Kus, 1991). Having basic knowledge of addiction has the potential to motivate a person to make healthier choices and avoid situations where he/she is likely to be triggered to use substances (San Diego Addiction Treatment Center, 2021). Being aware of the range of negatives that accompany substance abuse makes it easier to justify abstinence. In general, gaining a better understanding of the components of substance use disorder is the first step toward recovery (Family First Intervention, 2019).

Addiction education is a critical treatment component for adults with substance use disorder, particularly those who are currently undergoing inpatient treatment. Despite the

overwhelming amount of research on addiction education, limited research exists that specifically explores addiction education in the inpatient detoxification/withdrawal management setting. However, much of the research that has been conducted in outpatient settings and on other inpatient mental health and dual diagnoses units can be applied to the inpatient addiction population as well. A second significant gap in the literature was the lack of studies that discussed educating the families of individuals with substance use disorder. The importance of family support was highlighted but few studies included this aspect in their research. Nonetheless, many of the same principles apply to family centered education as well. Thus, previous research provides invaluable information when developing group education programs in inpatient addiction treatment programs for adults with substance use disorder and their families.

The purpose of this integrative literature review was to identify the range of existing literature that examined the provision of education to adults with substance use disorder and their families/support person(s). Two questions guided this literature review:

1. What are best practices on inpatient addiction units for educating individuals and families about substance use disorders? And,
2. What are the most effective delivery methods on inpatient units for increasing the client and family's knowledge and understanding of addiction?

Methods

An integrative literature review "reviews, critiques, and synthesizes representative literature on a topic" and presents this information in such a way that new perspectives on the topic are generated (Torraco, 2016, p. 404). A search strategy in an important step in the process.

Search Strategy

For this integrative review, a search of the literature was conducted using the CINAHL and PubMed online databases. A combination of the search terms “addiction”, “substance abuse”, “patient and family education”, “planning education session”, “addictions”, “inpatient”, “addiction education”, and “patient education” was used in four separate searches. The inclusion criteria for the selection of the studies for the review were: i) any relevant study published in the English language, ii) study populations were adults aged 18 and above, and iii) the education intervention was provided in either inpatient or outpatient settings. Studies that explored addiction education in the pediatric population were excluded from the review. The primary studies of interest were those that were completed in inpatient settings. However, by including studies that were conducted in outpatient settings, additional information pertinent to the education session was uncovered and proved valuable to the overall concept explored in this review. Additionally, in an effort to uncover as many studies as possible, no date limit was placed on the search but preference was given to the most recent studies. Quantitative and qualitative studies, as well as mixed methods designs were sought.

The four searches combined resulted in a total of 220 journal articles, with the inclusion and exclusion criteria applied. The abstracts of each of these articles were examined and considered for inclusion in the review. Those that were deemed appropriate to help achieve the goal of the integrative review were then evaluated for quality. Only studies of medium and high quality were included in the final review. The decision to exclude low quality studies was influenced by Mi (2017) who argued that the inclusion of low-quality studies in a literature review had the potential to result in inaccurate conclusions. Based on the quality ratings, fourteen studies were included in this literature review. The studies that were included were a

combination of quantitative, qualitative, and mixed methods studies, with the majority being quantitative.

Critical Appraisal

The studies were appraised for quality using both the Public Health Agency of Canada (PHAC) Critical Appraisal Toolkit (CAT) (2014) and the Critical Appraisal Skills Programme (CASP) (2018). The literature summary tables can be found in the appendix. The PHAC CAT is an appraisal tool used to evaluate the quality of quantitative studies. For this integrative literature review, the PHAC CAT was used to appraise the quantitative studies by Bair (2017), Ghouchani et al. (2017), Hero et al. (2016), Khazaal et al. (2008), Kirby et al. (2021), Roy-Byrne et al. (2014), Silverman (2016), Stalonas et al. (1979), Sussman et al. (2004), Vederhus et al. (2014), Zhang et al. (2019), and Zhang et al. (2017). The CASP is an appraisal tool used to evaluate the quality of qualitative studies. This tool was used in this review to evaluate the studies by Chilton et al. (2020) and Havnes et al. (2019). Havnes et al. (2019) used a mixed methods design, however, because the data contained in the qualitative component of the study was that of primary interest for this review, the study was appraised using the CASP tool.

The quantitative studies included in the review were a mix of randomized controlled trials, non-randomized controlled trials, controlled before after studies, uncontrolled before after studies, cohort studies, and cross-sectional studies. The quantitative design represented most in this integrative literature review was the randomized controlled trial. Six of the studies used this design (Roy-Byrne et al., 2014; Silverman, 2016; Sussman et al., 2004; Vederhus et al., 2014; Zhang et al., 2019; Zhang et al., 2017). Five out of six of these studies examined the effects of the implementation of educational programs on the lives of individuals with substance use disorder. The remaining study explored the effectiveness of music as a method of education

delivery. The settings of the studies were community addictions clinics and inpatient detoxification units.

Two of the quantitative studies included in this review used a non-randomized controlled trial design (Bair, 2017; Stalonas et al., 1979). The study by Bair (2017) took place in the outpatient setting, whereas the study by Stalonas et al. (1979) was conducted on an inpatient detoxification unit. Both explored the impacts of education programs but Stalonas et al. (1979) placed focus primarily on examining the effectiveness of different methods of delivery.

The designs of the four remaining quantitative studies were controlled before-after (CBA) (Ghouchani et al., 2017), uncontrolled before-after (UCBA) (Khazaal et al., 2008), cohort (Kirby et al., 2021), and cross-sectional (Hero et al., 2016). Both the CBA and the UCBA studies assessed methods of delivery for education programs. The use of video-based education and the implementation of a CBT based game were explored, respectively. The studies that used the cohort and cross-sectional designs both explored the impact that education sessions had on lifestyle changes of the individuals that took part in them.

Two qualitative studies were included in this review (Chilton et al., 2020; Havnes et al., 2019). Both used phenomenology as the methodology and were rated as high quality. These studies addressed the patients' perspective of their experiences attending addiction-focused education sessions. They described what went well and what could have been improved upon along with the important qualities that should be held by the individual leading the sessions.

Out of the fourteen studies, both quantitative and qualitative, eight were given an overall quality rating of high and the remaining six studies were given a medium rating.

Analytic Strategy

Once the studies were appraised for quality, the detailed findings of each study were analyzed. The studies were read through entirely, followed by a second read in which notes and highlights were made regarding key findings. During the third read through each study was summarized. The summarized findings were analyzed concurrently and similar findings were grouped together into common themes. The themes were organized to correspond with the research questions that guided the literature search. The themes will be presented in the following section.

Results

The fourteen studies contained in this literature review were conducted in six different countries. The United States was the country represented most frequently in the literature with nine out of the fourteen studies having been completed there. However, studies conducted in Norway, Australia, Switzerland, China and Iran were also included in this review. The range of countries represented in the literature illustrates the worldwide importance of this issue. The publication dates of the included literature ranged from 1979 to 2021, with the majority of the studies (n=12) being published in the last 15 years. The wide date range also highlights the ongoing nature of the issue as it has been of interest for many decades. Despite the numerous countries and extensive time period, commonalities existed across the literature. Six common themes were identified. These were: curriculum for the education session, effective approaches to support addiction education, benefits of a patient education session, the need for a non-judgemental environment, the importance of a therapeutic relationship, and the inclusion of family in addictions education. These themes will be expanded upon in the following sections.

Curriculum for the Education Session

Ten of the fourteen studies reviewed had similarities regarding the content that was provided in the education sessions. One of the most common components was ensuring factual information about drug and/or alcohol use was provided (Chilton et al., 2020; Havnes et al., 2019; Kirby et al., 2021; Stalonas et al., 1979; Sussman et al., 2005). A primary aspect of this content was a review and discussion of the psychological, physiological, and sociological effects of drug and alcohol use (Bair, 2017; Havnes et al., 2019; Khazaal et al., 2008; Roy-Byrne et al., 2014; Stalonas et al., 1979; Zhand et al., 2017). Including this information in a way that is understood by participants is critical because as identified by Chilton et al. (2020), many individuals who use substances are unaware of the long-term negative effects of their substance abuse.

A second, frequently explored topic in the education sessions was guidance on decision making and preparing participants to develop the skills to refuse substances (Chilton et al., 2020; Havnes et al., 2019; Roy-Byrne et al., 2014; Stalonas et al., 1979; Sussman et al., 2005; Zhand et al., 2017). Ensuring individuals are equipped with this knowledge is essential because as identified by Chilton et al. (2020), some individuals use substances to cope with the pain they experience in life and having the strength to resist drugs is one of the most difficult challenges. Increasing an individual's knowledge regarding the harmful effects of substances along with the skills to successfully resist and avoid them, can give recovering individuals the ability and sense of empowerment they need to be successful in sustaining their recovery.

Harm reduction education was also promoted across the literature and included information and techniques on how to minimize substance use if complete abstinence was unlikely. The importance of recognizing triggers to substance use, and specific to opioid use,

information about overdose and the administration of naloxone were also included in the education sessions (Bair, 2017; Chilton et al., 2020; Kirby et al., 2021; Sussman et al., 2005; Zhand et al., 2017). In several other studies, however, the content of the education sessions contained only abstinence specific information (Susman et al., 2005; Vederhus et al., 2014).

A range of other topics were often included in the education sessions. These included information related to: getting back into the workforce, relaxation training, information on the importance of nutrition and exercise, how to access different community-based resources, and generalized skills for coping with addiction and life stressors (Chilton et al., 2020; Kirby et al., 2021; Stalonas et al., 1979; Sussman et al., 2005; Zhand et al., 2017). The type of information that is included in addiction education is important. It is through the inclusion of the right kind of information that individuals are able to make meaningful changes (Chilton et al., 2020).

Effective Approaches to Support Addiction Education

Theme 2 was developed from the different approaches and delivery methods identified in the literature to support the education sessions (Bair, 2017; Chilton et al., 2020; Ghouchani et al., 2017; Hero et al., 2016; Khazaal et al., 2008; Kirby et al., 2021; Roy-Byrne et al., 2014; Silverman, 2016; Stalonas et al., 1979; Zhang et al., 2019). One common finding was related to the length of education sessions. It was recommended that the session be approximately one hour in length, and no longer than one hour and thirty minutes. For education sessions that require more time than this, it is suggested that they occur over a set period of days/weeks (Kirby et al., 2021; Roy-Byrne et al., 2014; Vederhus et al., 2014; Zhang et al., 2019).

In addition to time limits, integrating a number of different delivery methods into a session can help to hold participants attention and improve engagement. Some of the common delivery methods included videos, games, music, communication-based techniques, lectures,

brainstorming, worksheets, role-playing, and take-home material (Bair, 2017; Ghouchani et al., 2017; Hero et al., 2016; Khazaal et al., 2008; Silverman, 2016; Stalonas et al., 1979; Zhang et al., 2019). Of the variety of delivery methods identified, evidence points to the effectiveness of video-based education in particular (Ghouchani et al., 2017; Stalonas et al., 1979). The use of video-based education has been shown to assist in behaviour change and increase the engagement of the participants (Ghouchani et al., 2017).

Additionally, the significance of using a tailored approach depending on the audience was highlighted (Chilton et al., 2020; Roy-Byrne et al., 2014). For example, in a group of individuals who are not interested in completely eliminating substances from their lives, it may not be beneficial to discuss the abstinence approach. Instead, tailoring the education session to discuss harm-reduction principles would likely be more openly received (Roy-Byrne et al., 2014). The same is true when delivering addiction education to individuals with concurrent mental illness. An integrated approach that discusses addiction in the presence of mental illness would be most appropriate for this population (Chilton et al., 2020).

Group as opposed to individual education was also identified as important in the literature. The relationships that individuals are able to form in these groups are shown to be beneficial (Vederhus et al., 2014). Creating this type of social situation allows for open discussion and for individuals to hear the stories and opinions of others in a similar situation (Chilton et al., 2020). Furthermore, peer-based resources such as 12-step groups (i.e., Alcoholics Anonymous, Narcotics Anonymous, etc.) are known to be effective in initiating behaviour change for many participants (Vederhus et al., 2014). The peer support provided by 12-step groups has been a contributing factor in much of the success of individuals who attend (Donovan et al., 2013). The involvement in such groups leads individuals to not only reap the benefits of

the content covered in the 12-step process, but also to form support systems that have been shown effective in reducing relapse, as well as, the use of mental health and addictions treatment services. It is the changes in an individual's social network as a result of these groups that appear to have the biggest impact on overall lifestyle changes. (Donovan et al., 2013).

As will be presented in the subthemes, two of the most common therapeutic approaches employed in the literature were motivational interviewing and cognitive behavioural therapy.

Motivational Interviewing

Motivational interviewing (MI), as defined by Miller and Rollnick (2009), is a communication style that is designed to strengthen a person's own motivation and commitment to their personal goal. This is accomplished by ensuring acceptance and compassion when eliciting and exploring a person's reasons for wanting to change. From an MI lens, the clinician and the patient are equal partners. MI is one approach that the facilitator of the education session could use. This approach was highlighted in the literature as important in increasing participation and retention in treatment while also empowering individuals to make positive changes in their lives to promote recovery (Chilton et al., 2020; Kirby et al., 2021; Roy-Byrne et al., 2014; Vederhus et al., 2014).

Cognitive Behavioural Therapy

The second therapeutic approach that was encouraged throughout the literature was cognitive behavioural therapy (CBT). CBT aims to give people the tools they need to successfully change their thinking and behavioural patterns. Using a CBT approach, emphasis is placed on where an individual is currently in his/her life, as opposed to exploring the aspects of the past that has led to his/her current difficulties (American Psychological Association, 2017). Though CBT was originally intended for individual therapy, research conducted over the last 40

years illustrates the benefits of CBT when used in a group format (Bieling et al., 2006). However, when using CBT as an approach to group education, it is important to adapt the principles to be more appropriate to the larger group, as opposed to one individual (Bieling et al., 2006). When used appropriately, the evidence in the literature supported the use of CBT in group education sessions as it has been shown to improve patient outcomes in terms of meeting substance use goals and to be successful at preventing relapse (Chilton et al., 2020; Ghouchani et al., 2017; Khazaal et al., 2008; Kirby et al., 2021).

Benefits of Addiction Education

When appropriate information is provided to individuals with substance use disorder using evidence-based delivery methods and approaches, significant benefits have been observed. One of the primary benefits is the knowledge that individuals gain in the education sessions (Bair, 2017; Chilton et al., 2020; Havnes et al., 2019; Stalonas et al., 1979; Sussman et al., 2005). Many individuals with substance use disorder are not fully aware of the effects that substance use has on their mental health (Chilton et al., 2020). Providing individuals with substance use disorder with knowledge that they otherwise may not have enables them the opportunity to make informed decisions about their substance use choices. Even if the education session does not result in behaviour change, it still allows the participants to be informed of risks and possible harms of their substance use (Chilton et al., 2020).

Zhang et al. (2019) also highlighted that knowledge is required to help individuals make changes to their behaviour. Evaluation of the education sessions demonstrated positive changes in individuals' health behaviours. This was evidenced by improved attitudes towards treatment, lifestyle changes, reduced substance use, and accepting of naloxone in the harm-reduction education sessions (Bair, 2017; Chilton et al., 2020; Ghouchani et al., 2017; Havnes et al., 2019;

Hero et al., 2016; Khazaal et al., 2008; Kirby et al., 2021; Roy-Byrne et al., 2014; Stalonas et al., 1979; Sussman et al., 2005; Vederhus et al., 2014; Zhang et al., 2017; Zhang et al., 2019).

The relationships that were formed among participants in the group session was an additional benefit. Having peers in the group who have gone through similar experiences allowed the participants to benefit from mutual support and to learn from one another. The importance of the group dynamic was reported throughout the literature (Bair, 2017; Chilton et al., 2020; Stalonas et al., 1979). Being in a group of like-minded individuals provided a space of safety and comfort and it is in this space that individuals can examine their lifestyle and choices and rely on support from each other to move forward (Chilton et al., 2020). Additionally, the group setting gives participants the opportunity to learn from each other and to use the experiences of others to create new self-management skills (Bair, 2017).

The final benefit of the education sessions noted in the literature was a decrease in the rate of emergency department visits by those who participated in education sessions (Kirby et al., 2021; Roy-Byrne et al., 2014). This also led to a decrease in the number of inpatient hospital admissions. Thus, it can be concluded that addiction education sessions have the potential to reduce the economic burden placed on the health care system by individuals with substance use disorder.

The Need for a Non-Judgemental Educational Environment

Due to the stigma or prejudice that is often faced by individuals with substance use disorder, it is critical that education provided to this population is provided in a way that they do not feel any judgement (Havnes et al., 2019). The societal stigma towards substances users is well-known as is the stigma present within mental health services (Havnes et al., 2019). When individuals are able to attend an education group and not feel that stigma, the experience is more

positive. A non-judgemental environment provides a space where the participants feel accepted by both their peers and the group facilitator (Chilton et al., 2020). Throughout the literature, the importance of ensuring the education session was delivered in a way that participants do not feel threatened, judged, or guilty for their choice to use substances was illustrated by both researchers and participants (Havnes et al., 2019; Khazaal et al., 2008; Silverman, 2016).

The Importance of the Therapeutic Relationship

The relationship between the person providing the education and the participants was highlighted in the literature as vital to the success of the intervention (Chilton et al., 2020; Havnes et al., 2019; Silverman, 2016). In participant interviews, trust, honesty, knowledge and good rapport were identified as necessary characteristics of the individual providing the education (Chilton et al., 2020; Havnes et al., 2019; Silverman, 2016). The relationship that existed between the educator and the participants was determined as the most consistent predictor of positive changes in behaviour (Silverman, 2016). Participant responses collected by means of a survey highlighted the importance of the therapeutic relationship and ensuring when possible that the individual providing the education has a working alliance with the participants. Without this rapport, many individuals do not feel comfortable participating in open discussion and discussing personal issues (Silverman, 2016).

The Inclusion of Family in Addictions Education

Although not widely discussed in the literature, the importance of an individual's family to successful recovery was highlighted in several studies (Bair, 2017; Ghouchani et al. ,2017; Havnes et al., 2019). Having the support of family was shown to improve an individual's commitment to treatment (Ghouchani et al., 2017). Additionally, the significance of providing education to the families of those who have substance use disorder was presented. Educating

families can give them the knowledge to better support their loved ones. When provided with education, families have reported that the information is helpful in understanding the impacts of substance use, as well as, where they can seek treatment for both their loved one, and for themselves (Ghouchani et al., 2017; Havnes et al., 2019). However, there was an identified need presented in the literature to determine the best types of services to offer families (Bair, 2017; Havnes et al., 2019).

Discussion

The purpose of this integrative literature review was to examine the research literature to determine the best practices and most effective delivery methods for educating individuals and families about substance use disorders, primarily in the inpatient setting. After examining 14 studies, the findings were organized into six themes. These themes were: curriculum for the education session, the most effective approach, benefits of addiction education, the need for a non-judgemental educational environment, the importance of the therapeutic relationship, and the inclusion of family in addictions education.

In regards to best practices for developing an addiction education session, the findings suggested that a wide range of information was beneficial for participants. Factual information about substance use, the different impacts of substance use, building substance refusal skills, and educating about harm reduction principles was identified as important topics to include in the sessions (Chilton et al., 2020; Havnes et al., 2019; Kirby et al., 2021; Roy-Byrne et al., 2014; Stalonas et al., 1979; Sussman et al., 2005; Zhand et al., 2017). This information will be used in the development of the practicum project. While it would not be possible to include detailed information on each of these topics within the time constraints of the practicum project, findings from the literature review in combination with the consultations will support the information that

is included in the education session. There was also an emphasis on the value of conducting the education sessions in a group setting (Chilton et al., 2020; Vederhus et al., 2014). Additional benefits were gained from participants in the group, aside from the knowledge acquisition. Primarily, relationships were formed with like-minded individuals and it provided a safe space for sharing of opinions and experiences (Vederhus et al., 2014). This helped to promote a non-judgemental environment which was also highlighted as a significant factor in effective learning (Havnes et al., 2019). Including family in the education sessions was shown to have benefits for individuals with substance use disorder. Therefore, in terms of best practice, family should be included whenever possible (Bair, 2017; Ghouchani et al., 2017; Havnes et al., 2019).

When delivering the education session, several delivery methods and approaches were highlighted in the findings. First, it was suggested that the session itself should be approximately one hour in length and to not exceed one hour and thirty minutes (Kirby et al., 2021; Roy-Byrne et al., 2014; Zhang et al., 2019). Given this, the education session for the practicum project is planned to be one hour in length. When providing the education, the inclusion of a variety of delivery methods was described as beneficial for participant retention. While a lecture format is perhaps the easiest to plan, different methods such as role-play, videos, games, and handouts were illustrated throughout the literature (Bair, 2017; Ghouchani et al., 2017; Hero et al., 2016; Khazaal et al., 2008; Silverman, 2016; Stalonas et al., 1979; Zhang et al., 2019). In the development of the practicum project, a variety of delivery methods will be used. The exact methods will be dependent on the information gathered from the consultations with staff and patients. Additionally, providing the education using concepts from cognitive behavioural therapy and/or motivational interviewing was found to result in the most positive behavioural changes (Chilton et al., 2020; Ghouchani et al., 2017; Khazaal et al., 2008; Kirby et al., 2021;

Roy-Byrne et al., 2014; Vederhus et al., 2014). Finally, the most observable benefits occurred when the education was provided by someone who the participants knew, as this encouraged an environment of trust and honesty (Chilton et al., 2020; Havnes et al., 2019; Silverman, 2016).

This review presented some alarming statistics related to substance use disorder. Perhaps one of the most significant was the economic impact on the health care system as a result of this disease. This was evident by the number of emergency department visits and hospital admissions by individuals with substance use disorders (Addiction Center, 2021). As shown by the results of this review, the provision of education to this population has the potential to reduce this economic burden. Providing opportunities for individuals to increase their knowledge and understanding of the impact of addictions has resulted in the ability of individuals to make positive behaviour changes resulting in fewer emergency department visits (Kirby et al., 2021). Additionally, educating individuals about harm reduction strategies gives them the knowledge to make better health related decisions, even if abstinence is not their goal. For example, by providing overdose and safe injection education to injection drug users, there will be less overdose related emergency visits and less injection drug acquired infections (Kirby et al., 2021). This has an impact on the overall health care costs related to substance abuse.

Having relevant, appropriate knowledge has the potential to motivate people to make healthier personal choices. Knowing the long-term negative impacts of substance use can sometimes be enough for someone to decide to reduce his/her use or to abstain completely. As noted previously, addiction education is the first step towards recovery (Family First Intervention, 2019).

Strengths of the Review

This integrative literature review has several strengths. First, by not placing a date range on the inclusion criteria a wide range of studies from several decades was included. This provided perspective on the significance of the issue and also permitted an opportunity to gauge the progressiveness of the interventions that have been employed. While emphasis was placed on the most recent studies, the older studies had a valuable contribution to this review. Additionally, known appraisal tools were applied to each of the studies to assess their quality. This ensured that only the highest quality studies were chosen for inclusion in the final review. In doing so, the conclusions drawn from the findings were more credible than they would have been had lower quality studies been used, or if the studies had not been appraised using a non-validated appraisal tool.

Limitations

In discussing the strengths of this review, it is also important to acknowledge the limitations. Firstly, only studies that were published in the English language were considered. By eliminating other languages valuable findings may have been missed. Additionally, although only studies of medium and high quality were included, studies that used a weak design (such as the uncontrolled before after) were not excluded. The use of a weak design could have had an impact on the conclusions that were drawn, and thus could have influenced the findings of this review. Qualitative studies were also underrepresented in this review. Out of fourteen studies, only two used qualitative methodology. This is significant because it is often through the dialogue obtained in qualitative participant interview that the patient's perspective is truly understood. That was missing in this review. Finally, due to the inclusion of studies that were

conducted in the outpatient setting, generalizing to the inpatient setting would have to be done with caution.

Gaps in the Literature

Notable gaps were present in the literature. Firstly, while some studies mentioned the importance of including family in the education and the benefits of family support, the actual provision of education to family members was missing in the literature. Because family support is so significant to the successful recovery of individuals with substance use disorder, it is important that families are also given the supports they need. Addiction impacts not just the substance user themselves, but everyone close to them as well. Therefore, ensuring that families are supported can positively impact the level of support they give in return. This is important for the practicum project. Knowing that inclusion of families is supported by the literature, even if not studied, highlights the importance of a family specific component of the education session that is to be developed.

The second gap noted in the literature was the lack of studies completed on addiction specific detoxification units. The outpatient studies were conducted in primarily addiction specific clinics but the inpatient studies primarily took place on combination mental health/addiction units. This will be addressed by the practicum project as it will be implemented on an addictions withdrawal management unit. While the patients on this unit often have concurrent mental illness, it is not the primary focus of their stay.

Implications for Practice, Research, and Education

Implications for Practice

The findings presented in this review illustrate the importance of nurses providing education to the individuals in their care. Even if this education is not provided formally such as

in an education session, any amount of education, formal or informal, would be beneficial to patients. The type and level of education provided, if not formally prepared should be tailored to the individual patient. It is common practice on most medical units to provide discharge teaching to patients, but the same is not necessarily a regular part of practice within addictions nursing. However, this review highlights the importance of ensuring education is provided to this population as well.

Implications for Research

The identified gaps in the literature are areas that future research could address. First, this topic would benefit from research that explored addiction education dedicated specifically towards the families of individuals with substance use disorder. Research on the most effective type of education as well as the outcomes of the education is needed to advance this intervention. Additionally, limited research was found that explored education delivered in addiction specific units. Research that addressed this gap would be valuable. Finally, the studies explored in this review followed participants for a short period of time. Future research would benefit from longitudinal studies that monitored participants recovery over a longer period of time.

Implications for Education

The findings from this study illustrate the significance that education can have on patient outcomes. In addition to improved patient outcomes, such as lifestyle changes and reduced substance use, it has benefits for the health care system as a whole. Given this evidence, nursing students need to be aware of the importance and value of providing education to their patients. It should be practiced and learned as a student and then become part of the everyday work of the registered nurse. It is essential that nursing students and registered nurses go beyond discharge instructions and medication counselling. Educating patients about their illness and how to best

manage symptoms is equally important and should become part of every patient encounter (Stalonas et al., 1979).

Conclusion

It is evident that addiction specific education is a significant component of treatment for individuals with substance use disorder. When designing these education sessions, it is important to include factual information, the effects of substance use, relapse prevention and harm reduction principles. The sessions should employ a variety of delivery methods and should be delivered in a non-judgemental environment. Additionally, when possible, the education should be provided by an individual who has an existing relationship with the participants. When these principles are followed, significant benefits are observed including positive health behaviour changes and decreased hospital admissions. Finally, recognizing the importance of family support, families should be included whenever possible.

The findings from this review have important implications for nursing practice, research and education. The identified gaps in the literature can be filled with research that explores the significance of the family's role, is conducted on an addiction specific inpatient unit and that follows participants longitudinally. The importance of patient education and health literacy should be promoted in nursing education and demonstrated daily in nursing practice.

A significant portion of the world's population lives with a substance use disorder. Substance use leads to an overwhelming number of hospital admissions annually and places a great economic burden on the health care system. Therefore, when individuals enter into treatment it is important that they receive the support required to sustain their recovery after they are discharged. Educating individuals with substance use disorder about their disease empowers

them to make positive health behaviour changes that will encourage their recovery and/or ensure their safety if they continue to use substances.

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Appendix

Literature Summary Tables

Study/Design	Methods	Key Results	Comments
Authors: Kirby et al., 2021 Design: Retrospective Cohort study Purpose: To evaluate the impact of a focused inpatient educational intervention on rates of medication-assisted therapy for veteran with opioid use disorder.	N: 158 patients included, 95 in control group and 63 in intervention group Country/setting: United States of America. In an inpatient rehabilitation program for veterans Intervention group: N=63 • Completed rehabilitation after implementation of education program Control group: N = 95 • Completed rehabilitation prior to implementation of education Data collection: Data was extracted from patient medical record for up to 6 months prior to admission and 12 months after discharge. Outcomes: **Rates of medication-assisted therapy:** 71 of 158 patients used MAT within 30 days of rehab (44.9%)	**Rates of medication-assisted therapy** Intervention group: 74.6% Control group: 25.3% • $p < 0.01$ **Receipt of a naloxone rescue kit prescription** Intervention group: 85.7% Control group: 42.1% • $p < 0.01$ **Opioid use associated emergency department visits** Intervention group: 9.5% Control group: 51.6% • $p < 0.01$	Strength of Design: **Moderate** Quality: **High** Issues: • Participants only recruited from one location which may have excluded members of the population

	Receipt of naloxone prescription: significantly more likely in intervention group **ED admissions:** admissions within 1 year of discharge occurred in 54 of 158 patients (34.8%)		
Authors: Zhang et al., 2019 Design: Randomized controlled trial Purpose: To explore whether a hepatitis c (HCV) and HIV intervention program was effective in improving patients' knowledge and infection awareness	N: 240 patients included, 120 in intervention group, 120 in control group. Due to those lost to follow-up, 86 remained in intervention and 108 in control Country/setting: China. Four methadone maintenance clinics in Shanghai Intervention group: N = 86 • Received usual care plus twelve 1.5-hour education sessions over 12 weeks Control group: N = 108 • Received usual care only (this includes physical exam, and weekly consultations) Data collection: Questionnaires distributed to aid in data collection Outcomes:	**HCV knowledge** Intervention group: Baseline: 6.73 24-week follow up: 12.25 Control group: Baseline: 5.94 24-week follow up: 8.36 • $p < 0.001$ **HIV knowledge** Intervention group: Baseline: 21.05 24-week follow up: 25.87 Control group: Baseline: 18.71 24-week follow up: 18.83 • $p < 0.001$ **Infection awareness** Intervention group:	Strength of design: **Strong** Quality: **High** Issues: • Assessors were not blinded to data collection • Unclear if patients were blinded

	HCV knowledge: questionnaire using 20 items that assesses HCV related knowledge **HIV knowledge:** questionnaire using 45 items that assesses HIV related knowledge **Infection awareness:** self-rating questionnaire to determine participants knowledge of HCV/HIV infection	Baseline: 9.47 24-week follow up: 9.64 Control group: Baseline: 10.28 24-week follow up: 9.76	
Authors: Vederhus et al., 2014 Design: Randomized controlled trial Purpose: To compare a motivational intervention (MI) focused on increasing involvement in 12-step groups vs. brief advice (BA) to attend	N = 140 patients, 68 in intervention group, 72 in control group. As a result of deaths and those lost to follow up, final data included 56 in intervention group and 57 in control group Country/setting: Norway. In a detox unit at a hospital in Norway Intervention group: N = 56 • Standard detox plus two weekly 30 minute education sessions designed to acquaint patients with 12-step groups Control group: N = 57 • Standard detox and given meeting lists for 12-step groups in their area	**12-step group affiliation:** Intervention group: 2.53 Control group: 1.51 • p = 0.041 **Alcohol use:** Intervention group: 0.17 Control group: 0.24 • p = 0.095 **Drug use:** Intervention group: 0.11 Control group: 0.10	Strength of design: **Strong** Quality: **High** Issues: • participants only recruited from one single source • random sampling not use – participants placed into intervention/control group based on weekly schedule • significant number of participants lost to follow up

	Data collection: AA Affiliation Scale (AAAS) and Addiction Severity Index used Outcomes: **12-step group affiliation:** AAAS used to determine the level of involvement of participants in 12-step groups **Substance use:** data on drug and alcohol use gathered using the addiction severity index		
Authors: Sussman et al., 2004 Design: Randomized controlled trial Purpose: to assess whether or not educational programming exerted lifestyles improvements among alcoholic liver disease inpatients	N = 44 patients initially entered study, 25 provided 3 month follow up data – 13 in the intervention group and 12 in the control group Country/setting: United States of America Intervention group: N = 13 • education program that consisted of five education sessions, plus standard care Control group: N = 12 • Received standard care (medical care, consults for social work and psychological care)	**Knowledge gained:** Intervention group: 9.34 to 14.86 Control group: 10.92 to 12.76 • $p < 0.0001$ **Self-reported lifestyle changes:** Intervention group: 27.32 to 33.06 Control group: 27.85 to 31.49 • $p < 0.05$	Strength of design: **Strong** Quality: **High** Issues: • Participants recruited from one single location • Assessors were not blinded in data collection • A significant number of initial participants were lost to follow up

	Data Collection: Marlatt's drinking profile to assess baseline alcohol use, rating scales to assess drug use, knowledge of lifestyle behaviours impacting alcohol liver disease assessed using a 19-question questionnaire Outcomes: **Knowledge gained:** Assessed using a pre-test post-test **Lifestyle changes:** Self-reported scale, assessed pre and post intervention		
Authors: Roy-Byrne et al., 2014 Design: Randomized controlled trial Purpose: To determine whether brief intervention improves drug use outcomes compared with enhanced care as usual	N = 868 included, 435 in intervention group, 433 in control group Country/setting: United States of America. 7 primary care clinics in Washington Intervention group: N = 435 • Received a 30 minute brief intervention education session using a motivational interviewing approach plus enhanced care as usual Control group: N = 433 • Regular care and a handout listing substance abuse treatment resources	**Functional correlates of drug use:** **Psychiatric:** Intervention group: Baseline: 0.37 1 year follow up: 0.31 Control group: Baseline: 0.39 1 year follow up: 0.32 • p = 0.79 **ER visits:** Intervention group: Baseline: 215 1 year follow up: 204	Strength of design: **Strong** Quality: **High** Issues: • significant number of people were lost to follow up

	Data collection: Self reported drug use during the past 30 days assessed using the addiction severity index (ASI). Functional correlates of drug use assessed using medical, psychiatric, social and legal subscales of the ASI. Re-admissions and ER visits explored using health record data Outcomes: **Drug use:** Assessed using the addiction severity index (ASI). **Functional correlates of drug use:** Assessed using subscales of the ASI **Hospital admissions and ER visits:** Assessed using health records	Control group: Baseline: 213 1 year follow up: 198 • p = 0.77	

Appendix B

Consultation and Environmental Scan Report

Consultation and Environmental Scan Report

Lindsay D. Maxwell

Memorial University of Newfoundland

N6660: Practicum I

Dr. Joy Maddigan

August 14, 2021

Consultation and Environmental Scan Report

Background

This practicum project consists of two parts. The first, is a person-centered education resource intended to increase the addictions knowledge in patients admitted to the inpatient withdrawal management unit. The patient education session will consist of three overall components. First, information will be provided regarding the causes of addiction. The second component will go into more specific detail about the different types of substance use disorders most commonly encountered in an inpatient withdrawal setting. This will include a discussion on alcohol use disorder, opioid use disorder, stimulant use disorder and polysubstance use disorder. The final component of the education session will be recovery focused. It will discuss what the road to recovery looks like, different relapse prevention tools, and finally information about the variety of community supports that are available to patients after they discharge from the inpatient unit. This will include a take home resource available to all patients admitted to the unit that outlines the main points of the education session as well as a comprehensive list of available community resources.

The second part of the practicum project is a resource intended for the families/support persons of individuals with substance use disorder. Due to limitations within the context of the inpatient unit, this component of the practicum project will not be an in-person session, but instead will exist in the form of a take home resource. It will include information on the causes of substance use disorder from the perspective of the biopsychosocial model. Secondly, it will include advice on ways to effectively support a loved one in different stages of illness and recovery. Finally, information on available community resources specifically for support persons will be presented.

With this in mind, several consultations as well as an environmental scan were

necessary. First, the consultations allowed key individuals to provide their input on the details of the practicum project. It was through the consultation phase that individuals were given the opportunity to provide their perspective on what they believed to be most important to include in both the education session and the take home resource for families/support persons. Additionally, feedback was gathered on the best way to present this information. Consultations are important as it ensures the opinions of those who will be directly impacted by the project are taken into consideration in the development phase.

A thorough environmental scan was also an important part of this project. While the bulk of the information to be included in the education session could be gathered through consultations, a key part of this project is the focus on recovery from substance use disorder. Therefore, it was vital that the available community resources were explored. This was accomplished through an environmental scan that included interviews as well as an internet search.

Participants

The consultations included discussions with four categories of individuals. First, different staff members were consulted. These are the people directly involved in patient care and also those who will be implementing the education session and distributing the take home material once it is developed. Therefore, their opinions were significant for the development of the project. The direct care providers selected for interview were registered nurses (RNs), a licensed practical nurse (LPN) and a social worker. In total, four registered nurses were consulted. In the initial consultation plan, the intention was to interview three senior RNs and one novice RN. However, due to high turnover and the number of newly hired staff, the novice RNs that were approached for an interview did not feel comfortable providing their input as they had only been

working in the addictions field for a couple months. As a result, the consultations with RNs included four senior RN staff members. The LPN that was consulted was a senior LPN. Finally, one of the two social workers on the withdrawal management unit agreed to participate in the consultations.

The second category of consultations was with individuals in a leadership role. This included both the health services manager for the withdrawal management unit as well as the clinical nurse educator for the unit. Ultimately, any project implemented on the unit requires approval from both of these individuals. Thus, consultation with them was required. Additionally, it was beneficial to explore recommended inclusion material from the perspective of individuals not directly involved in patient care. Consultations with leadership also highlighted what should and should not be included in the project along with the potential benefits of the project, from an organizational perspective.

The third group of individuals consulted were patients. These consultations were necessary, as it is this group that will be the direct recipients of the education session. Therefore, it is critical that the information delivered is information that the patients can use and see as valuable. The education session will have more impact if input and feedback from patients is incorporated. The consultation plan suggested a target of five patients to be included. However, due to unit census as well as patients being in acute withdrawal during time of consultation, only three patients were consulted.

The final group included in the consultation phase were support persons. The input from support persons was valuable for consideration of what to include in the take home resource targeted directly at families/support persons. Similar to the input sought from patients, it was important to talk to support persons directly to ensure the information that was developed was in

line with what they viewed as important. The consultation plan outlined a target of two support people for consultation. However, due to difficulty in recruiting these participants, only one support person was consulted.

For the environmental scan, in addition to a comprehensive internet search, two individuals were interviewed to ensure a variety of available community resources was captured. In the plan for the environmental scan, the intention was to consult two community outreach workers, one in each of the community mental health and addictions (CMHA) clinics. However, the participants for the final environmental scan differed slightly from the original plan. Only one community outreach worker from one of the CMHA clinics was interviewed. The second participant for the environmental scan was recruited from the Nova Scotia 211 line. 211 is a provincial resource that provides free and confidential information on available community and social services in Nova Scotia. This was used in an effort to ensure resources outside of those that exist within the health authority were also included.

Methods

Recruitment

The direct care providers (RNs, LPNs, and social workers) as well as the health services manager and clinical educator were recruited through email invitation. The recruitment email that was sent to these individuals can be found in Appendix A. Once these individuals agreed to participate in the consultations, they were provided with an information letter to inform them of the details of the practicum project and an expectation of what the consultations would entail. The information letters that were provided to staff and leadership can be found in Appendix B.

The patients were recruited through direct face to face contact while they were inpatients on the withdrawal management unit. As mentioned above, the recruitment of suitable

participants was challenging due to low unit census as well as the patients experiencing acute withdrawal at the time of consultation. As a result, patients who were close to their discharge date (therefore less ill than those at the beginning of their admission) were approached for participation. Individuals deemed suitable were provided with an information letter that detailed the practicum project along with the purpose of consultation with them. This letter was read aloud to each patient and they were also provided with their own physical copy. The letter was read aloud so as not to assume the literacy level of the patients. This ensured that each patient had a thorough understanding of the purpose of their participation. The information letter that was provided to patients can be found in Appendix C.

Recruitment of support persons proved to be the most challenging. Family/support persons could not be recruited without prior consent from the patient. Therefore, these individuals were limited to the patients that were currently inpatient on the withdrawal management unit. After a patient provided consent to communicate with his/her support person(s), these individuals were contacted by phone for consultation. As a result of the communication occurring by phone, the information letter was read aloud over the phone to ensure informed consent before participating. Additionally, the support person was given the option to have a paper copy of the information letter given to his/her loved one who was on the inpatient unit, with the intention that the letter would be given to him/her upon the patient's discharge. The letter that was provided to support persons can be found in Appendix D.

For the environmental scan, the same email invitation that was used for direct care providers and leadership was used to recruit the community outreach worker. This email script can be found in Appendix A. Due to the nature of the 211 telephone line, an email invitation was unable to be sent. Instead, the staff member who answered the phone was informed of the nature

of the call and provided with the opportunity to accept or deny the invitation to participate. Similar to the participants for the consultation phase, those approached for the environmental scan were also provided with an information letter detailing the practicum project and the purpose of the environmental scan. Due to the contact with 211 being over the phone, the letter was read aloud to this participant. The letter that was used is presented in Appendix E.

Data Collection

After individuals agreed to participate in the project, the data collection phase began. Data collection for all consultations as well as the environmental scan occurred in the format of one-on-one interviews. The intention was to complete all interviews with direct care providers, leadership, and patients onsite on the withdrawal management unit. However, to accommodate staff members who agreed to participate but were on vacation at the time of consultation, several of the interviews were conducted over the secure video platform, "Zoom for Healthcare". The staff members that were available for in-person interviews were interviewed separately on the withdrawal management unit in a private room. Similarly, all interviews with patients were conducted on the inpatient unit, in private rooms. The interview with both the support person and the 211 information line took place over the phone. Finally, the interview with the community outreach worker as part of the environmental scan was conducted using "Zoom for Healthcare".

Each interview was guided by a number of questions developed for each individual group. The interview guides used for direct care providers, leadership, patients, and support persons can be found in Appendices F, G, H, and I, respectively. The interview guide that was used for the environmental scan is presented in Appendix J. For the interviews that took place over the phone and via Zoom for Healthcare, participants' responses were typed and for those interviews that took place in-person, hand written notes of responses were recorded.

Data Management and Analysis

Once data was collected it was entered into a Microsoft word document. The participants responses were typed as close to verbatim as possible. Each individual response was typed underneath the question that it corresponded to. This was done in an effort to keep data managed and organized in between participant interviews. For the interviews that were conducted in person, the hand written notes were transferred into the word document immediately after the interview was completed.

Upon completion of all interviews and once all data was entered into the word document, a content analysis was completed. First, the data were analyzed by participant group. For example, the data gleaned from consultation with direct care providers (RNs, LPNs and social work) was analyzed separately from the others initially. The rationale for this was that each participant group was asked the same questions and these questions differed slightly from those asked of the other groups.

After data were analyzed by group, all responses were combined and a group analysis was completed. This was done for the questions that elicited similar responses from the participants. For example, each group was consulted regarding what specific material they believed should be included in the education session. The data were then organized into a table grouped by similar responses. The headings on the table read: “important to include patient”, “important to include family”, “what to avoid”, “delivery methods”, “length”, “patient resources” and “support person resources”.

The information gathered from the environmental scan was entered into the table mentioned above in the relevant categories but then was also further subdivided into a second table with headings that read: “general patient resources”, “resources for patients who identify as

male", "resources for patients who identify as female", "2SLGBTQ+ patient resources" and "support person resources". While this was not asked directly in the interviews, several resources that were specific to the Indigenous population were identified so a separate category was developed for this. Any data corresponding to these specific resources were coded as "Indigenous patient resources".

Consent/Ethical Considerations

Firstly, the Health Research Ethics Authority (HREA) screening tool was completed and it was determined that this practicum project was exempt from Health Research Ethics Board approval because it falls under the category of "quality assurance and quality improvement studies". Please see the completed HREA screening tool in Appendix K for details.

However, consent was required at the individual and institutional level to conduct consultations and interviews. Permission was first obtained from the health services manager to consult both direct care providers and patients on the withdrawal management unit. Once this permission was received, it was up to the individuals consulted to provide their individual consent for participation.

To ensure informed consent, all participants were provided with an information letter that detailed the practicum project as well as the purpose of their involvement. Once they were given time to read through the letter, they were provided with an opportunity to ask any questions about the project and/or about the extent of their involvement. Additionally, all participants were made aware that their participation in the project was completely voluntary and they were informed that they could stop the interview at any time should they not want to continue. For the patients that were approached for consultation, it was made explicit that their decision whether or

not to participate in the interview would have no impact on the care that they were receiving on the unit.

For the support person that was consulted, additional consent was required at the institutional level. The support person was someone identified by one of the patients on the withdrawal management unit. Within the mental health and addictions program, to have any contact with a family member/friend of a patient, a consent form must be signed by the patient themselves. This form details the relationship of the person to the patient as well as any specific information they do/do not want shared. As this project was unrelated to the patients care on the inpatient withdrawal management unit, it was made explicit on the consent form that the purpose of the contact was specifically related to this practicum project, no information about the patient or about the patient's care was to be discussed and the consent to contact the support person expired immediately upon completion of the interview.

In addition to the steps taken to ensure appropriate consent was received, several steps were also taken to ensure privacy and confidentiality of participants. For the interviews that took place over the phone, the participant was asked to confirm that he/she was in a private location where the conversation would not be overheard by others. The interview did not commence until this confirmation was received. The video-based interviews were conducted using Zoom for Healthcare which is a secure video platform intended for direct patient care and thus abides by the Nova Scotia Health Authority's standards for privacy and confidentiality. All of the in-person interviews were conducted in a private room, away from others.

Participants were made aware that their responses would not be shared with anyone else and would not be linked to them personally. The data was kept in a secure location where only myself and my academic supervisor had access. After each interview, the data was entered into a

word document on my personal password protected laptop. All paper copies of the interview responses were shredded immediately upon being entered into the word document.

Results

Important to Include – Patient

The consultations with direct care providers, leadership and patients highlighted several key components that the participants believed was necessary to include in the patient education session. The overarching question of "what is it about *me* that causes me to have an addiction?" was mentioned throughout the consultations. This led to the point of ensuring addiction was explained from the perspective of both genetics and social factors. Many participants mentioned the need to include information on what is actually happening to the brain of someone with substance use disorder. The significance of talking briefly about each different type of substance use disorder (alcohol, opioid and cocaine specifically) and the unique impacts of each was also discussed.

Several commonalities existed in participant responses when discussing recovery as well. Many believed it was significant to provide education on the trajectory of recovery and emphasize that it is not a linear path. Additionally, the importance of highlighting the commitment that is required on the patient's behalf was raised throughout the interviews. Many participants discussed the necessity to include information on developing a relapse prevention plan that included aspects such as leisure, nutrition, community supports, and support from family and friends.

Important to Include – Family

Similar to what was recommended for the patient education session, it was highlighted as important to also provide families/support persons with a general understanding of the

physiology of addiction. Additionally, providing support persons with advice on ways that they can effectively support their loved one through both active use as well as recovery was brought up in participant interviews.

What to Avoid

The most common point that was raised in the participant interviews regarding what to avoid in the education session was a need to ensure the session was provided using language that is not too complicated. Avoiding medical jargon and presenting the information at an appropriate literacy level is necessary. Many participants also identified the need to ensure the information was presented in a way that was not punitive in nature, but instead simply informative.

Delivery Methods/Length

Many participants highlighted the benefits of including a variety of mediums when delivering this information. The most common suggestions included PowerPoint presentation, open discussion, videos and visuals. Summarizing the information taught in the education session into a take home handout was also a common response among participants. The point raised most frequently in the interviews was ensuring the education session was interactive to maintain patients' attention. Similarly, all participants reported that the session should be one hour or less in length.

Patient Resources/Support Person Resources

The consultations and environmental scan revealed a number of community resources available to both patients and their support persons. However, it was clear that the resources available for support persons is lacking significantly. The resources will be detailed in the practicum project but some of the most common ones identified in the consultations and environmental scan were: community mental health and addictions programs, 12-step programs,

opioid replacement programs, mental health day treatment program, AL-ANON and different recovery homes throughout the province.

Conclusion

The results obtained from the consultations and the environmental scan will be used to inform the development of both the patient education session and the take home resource for support persons. First, the content of the education session will be based on the results from the participant interviews. Second, how the information is presented (i.e., delivery methods) will be informed by the opinions of the participants. Using the feedback from consultations, the practicum project will contain a take home component for the patients who attend the education session as well. The results of both the consultations and the environmental scan allow for the development of a comprehensive list of community resources that can be provided to patients upon discharge and also to support persons. Finally, for the resource intended for support persons, the content of this resource will be informed by the results of the consultations and environmental scan.

The consultations and environmental scan are extremely valuable for the practicum project. The resource itself is beneficial for the population it intends to serve, but having the education session informed by those that will deliver it, as well as those that will receive it is important. Interviewing both patients and direct care providers ensures that the most appropriate information is included. Additionally, including individuals from leadership in the process ensures that the project will be well received from an organizational standpoint and encourages its implementation.

Appendix A

Email Invitation Script

Dear (staff name),

As you are aware, I am in the process of completing my Masters of Nursing degree. The final requirement of this degree is the completion of a practicum project. I am now moving into the consultation phase of this project and as such am looking for individuals to help me gather valuable information that will be used in the development of the project. I am writing this email as an invitation for you to participate in the consultation phase of my project. I have attached an information letter for your review that explains the project in more detail, as well the purpose of the consultations. If you have any questions about the consultations themselves or in general about the project, I will be happy to answer them. I can be reached through response to this email, or via telephone at 782-414-8118.

Thank you in advance for your consideration. I look forward to hearing from you,

Lindsay

Appendix B

Information Letter – Staff/Leadership

To whom it may concern,

The purpose of this letter is to provide you with information regarding who I am, why I am contacting you and what my practicum project is about. My name is Lindsay Maxwell, I am a registered nurse currently completing my Masters of Nursing degree. The final requirement of my degree is the completion of a practicum project. I would like to consult with you and seek your perspective on the best way to develop the project, which is an educational resource for individuals on the withdrawal management unit.

The tentative title for my project is "Addiction 101: A person-centered resource". This project will be delivered in the form of an education session and will be targeted towards patients on the inpatient withdrawal management unit. The session aims to educate patients on the physiology of substance use disorders as well as the community resources/supports that are available to them upon discharge from the unit. Additionally, a family centered component will be developed with the goal of educating support persons on resources that are available to them, as well as information on what it means to have someone in their lives who suffers from a substance use disorder.

To ensure the most appropriate information is included in this education session and in the family resources, I am consulting key individuals to gain a broader understanding of what should and should not be included. I believe you would have valuable expertise that would help strengthen the project.

The information that I am requesting will be gathered through a one-on-one interview that will be between 20 and 30 minutes long. Your participation in this interview is completely voluntary. Should you choose to participate, please be aware that you are able to withdraw your consent at any time. If you do complete the interview, your responses to the interview questions will be recorded by myself during the interview. All responses will be kept confidential. Additionally, the data will be securely stored and I will be the only person who has access to it.

If you have any questions or would like more information about this project, please let me know and I will be happy to answer them.

Thank you for considering participation in this project,

Lindsay Maxwell

Appendix C

Information Letter – Patients

The purpose of this letter is to provide you with information regarding who I am, why I am contacting you and what my practicum project is about. My name is Lindsay Maxwell, I am a registered nurse currently completing my Masters of Nursing degree. The final requirement of my degree is the completion of a practicum project. I would like to consult with you and seek your perspective on the best way to develop the project, which is an educational resource for individuals on the withdrawal management unit.

The tentative title for my project is "Addiction 101: A person-centered resource". This project will be delivered in the form of an education session and will be targeted towards patients on the inpatient withdrawal management unit. The session aims to educate patients on substance use disorders as well as the community resources/supports that are available to you upon discharge from the unit. Additionally, a family centered component will be developed with the goal of educating support persons on resources that are available to them, as well as information on what it means to have someone in their lives who suffers from a substance use disorder.

To ensure the most appropriate information is included in this education session, I am consulting key individuals to gain a broader understanding of what should and should not be included. I believe you would have valuable expertise that would help strengthen the project.

The information that I am requesting will be gathered through a one-on-one interview that will be between 20 and 30 minutes long. Your participation in this interview is completely voluntary. Should you choose to participate, please be aware that you are able to withdraw your consent at any time. If you do complete the interview, your responses to the interview questions will be recorded by myself during the interview. All responses will be kept confidential. Additionally, the data will be securely stored and I will be the only person who has access to it. It is important to note that if you choose not to participate in this interview, it will not have any impact on the care that you receive on the inpatient withdrawal management unit.

If you have any questions or would like more information about this project, please let me know and I will be happy to answer them.

Thank you for considering participation in this project,

Lindsay Maxwell

Appendix D

Information Letter – Support Persons

To whom it may concern,

The purpose of this letter is to provide you with information regarding who I am, why I am contacting you and what my practicum project is about. My name is Lindsay Maxwell, I am a registered nurse currently completing my Masters of Nursing degree. The final requirement of my degree is the completion of a practicum project. I would like to consult with you and seek your perspective on the best way to develop the project, which is an educational resource for individuals on the withdrawal management unit.

The tentative title for my project is "Addiction 101: A person-centered resource". This project will be delivered in the form of an education session and will be targeted towards patients on the inpatient withdrawal management unit. The session aims to educate patients on the physiology of substance use disorders as well as the community resources/supports that are available to them upon discharge from the unit. Additionally, a family centered component will be developed with the goal of educating support persons on resources that are available to them, as well as information on what it means to have someone in their lives who suffers from a substance use disorder.

To ensure the most appropriate information is included in the family centered component, I am consulting support persons of individuals with substance use disorder to gain a broader understanding of what should and should not be included. I believe you would have valuable expertise that would help strengthen the project.

The information that I am requesting will be gathered through a one-on-one interview, lasting 20-30 minutes, conducted over the telephone. Your participation in this interview is completely voluntary. Should you choose to participate, please be aware that you are able to withdraw your consent at any time. If you do complete the interview, your responses to the interview questions will be recorded by myself during the interview. All responses will be kept confidential. Additionally, the data will be securely stored and I will be the only person who has access to it.

If you have any questions or would like more information about this project, please let me know and I will be happy to answer them.

Thank you for considering participation in this project,

Lindsay Maxwell

Appendix E

Information Letter – Environmental Scan

To whom it may concern,

The purpose of this letter is to provide you with information regarding who I am, why I am contacting you and what my practicum project is about. My name is Lindsay Maxwell, I am a registered nurse currently completing my Masters of Nursing degree. The final requirement of my degree is the completion of a practicum project. As part of this project, I am including a take home resource detailing the available community supports for individuals with substance use disorder. Therefore, I would like to ask you three questions regarding the community supports that are available to both individuals with substance use disorder and their support person(s).

The tentative title for my project is "Addiction 101: A person-centered resource". This project will be delivered in the form of an education session and will be targeted towards patients on the inpatient withdrawal management unit. The session aims to educate patients on the physiology of substance use disorders as well as the community resources/supports that are available to them upon discharge from the unit. Additionally, a family centered component will be developed with the goal of educating support persons on resources that are available to them, as well as information on what it means to have someone in their lives who suffers from a substance use disorder.

To ensure I obtain a comprehensive overview of the different community supports that are available for this population, I would like to interview you. I believe you would have valuable expertise that would help strengthen the project.

The information that I am requesting will be gathered through a one-on-one interview that will be between 10 and 15 minutes long. Your participation in this interview is completely voluntary. Should you choose to participate, please be aware that you are able to withdraw your consent at any time. If you do complete the interview, your responses to the interview questions will be recorded by myself during the interview. All responses will be kept confidential. Additionally, the data will be securely stored and I will be the only person who has access to it.

If you have any questions or would like more information about this project, please let me know and I will be happy to answer them.

Thank you for considering participation in this project,

Lindsay Maxwell

Appendix F

Interview Guide – Direct Care Providers

1. What information should be included in an educational session developed to provide individuals with substance use disorders useful information about their disorders and how to address or overcome them?

2. Based on your experience with similar sessions in the past, is there anything that was not particularly helpful?

3. What activities or interactive components could be included in the session to facilitate learning and engagement?

4. How long should the session last to maintain the attention and interest of the patients?

5. Is there a particular mode of delivery that you would like to see?

6. What community resources are you aware of that are available to patients and/or their support person(s) after discharge?

Appendix G

Interview Guide – Leadership

1. What specific information should be included in the education session?

2. Is there any information that would not be helpful to include in the education session?

3. From an organization perspective, is there information that you would like to see included in either the patient education session or the family centered resource?

4. Do you have any advice on the most appropriate methods of delivery for this information?

5. Do you have any information regarding readmission trends?

6. Are you aware of the current uptake of community resources from individuals discharged from this service?

Appendix H

Interview Guide – Patients

1. Is there anything in particular that you would like to know about substance use disorders?

2. In an education session that provides information on substance use disorders, is there a specific way that you would like this information delivered (i.e., lecture format, video, group discussion)

3. Would you participate in an educational session about substance use disorders if available on the unit?

4. What community resources are you aware of that are available to you after discharge?

5. Would you be interested in continued community support to help with your recovery after you discharge from detox?

Appendix I

Interview Guide – Support Persons

1. Is there anything in particular that you would like to know about substance use disorders?

2. When it comes to having someone in your life who has a substance use disorder, what would you like to better understand about their disorder?

3. Are you aware of any community resources available to you (not your loved one) to help you cope with your loved ones SUD?

4. Do you feel that you have adequate support/information regarding your loved ones SUD? Please explain.

Appendix J

Interview Guide – Environmental Scan

1. What community resources are you aware of that are available to individuals with substance use disorder?

2. Are you aware of any gender specific/2SLGBTQ+ community resources for this population?

3. What community resources are you aware of that are available to the support persons of individuals with substance use disorder?

Appendix K

Health Research Ethics Authority (HREA) Screening Tool

Student Name: Lindsay Maxwell

Title of Practicum Project: Addiction 101: A person-centered resource

Date Checklist Completed: June 25, 2021

This project is exempt from Health Research Ethics Board approval because it matches item number 3 from the list below.

1. Research that relies exclusively on publicly available information when the information is legally accessible to the public and appropriately protected by law; or the information is publicly accessible and there is no reasonable expectation of privacy.
2. Research involving naturalistic observation in public places (where it does not involve any intervention staged by the researcher, or direct interaction with the individual or groups; individuals or groups targeted for observation have no reasonable expectation of privacy; and any dissemination of research results does not allow identification of specific individuals).
3. Quality assurance and quality improvement studies, program evaluation activities, performance reviews, and testing within normal educational requirements if there is no research question involved (used exclusively for assessment, management or improvement purposes).
4. Research based on review of published/publicly reported literature.
5. Research exclusively involving secondary use of anonymous information or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information.
6. Research based solely on the researcher's personal reflections and self-observation (e.g. auto-ethnography).
7. Case reports.
8. Creative practice activities (where an artist makes or interprets a work or works of art).

For more information please visit the Health Research Ethics Authority (HREA) at https://rpresources.mun.ca/triage/is-your-project-exempt-from-review/

Appendix C

Facilitators Guide and

Education Session for Individuals with Substance Use Disorders

Substance Use Disorders
Group Content

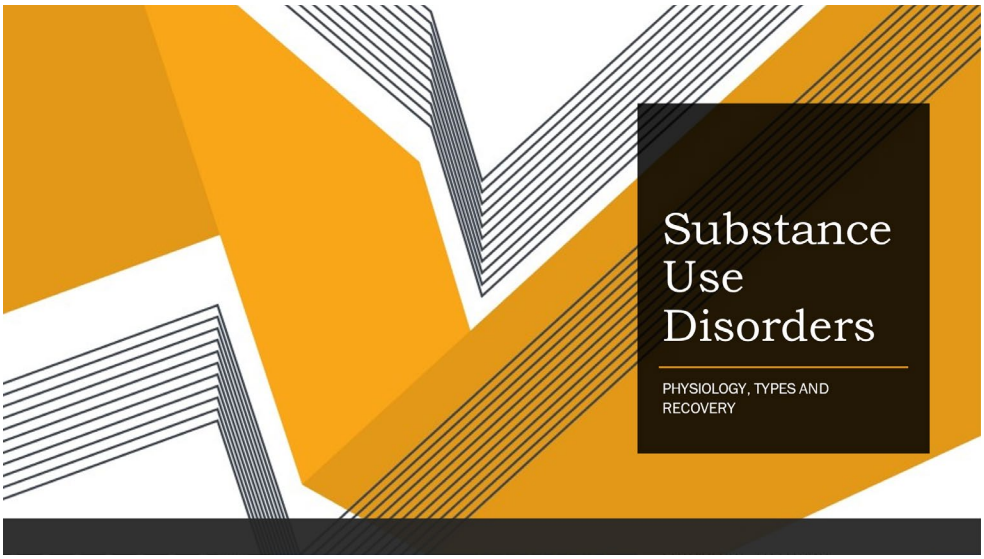
<u>Facilitator's Guide</u>

For the Group Facilitator:

This guide will provide you with talking points for each slide as you conduct the education session.

Important points to note:

- If there is a question that you don't know the answer to, that's ok! Just tell the person that's asking that you will get back to them with the answer
- For some of the open discussion, it may have to be prompted by you. The level of participation will be dependent on the group of patients and will be different each time
- You will become more comfortable with leading the group with experience. Be sure to share any helpful tips with your colleagues
- Most importantly, the information from this session is meant to be informative for the patients. Present it in a way that is open, accepting and non-judgemental. You aren't trying to "scare" them out of substance use, you're simply providing them with information.



Facilitators Speaking Notes:

- Begin by introducing yourself. Though most of the patients will know you, tell them a little about yourself – how long you have been working on WMU and what made you want to explore this area of nursing. It is a good opportunity to set the stage for the group to be less formal
- Allow patients to introduce themselves and give them the choice to share one thing about themselves. A good way to present this is by saying: "If people knew only one thing about you, what would you want that to be".
- Remind patients that everything discussed in the group is confidential and they are expected to maintain the privacy of the others in the group
- Inform patient that some of the information in the education session is complex and can be difficult to understand
- Encourage patients to ask questions if there is anything that they don't understand or want more information on
- This group will discuss the causes of substance use disorder, the three main types of substance use disorders that we treat on the inpatient unit and finally, what recovery looks like
- To start, we are going to answer some true and false questions about SUD and recovery
- Use your true/false paddle to participate and feel free to speak up if there are any questions in particular, you'd like to discuss

SUD affects men and women equally

FALSE

Facilitator's Speaking Notes:

- Overall, men are about one and a half to two times more likely to have a substance use disorder than women are

The younger you are when you begin using substances, the higher the chances that you will develop a SUD

TRUE

Facilitator's Speaking Notes:

- Regardless of genetics, the earlier a person starts using substances, the higher the risk that they will develop a substance use disorder in the future

Many people with a SUD also have another mental illness

TRUE

Facilitator's Speaking Notes:

- Many people experience substance use disorder as well as another mental health issue.
- Often, the other mental illness comes first but the use of drugs and/or alcohol could trigger a mental illness that has not surfaced previously
- Substance use can also worsen a mental illness

Long term substance use changes your brain structure and function

TRUE

Facilitator's Speaking Notes:

- Changes in the brain's structure and function are what cause people to have cravings, personality changes and other behaviour changes.
- Images have been taken of the brain of people with substance use disorder and those images show changes in the areas of the brain that are responsible for judgement, decision making, learning, memory and behavioural control

Substance use disorders (SUD) cannot be treated

FALSE

Facilitator's Speaking Notes:

- Effective treatments for substance use disorders are available
- A combination of medication and individual or group therapy has been shown to be the best treatment

Medical detox is the most important step in treatment

FALSE

Facilitator's Speaking Notes:

- Medically assisted detox is just the first stage of substance use treatment
- On its own, medication and medical detox does little to change long-term substance use

Only some people can benefit from treatment for SUDs

FALSE

Facilitator's Speaking Notes:

- Every single person with substance use disorder can benefit from treatment
- This is true regardless of whether a person's disorder is considered mild, moderate or severe

A general recovery plan can be used by anyone who undergoes treatment for SUD

FALSE

Facilitator's Speaking Notes:

- Each one of you is different and everyone's recovery journey looks different

- To increase your chances of a successful recovery, your recovery plan needs to be unique to your specific needs

Treatment and recovery plans should be monitored and changed frequently

TRUE

Facilitator's Speaking Notes:

- Both your treatment plan and your recovery plan should be assessed continuously and changed as required to be sure it continuously meets your needs
- You are going to change throughout your recovery so it is important that your recovery plan reflects this

Being aware of your triggers is one of the key ways to prevent relapse

TRUE

Facilitator's Speaking Notes:

- A big part of preventing relapse to substance use is mainly a matter of becoming aware of your triggers to substance use
- Once you are aware of your triggers you should then find ways that you can either avoid them or cope with them

After True/False Questions Completed:

- Begin by telling patients that the rest of the group will go into more detail about the true and false questions they just answered
- The first part of the group is going to discuss the different causes of substance use disorder

Biopsychosocial Model of Substance Use Disorder

VIDEO

Facilitator's Speaking Notes:

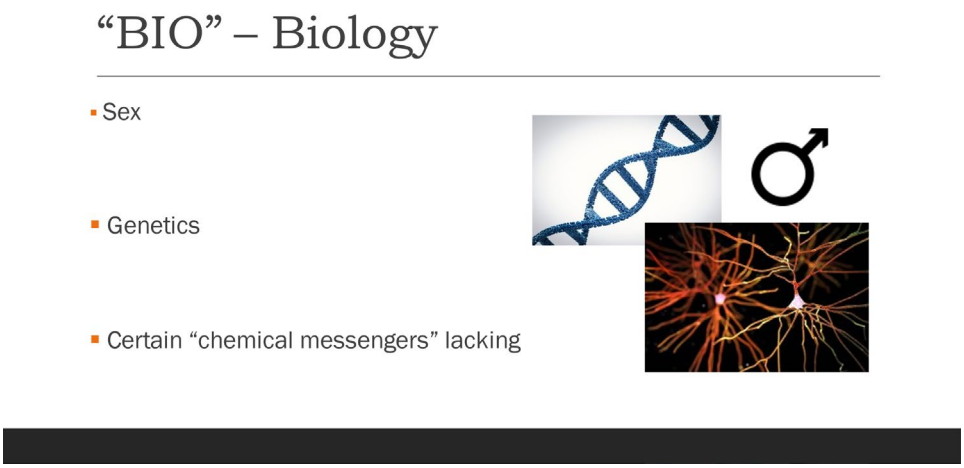
- The biopsychosocial model is a model that is used to explain a variety of health conditions
- This model looks at substance use disorder holistically and highlights how complex SUD is
- To help explain this model, a short 1-minute video will be shown

For the Group Facilitator:

- After video is played, ask participants if they have any questions – ensuring you highlight that the following slides will go into more detail about the 3 parts of the model (bio, psych, and social)

Facilitator's Speaking Notes:

- This is a picture of the biopsychosocial model
- You can see how all three of the areas intersect and together the different components can lead to a substance use disorder
- This is important because it really shows how complex substance use disorder is
- Substance use disorder is **not** your fault
- There are many factors that contribute to someone developing a substance use disorder and most of these factors are out of your control



Facilitator's Speaking Notes:

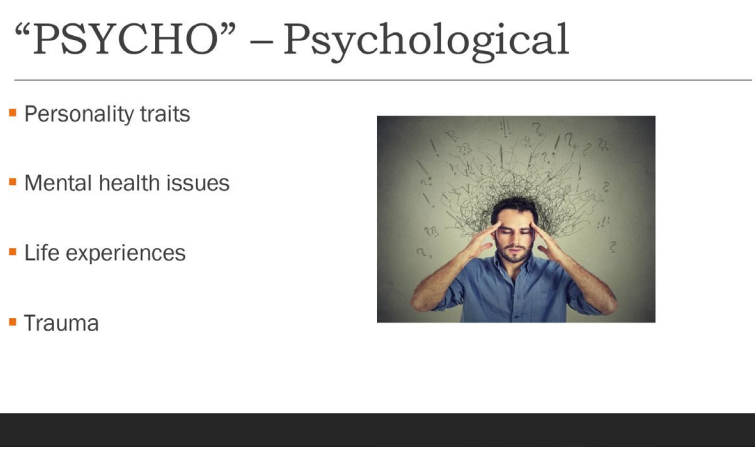
- As we talked about during the true and false questions, being born a male puts you at higher risk for developing a substance use disorder when compared to females
- There is a strong genetic link with substance use disorders
- While there is no "substance use gene" as there is for example for your eye color, there have been many studies done that show how big of a role genetics play in developing substance use disorder
- Studies have been done among identical twins (who share the same genetic make up) as well as among families where some members have substance use disorder and the results of these studies show that there is a strong genetic link

Ask Participants: Does that mean if someone in your family has a substance use disorder you will get it? – Leave time for participants to respond

> **Answer:** Absolutely **not!** BUT it does mean that if there is substance use disorder in your family, you do have a greater risk of developing it than someone who does not have any SUD in their family

Facilitator's Speaking Notes:

- We will discuss the role of the "chemical messengers" in more detail later
- Conclude by asking if anyone has questions about the "biology" of SUD



Facilitator's Speaking Notes:

- Psychological factors also play a role in the development of SUDs
- Some personality traits can make a person more likely to use substances. For example: being impulsive or being a risk taker
- Again, like genetics, that does not mean if you have these characteristics that you will develop a substance use disorder and many people with a substance use disorder do not possess these personality traits
- As was highlighted in the true and false questions, it is very common to experience substance use disorder along with another mental health issue
- The most common co-occurring mental health issues are anxiety and depression
- Many people say that their substance use is a form of self medication to help with the distressing symptoms from their mental health issues
- Certain life experiences, such as negative experiences in childhood (seeing domestic abuse, for example) can increase your chances for developing substance use disorder
- One of the most significant psychological factors that contribute to someone developing substance use disorder is the experience of trauma
- This trauma can be a variety of things including: abuse, bullying, witnessing a distressing event, the sudden death of someone close to you. Trauma comes in many forms
- The experience of trauma impacts your body's stress response and as a result stress hormones are consistently elevated
- Using substances can actually help you to regulate those emotional experiences and the painful emotions that you have because of the trauma(s)

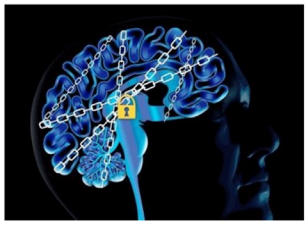
"SOCIAL" – Social Environment

- Social norms
- Childhood
- Social environment

Facilitator's Speaking Notes:

- Many parts of your social environment can increase your risk for developing a substance use disorder
- There are social norms, such as the thought "everyone experiments with drugs in college" that are considered acceptable
- However, this normalizing of substance use can contribute to the development of a substance use disorder
- Your childhood environment, including whether or not you were exposed to drugs and/or alcohol at an early age is also an important factor
- This doesn't mean that you personally used substances in childhood, but seeing the people around you using substances can increase your risk
- Cultural beliefs and norms can also contribute. Drugs and/or alcohol are considered acceptable in many cultures
- A lack of social support can also increase your risk for developing a substance use disorder

How Do Substances Affect the Brain?



VIDEO

Facilitator's Speaking Notes:

- Now that we've reviewed the different factors that can cause someone to develop a substance use disorder, we'll talk in a little more detail about the impacts that substance use has on the brain

Ask Participants:

- How do you think substances affect your brain?
- If you're comfortable doing so, you may discuss personal examples but this is not required

- If appropriate, you can write down participants responses on the whiteboard. Otherwise, just facilitate open discussion. Use your own judgement here.

Facilitator's Speaking Notes:

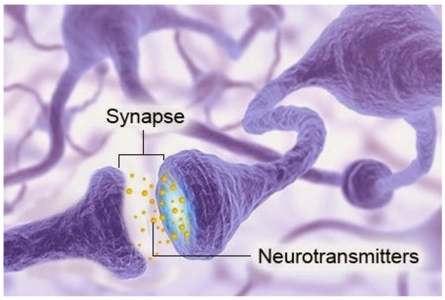
- We will now watch a 3-minute video that summarizes the impacts that substance use has on the brain

Once Video Complete:

- Reiterate the message at the end of the video: "While substance use does have significant impacts on the brain, the most important message is that the brain *can* repair itself. These physical changes do not have to be permanent"
- Ask participants if they have any questions

Neurotransmitters

- Neurotransmitters are "chemical messengers" that send information throughout our brain and from our brain to different areas of our body
- Substance use impacts the ability of these messengers to function as they are supposed to
- Neurotransmitters explained



Facilitator's Speaking Notes:

- Neurotransmitters are like the little carrier pigeons of our brain
- They relay messages within our brain and also between our brain and body
- It is through these messengers that our brain knows when we're in pain, when we're happy, when we're sad, etc.
- Substance use affects the way these messages are sent and received
- We're going to watch a one-minute-long video that explains exactly what neurotransmitters are and what role they play in our body
- The video does use some complex words and explanations, but don't worry about the little details, we will go into more detail about how it relates to substance use disorder

Once Video Complete:

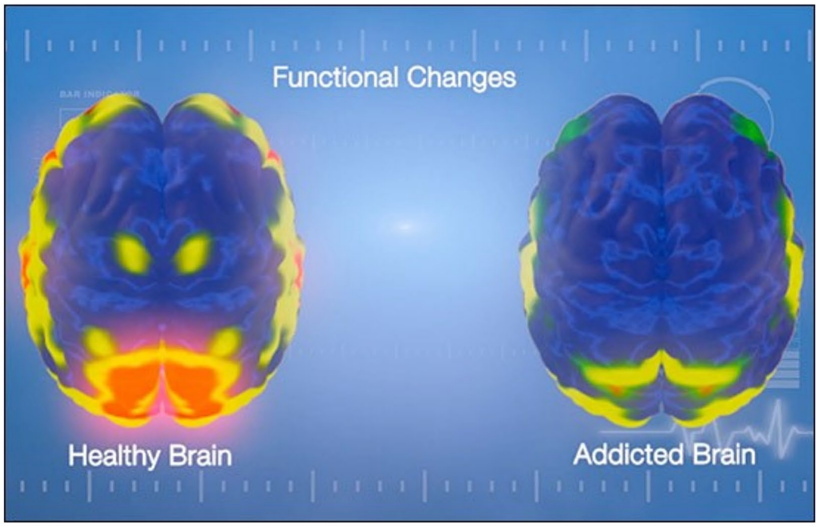
- Reiterate that the complexity of how neurotransmitters work is not important
- Ask participants if they have any questions

Behaviour Changes From SUD

- Dishonesty
- Aggression/anger
- Manipulation
- Risk taking
- Forgetfulness
- Frequent mood swings
- Depression and anxiety
- Paranoia
- Isolation
- Lack of interest

Facilitator's Speaking Notes:

- Substance use disorder changes the way the brain communicates, the brain's chemistry, and its structure and function
- All of this can change a person's behaviour and personality
- Substance use can cause a person to be dishonest, angry, manipulative, impulsive, forgetful, depressed, paranoid, socially isolated, and to develop a lack of interest in things that were once enjoyed
- These behaviour changes come from the different areas of the brain that are affected, primarily the prefrontal cortex



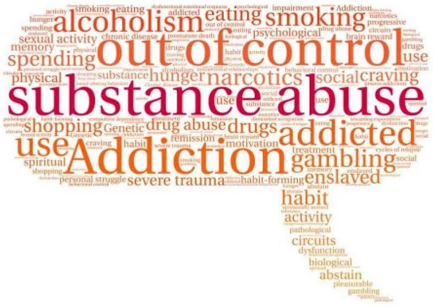
Facilitator's Speaking Notes:

- This picture shows a side-by-side comparison of the brain of a person who does not use substances, compared to someone with substance use disorder
- The "healthy brain" on the left has much more activity than the brain on the right
- This is shown by the areas that are displayed in orange and yellow on the brain on the left
- It is important to remember, as we discussed earlier, these changes ARE reversible

SUD is *Chronic* and *Progressive*

- SUD is a chronic disease– it can be thought of in the same way that we view heart disease or diabetes

- SUD is a progressive disease– it does get worse over time



Facilitator's Speaking Notes:

- Substance use disorder is a chronic disease
- Unfortunately, there is still a lot of stigma around substance use disorders, but they can be thought about in the same way that we think about other chronic diseases like diabetes
- Substance use disorder is also a progressive disease, meaning that it does get worse over time, in many aspects
- If any of you have been through detox before, you would likely agree that the withdrawal from substances is worse each time you go through it. That is an example of how it is progressive
- Tolerance, or needing more of the substance to get the same effects, also increases
- And the physical consequences of substance use, such as how it impacts the brain and the body, also get progressively worse with continued use

3 Main Types of SUDs

1. Alcohol use disorder
2. Stimulant use disorder
3. Opioid use disorder

Facilitator's Speaking Notes:

- Now that we've covered the causes and the impacts of substance use disorders as a whole, we'll go into more detail about the 3 main types of substance use disorders that we treat on the inpatient detox unit
- These three types are: alcohol use disorder, stimulant use disorder (which on this unit is primarily concerning cocaine use) and opioid use disorder

Alcohol Use Disorder

- Your body becomes used to having alcohol and when you take it away your brain and body cannot easily adapt to the lack of alcohol

- The lack of alcohol results in withdrawal symptoms

Facilitator's Speaking Notes:

- The first, and most common substance use disorder is alcohol use disorder
- With continued alcohol use, your brain and body become dependent on alcohol to function
- If you take away the alcohol completely or significantly reduce the amount you're using your body cannot easily adapt to the lack of alcohol
- Alcohol has a slowing effect on your brain so when it is used continuously, your brain changes its natural chemicals to compensate
- Because of this, when you take the alcohol away, it results in withdrawal symptoms
- In withdrawal everything is "sped up" compared to the slowing effects of alcohol

- **Before you put the withdrawal symptoms up on the screen**
- **Ask Participants:** Think about the fact that withdrawal symptoms are opposite from the slowing effects of alcohol, so everything is "sped up". What do you think alcohol withdrawal looks like?
    - Write participants' responses on the board
    - After adequate time to brainstorm, bring the withdrawal symptoms up on the slide one at a time

Facilitator's Speaking Notes:

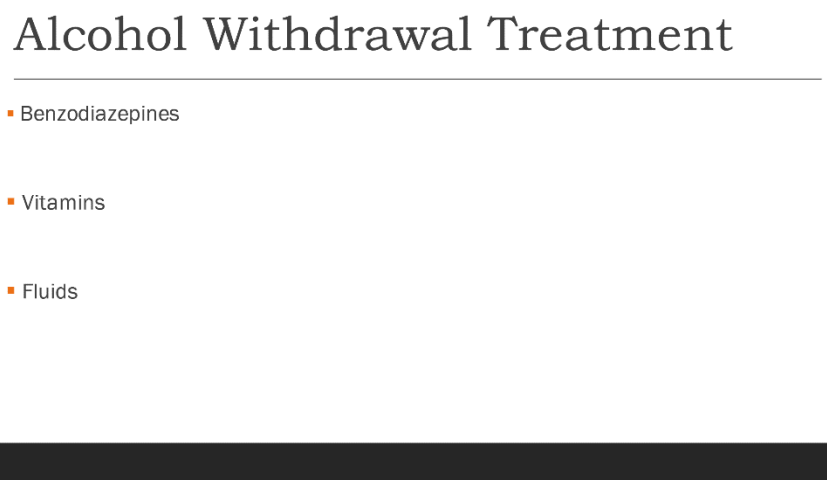
- Looking at the withdrawal symptoms, you can see what is meant by your body systems being "sped up"
- One of the more uncommon alcohol withdrawal symptoms is delirium tremens, also known as DTs

Ask Participants: Have any of you ever heard of DTs?

- Allow time for discussion

Facilitator's Speaking Notes:

- DTs will not occur in the majority of people who experience alcohol withdrawal
- Only about 5% of people who go through alcohol withdrawal will experience DTs
- When it does occur, it is a medical emergency as it can be life threatening
- Along with the "typical" alcohol withdrawal symptoms, someone who experiences DTs will also have extreme confusion, extreme agitation, fever, seizures and hallucinations
- DTs usually occur 2-3 days after someone stops drinking



Facilitator's Speaking Notes:

- Because of the "sped up" effect of alcohol withdrawal, it is important that it is treated properly to decrease the risk of experiencing withdrawal seizures
- The primary class of medication used to treat alcohol withdrawal is benzodiazepines
- There are many different medications within this class, but the two most common used in alcohol withdrawal treatment are diazepam (also known as valium) and lorazepam (also known as Ativan)
- Diazepam is typically the first choice but lorazepam is the best option for people who have liver issues, or for those who are older
- The medication for alcohol withdrawal is given in what is called "symptom triggered therapy". That means, the medication is only given if the person is showing symptoms of alcohol withdrawal
- That is why on the unit the nurses do an assessment, or ask a set of questions prior to giving you withdrawal medication
- There is no evidence to suggest that there is any benefit to giving someone medication if they are not showing signs of withdrawal
- Vitamins are also an important part of alcohol withdrawal treatment. Many essential vitamins are lacking in someone who uses alcohol regularly so vitamin supplements can help to replace them
- Thiamine is given to prevent a condition called Wernicke encephalopathy which is caused by low levels of thiamine from chronic alcohol use
- If this condition is present, a person's vision, balance and speech are affected and they will likely appear confused
- Fluids are another important part of treatment. Depending on the severity of alcohol withdrawal, IV fluids may be required but for the most part, fluids can be replaced just by drinking lots of water

Ask Participants: Are there any questions or comments about alcohol use disorder?

Stimulant Use Disorder

- Includes cocaine, methamphetamine and prescription stimulants

- Stimulant use increases the dopamine neurotransmitter in the brain which causes talkativeness, decreased appetite, increased activity, restlessness and changes in heart rate and blood pressure

Facilitator's Speaking Notes:

- The second type of substance use disorder that is commonly treated on the inpatient detox unit is stimulant use disorder
- This includes cocaine, methamphetamine and prescription stimulants
- On the inpatient unit the "type" of stimulant use we treat most commonly is cocaine
- The use of stimulants increases the amount of the neurotransmitter dopamine present in the brain
- This results in a feeling of over well-being, talkativeness, decreased appetite, increased activity, restlessness and changes to heart rate and blood pressure

Stimulant Withdrawal

INCREASED APPETITE

LOW MOOD

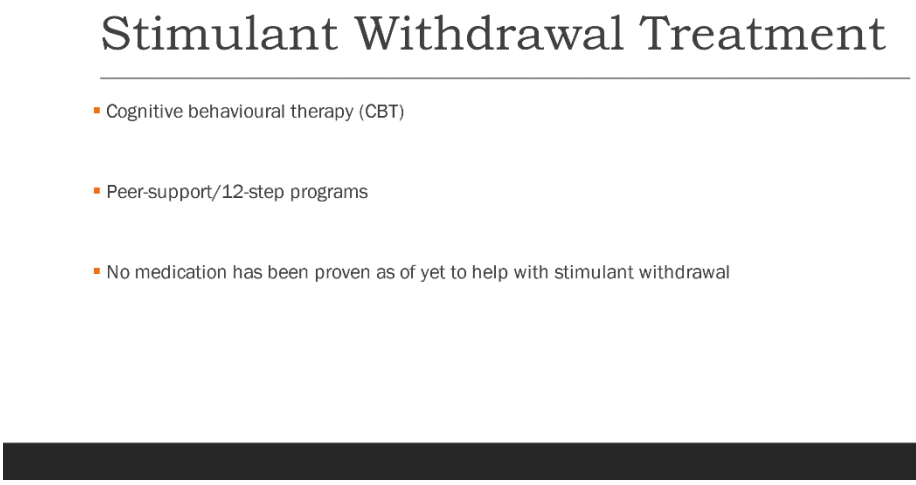
FATIGUE

UNPLEASANT DREAMS

- **Before you put the withdrawal symptoms up on the screen**
- **Ask Participants:** What do you think stimulant withdrawal looks like?
    - Write participants' responses on the board
    - After adequate time to brainstorm, bring the withdrawal symptoms up on the slide one at a time

Facilitator's Speaking Notes:

- These are the most common symptoms of stimulant withdrawal
- In addition to unpleasant dreams, some people report that they have very vivid dreams, but that they are not necessarily unpleasant



Facilitator's Speaking Notes:

- The two most effective treatments for stimulant withdrawal are cognitive behaviour therapy (CBT) and peer support programs
- CBT is a type of therapy that focuses on changing a person's thought patterns, emotions and behaviours
- Through CBT treatment, a person is able to develop healthy coping strategies and work on solving different problems in their life
- There are many resources about how cognitive behavioural therapy is used in addiction treatment
- If this is something you are interested in, there are a lot of free resources available online
- Peer support and 12-step programs are also very beneficial in treatment of stimulant withdrawal
- It can be beneficial to find a sponsor who is able to help you navigate the early days of stimulant withdrawal
- Learning from another person's lived experience can be very valuable and can help to give you hope!
- Although research is still ongoing, as of now, there have not been any medications that have been proven to help with cocaine withdrawal
- On this unit we use diazepam (valium) for a short period of time to help minimize some of the distressing symptoms such as sleep disturbances and anxiety
- Because there hasn't been anything proven to clinically treat stimulant withdrawal, that is why the diazepam on the unit is used for such a short period of time and in such small amounts

Ask Participants: Does anyone have any questions about stimulant use disorder?

Opioid Use Disorder

- Includes prescription opioids (morphine, codeine, oxycodone, hydrocodone, fentanyl, tramadol and methadone) as well as heroin

- Opioids block pain messages that your body is sending to your brain and releases the neurotransmitter, dopamine

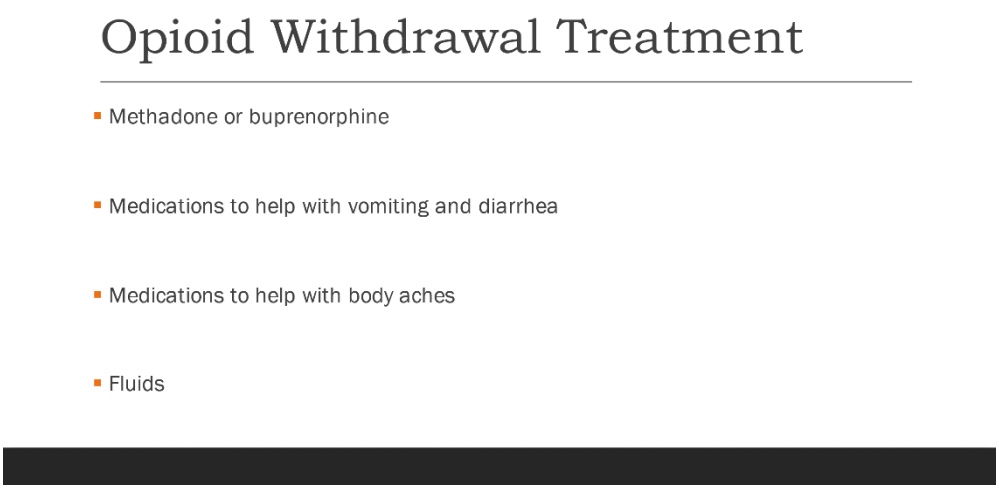
Facilitator's Speaking Notes:

- Opioid use disorder includes prescription opioids as well as heroin
- When opioids are consumed, the pain messages that your body is sending to your brain are blocked and dopamine is released to result in a feeling of well-being

- **Before you put the withdrawal symptoms up on the screen**
- **Ask Participants:** What do you think opioid withdrawal looks like?
    - Write participants' responses on the board
    - After adequate time to brainstorm, bring the withdrawal symptoms up on the slide one at a time

Facilitator's Speaking Notes:

- As you can see, opioid withdrawal is quite complex
- Although it is not particularly dangerous, withdrawal from opioids can be very very uncomfortable
- However, if not appropriately treated, vomiting and diarrhea caused by opiate withdrawal can cause severe dehydration and this can be dangerous



Facilitator's Speaking Notes:

- The two most common medications use to treat opioid withdrawal are methadone and buprenorphine (known as suboxone)
- These medications are adjusted until a dose is reached that minimizes or eliminates withdrawal symptoms
- For most people, this medication is continued for several years
- It is possible to use one of these medications to come off of an opioid and then stop taking it before you leave detox BUT you need to be very careful if you choose this route. After going through withdrawal, and tapering off of these meds, if you relapse, your tolerance is much lower so your risk for overdose is much higher
- If you are someone who has an opioid use disorder, or if you are using an ORT, please speak to your nurse about Naloxone (Narcan) and ensure you receive a naloxone kit on discharge from the unit
- Other medications are used to help withdrawal including those for vomiting and diarrhea and Tylenol and ibuprofen for headaches and joint pain
- Even with this combination of medication, a person experiencing opioid withdrawal will still be quite uncomfortable for a few days
- It is also important to drink lots of water, especially if you are having vomiting and diarrhea. You want to replace the fluids that you are losing

Ask Participants: Does anyone have any questions about opioid use disorder or anything we have discussed so far?

- Encourage open discussion between participants, if it presents

Otherwise: Inform participants that we will take a 5-minute break then we will come back and discuss recovery

Recovery From Substance Use Disorders

A RECOVERY STORY

Facilitator's Speaking Notes:

- We are going to spend the rest of the time left in this group to discuss recovery from substance use disorders
- Recovery **is** possible
- It will require a significant commitment from you, but there are millions of people living in recovery from substance use. There is no reason why you can't be one of those
- First, we are going to watch a 4-minute video of one woman discussing her recovery story

Once Video is Finished:

- Ask participants for their opinions on the video
- Ask participants if they have any recovery stories they would like to share

Facilitator's Speaking Notes:

- Prompt participants to think about their own recovery with the question: When you picture yourself living in recovery from your substance use disorder, what does that look like for you?
- Think about how your life would look different from how it looks now

Additional Question to Stimulate Discussion:

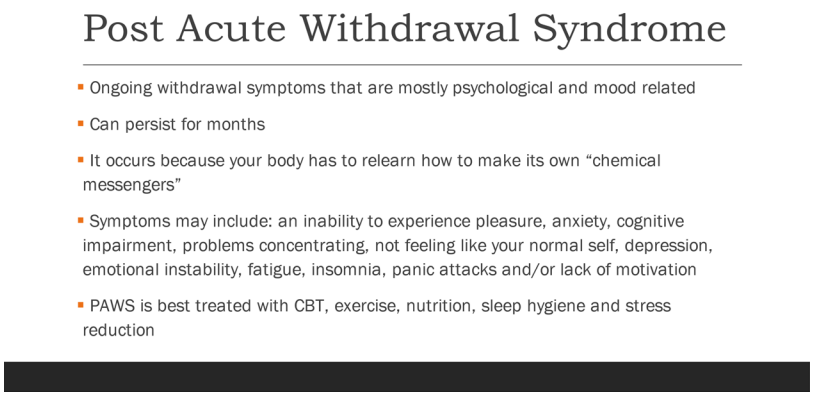
- If you went to sleep tonight and woke up tomorrow living the life you have always dreamed of, what does that life look like?

Remember:

- Recovery looks different for everyone
- It is an ongoing journey – there is no endpoint when it comes to recovery
- Relapse is a part of recovery
- Early recovery is the hardest

Facilitator's Speaking Notes:

- As you can see from what everyone has shared, life in recovery looks different for everyone
- The road to recovery is also different for everyone
- A "one size fits all" approach to recovery is impossible, your recovery plan has to be specific for you
- For many people, recovery doesn't always happen on the first try. Relapse is a completely normal part of recovery
- If you do relapse, try to not get discouraged. Remind yourself that relapse is **not** failure, but part of the journey
- Prepare yourself for the early days. While no part of recovery is easy, early recovery is the hardest



Facilitator's Speaking Notes:

- Part of what makes early recovery so hard is the presence of post acute withdrawal syndrome, also known as PAWS
- Post acute withdrawal syndrome is a series of symptoms that are mostly psychological and mood related
- These symptoms for some people can feel as intense as acute withdrawal and it does put a person at a higher risk of relapse in an effort to stop the unpleasant symptoms
- These symptoms can last for months and in rare cases, years.
- Many studies show that the symptoms can last anywhere between 6 months to 4 years but for the majority of people the symptoms clear up within the first year
- PAWS happens because your body has to re-learn how to make its own neurotransmitters after you stop using drugs or alcohol and this process can take time
- The most common symptoms of PAWS are an inability to experience pleasure, anxiety, cognitive impairment, difficulty concentrating, not feeling like yourself, depression, unstable emotions, fatigue, being more sensitive to lights and sounds, insomnia, memory problems, lack of motivation, panic attacks, social withdrawal and suicidal thoughts
- If you feel like you are experiencing PAWS, you should not hesitate to reach out for help
- PAWS can be treated or managed effectively with cognitive behavioural therapy, and lifestyle changes such as exercise, good nutrition, sleep hygiene and stress reduction

Ask Participants: Does anyone have any questions about PAWS?

Relapse Prevention Planning

- Helps you from returning to your old behaviours

Facilitator's Speaking Notes:

- Developing a relapse prevention plan, or a recovery plan, can help prevent you from returning to substance use or the behaviours that lead you to use substances

Ask Participants: Have any of you begun to think about a relapse prevention plan? If so, ask if they would be willing to share what they see as important to include in the plan

Facilitator's Speaking Notes:

- There are important things you should consider when making your relapse prevention plan
- Consider the circumstances where you are more likely to use substances
- How will you manage your cravings?
- Consider scenarios that could lead to relapse, know your personal triggers
- Common triggers are: people that you use substances with, places where you use or get substances, thoughts, anniversaries or specific times of the year
- Create an action plan for yourself – what are some things you can do instead of using drugs or alcohol
- Try to fill your action plan with a variety of things including: leisure activities, good nutrition, available community supports, family and friends that you can lean on, journaling, etc.
- As we discussed earlier, the early days of recovery are the hardest
- Create a concrete plan for yourself for the early days. Think about what life will look like when you leave detox
- Keep yourself as busy as possible in the first couple weeks after you leave detox

Reminders:

- Give yourself grace – this is not an easy road
- Relapse does not equal failure
- Life will still throw you curveballs, plan ahead for these situations

Facilitator's Speaking Notes:

- Recovery is not easy, be kind to yourself
- Relapse is a completely normal part of recovery. If you do relapse, that does not mean that you failed
- Life will still be unfair at times. Don't paint yourself an image of recovery being all "sunshine and rainbows". Prepare yourself for the curveballs that life will throw your way
- You can't prevent bad things from happening, but you can prepare for them and change the way that you respond to them

You are *NOT* responsible for
your illness
but you *ARE* responsible for
your recovery

Facilitator's Speaking Notes:

- The most important takeaway from this group is: you are **not** responsible for your illness but you **are** responsible your recovery
- Take the time while you are here in a safe place, away from your triggers, and develop a recovery plan for yourself. It will be your best tool to prevent relapse once you leave the detox unit

- Are there any questions about recovery, or developing relapse prevention plans?
- Does anyone have any comments about developing a recovery plan?

- Once questions/comments are completed, hand out the recovery plan template and encourage participants to begin working on it
- Inform participants that their assigned nurse is available to help them with their recovery plan if they need additional support

- Provide each participant with the group summary, take home resource
- Give each participant the opportunity to complete the evaluation form. These do not need to be collected at the end of the session as there will be some individuals with inability to read/write that may need help to complete the evaluation form.
    - In an effort to not single these individuals out, please inform the group that if anyone requires assistance filling out the form, they can request help from their assigned nurse

Appendix A

Education Session Implementation Plan

1. Staff nurses will be given training to improve comfortability with conducting the education session
2. The education session will be piloted before being conducted by the unit staff
3. After staff nurses have completed training, they will be responsible for conducting the education session weekly
4. After the initial staff training is complete, any newly hired nurses who express interest in conducting the education session should be provided the opportunity to attend a session as part of their orientation to the unit
5. Conducting of the education should be rotated between nurses so everyone gains experience
6. When dividing the patient assignment, consideration should be given to the nurse who will be conducting the education session taking into account that he/she will be occupied for at least 1 hour as a result
7. The education session will be conducted weekly, every **Saturday morning**
8. Patients on the unit should be encouraged to attended the education session but made aware that it is not a mandatory part of their treatment
9. To increase participation, each nurse should provide their assigned patients with a brief description of the education session as well as the benefits of attending

Appendix B

Education Session Evaluation Plan

In an effort to ensure the education session continuously meets the needs of the patients, they will be given the opportunity to provide their feedback at the end of the session.

Inform participants that the completion of this evaluation form is voluntary.

The evaluation form that can be distributed to participants can be found at the end of this guide.

Please keep in mind, there will be patients who are not able to read and/or write. In an effort to ensure that these patients are not singled out, inform the group that they can take the form back to their rooms to complete and can bring it to the nursing station after it is completed. Please inform them that anyone who requires assistance filling out the form can request help from their assigned nurse.

Evaluation Form

1. Did you find the education session helpful (circle one)?
   YES **NO**

2. If **no**, please explain why:
   _____
   _____
   _____

3. What did you like about the education session?
   _____
   _____
   _____

4. What about the education session do you feel could be improved?
   _____
   _____
   _____

5. Would you recommend this education session to patients who did not attend (circle one)?
   YES **NO**

6. If you answered **no** to question 5, please explain why:
   _____
   _____
   _____

7. Do you have more knowledge about your substance use disorder and recovery plan after attending this education session (circle one)?
   YES **NO**

Appendix D

Recovery Plan Template

_____’s

Recovery Plan

Use this template to help guide your recovery and prevent relapse upon discharge from the withdrawal management unit. Make sure you reference it frequently in the early days of recovery.

My Motivators to Stay Sober Are:	

Use this table to outline what your biggest motivating factors are to maintain sobriety. Some common examples are: physical health, mental health, children, family relationships, etc.

My Biggest Triggers Are:	

Use this table to identify your biggest triggers. Think about people, situations, places, emotions etc.

Warning Signs That I Might Be Slipping Back into Old Behaviours:	

Use this table to outline your personal warning signs that you are letting your recovery slip. For example, engaging in less self-care, communicating with friends that you used with, ignoring your mental health, etc.

People I Can Rely on for Support:	
Name: Phone Number:	Name: Phone Number:
Name: Phone Number:	Name: Phone Number:
Name: Phone Number:	Name: Phone Number:

Use this table to identify the people in your support system. Think of as many people as you can, and also list their contact information so you have it on hand when you need it.

My Coping Skills/Action Plan:	

Use this table to outline your coping skills and things that you can do instead of using substances. Some examples include: journaling, mindfulness, exercise, calling a support person, reading, watching a movie, etc.

What Will Happen if I Relapse?	What Will Happen if I Stay Sober?

Use this table to think about how your life will look if you relapse to substance use versus it will look if you maintain sobriety. Reference this table when you are in a moment of immediate decision making regarding whether or not to use substances to help guide your decision.

My Pocket Recovery

My Motivators to Stay Sober:

_____
_____
_____
_____

My Coping Skills:

_____
_____
_____
_____

People I can call for Support:

_____
_____
_____
_____

What Will Happen if I Relapse:

_____
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What Will Happen if I Stay Sober:

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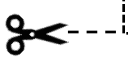

Cut along dotted line and keep this recovery plan with you for quick reference when you are faced with one of your triggers or are feeling the urge to use

Appendix E

Patient Take Home Resource

Your Mental Health and Addictions Team is Always There to Support You!

Mental Health Mobile Crisis Team: 1-888-429-8167

Central Intake Line: 1-855-922-1122 for connection to a variety of services offered within NSHA including:

- Addictions Day Treatment Program
- Community Mental Health and Addictions Services (individual and group therapy)
- Driving While Impaired (DWI) Program
- Stop Smoking Services

Remind Yourself

"I am not defined by my relapses, but by my decision to remain in recovery despite them"

– Anonymous

MEMORIAL UNIVERSITY

CREATED BY LINDSAY MAXWELL, RN BN MN
As part of the requirement for the Masters of Nursing
Degree obtained from Memorial University of Newfoundland

Substance Use Disorders

PHYSIOLOGY, TYPES AND RECOVERY

Patient Information Booklet

Table of Contents

Community Resources

For the most up to date resources please call 211

General Resources

Wellness Together Canada – 1-866-585-0445
Community Addictions Peer Support Association (CAPSA) – www.capsa.ca
Therapy Assistance Online (TAO) – www.taoconnect.org
Breaking Free Wellness – wellness.breakingfreeonline.ca
Together All – www.togetherall.com
12-step meetings (AA, NA and CA)
Canadian Mental Health Association – branches across NS
Direction 180 – Opioid treatment program
Mainline Needle Exchange – 1-877-904-4555
SMART Recovery – www.smartrecovery.org
Mindwell U – mindwellu.com/novascotia
Sober City – sobercity.ca
Mobile Outreach Street Health (MOSH) – 902-429-5290
Searidge Recovery Home – 1-888-777-9953
Terradyne Wellness Center – 1-902-889-2121

2SLGBTQIA+ Resources

Untoxicated Queers – Facebook group "Untoxicated Queers"
The Tribe Wellness Community – support.therapytribe.com

Gender Specific Resources

For Women:
Marguerite Centre – www.themargueritecentre.com
Women's Wellness Program – 1-855-922-1122
Ledgehill for Women – 1-866-750-3181
For Men:
Ledgehill for Men – 1-866-750-3181
Freedom Foundation – 1-902-466-0299
Alcare Place – 1-902-423-9565

BIPOC Resources

Eskasoni Mental Health – for Mi'kmaq people of Eskasoni, Cape Breton
First Nations Services – available in First Nations communities across NS
Hope for Wellness Help Line – 1-855-242-3310
Hope for Wellness Online Chat – www.hopeforwellness.ca
Nova Scotia Brotherhood Initiative – 902-434-0824

Recovery from SUD

Remind Yourself:

- Recovery looks different for everyone
- Early recovery is the hardest
- Recovery is on ongoing journey
- Relapse is a part of recovery

You are not responsible for your illness but you are responsible for your recovery

Post-Acute Withdrawal Syndrome (PAWS)

Ongoing psychological and mood symptoms that persist for several months up to a year

Occurs because your body is "relearning" to make its own chemical messengers

Symptoms: low mood, anxiety, inability to experience pleasure, fatigue, insomnia, not feeling like yourself and decreased concentration

Relapse Prevention Planning

Ensure you have a detailed relapse prevention plan completed **before** you leave detox

Consider your triggers, cravings, healthy tools, and an action plan

Remember that the early days of recovery are the hardest

Recovery is **not** easy – plan ahead for stressful situations you may experience and consider how you will cope with them

Overview of SUD

BIO

Parts of your biology put you at risk for SUD
Sex – males are more likely to have SUD than females
Genetics – there is a genetic link with SUD
Neurotransmitters – a lack of specific chemical messengers in the brain can make you more likely to develop a SUD

PSYCHO

Psychological factors also contribute to your risk for developing SUD
These factors include: personality traits, mental health issues such as anxiety and depression, past life experiences and a history of trauma

SOCIAL

Your social environment also plays a part in your risk for developing a SUD
Factors such as social norms, exposure to drugs/alcohol at an early age, cultural beliefs, socioeconomic status and a lack of social support all contribute to the likelihood of developing a SUD

How SUD Affects the Brain

Neurotransmitters

Neurotransmitters are the "chemical messengers" that send information throughout our brain and to different areas of our body

Substance use prevents neurotransmitters from functioning the way they are supposed to

Large amounts of neurotransmitters "teach" your brain to want more drugs/alcohol to maintain the feeling of pleasure

Behaviour Changes

SUD and withdrawal from substances can change your behaviour and personality. Common symptoms include:

- Dishonesty
- Anger and/or aggression
- Manipulative behaviours
- Risk taking
- Forgetfulness
- Frequent mood swings
- Depression and anxiety
- Paranoia
- Isolation
- Lack of interest in things you once enjoyed

Types of SUDs

Alcohol Use Disorder

- Your brain/body becomes used to having alcohol and struggles to function when you take it away
- Withdrawal symptoms: tremors, anxiety, nausea/vomiting, headache, increase heart rate and blood pressure, sweating, irritability, confusion, insomnia, nightmares and in extreme cases delirium tremens (DTs)
- Treatment: benzodiazepines (primarily diazepam or lorazepam), vitamins, thiamine and fluids

Stimulant Use Disorder

- Stimulants increase dopamine in your brain which "speeds up" many body systems
- Withdrawal symptoms: increased appetite, fatigue, low mood, nightmares/unpleasant dreams
- Treatment: cognitive behavioural therapy (CBT), 12-step programs/peer support
- No medication, as of yet, has been shown to help with stimulant withdrawal

Opioid Use Disorder

- Opioids block pain messages being sent to your brain and releases dopamine
- Withdrawal symptoms: anxiety, goosebumps, restlessness, insomnia, yawning, runny nose, watery eyes, dilated pupils, body aches, sweating, vomiting, belly cramps, diarrhea, fever, shaking, high heart rate and blood pressure, rapid breathing, hallucinations and seizures
- Treatment: methadone/suboxone, medications for vomiting, diarrhea and body aches

Appendix F

Support Person Resource

BIOPSYCHOSOCIAL MODEL

Biological Factors

- Certain "brain chemicals" lacking
- Genetics

Psychological Factors

- Mental illnesses
- Personality traits
- Trauma

Social Factors

- Childhood
- Social environment
- Social norms

Document References:

Families for Addiction Recovery (n.d.). *Understanding addiction.* FAR Canada. https://www.farcanada.org/understanding-addiction/what-is-addiction/

Villa, L. (2021, August 6). *Addiction signs, symptoms, effects and treatment.* American Addiction Centers. https://www.recovery.org/addiction/

Created by:
Lindsay Maxwell, RN BN MN
As part of the requirement for the Masters of Nursing degree
MEMORIAL UNIVERSITY

SUPPORTING A LOVED ONE WITH A SUBSTANCE USE DISORDER

HOW TO SUPPORT THEM AND YOURSELF

UNDERSTANDING ADDICTION

Substance use disorder (SUD) is a brain disorder that occurs when an individual cannot control substance use despite negative consequences

Biology, psychological and social factors all play a part in someone developing a SUD. This is presented in the "biopsychosocial model"

SUD tricks the brain into wanting to use substances to feel good

Substances help those with addiction to feel normal or to numb their pain

Addiction is *not* a moral failing and it *is* a treatable disease

Relapse is a normal and expected part of recovery

HOW TO SUPPORT YOUR LOVED ONE

- Care for yourself so you are able to be a strong support person (Resources available for you are presented in this pamphlet)
- Equip yourself with knowledge and an understanding of addiction
- Remind yourself that addiction is a disease and your loved one is sick
- Maintain hope and use positive reinforcement
- Set appropriate boundaries and work hard to stick to them
- Do not use shame or guilt as a way to change your love one's behaviour. They are already feeling this pain

"Never underestimate a recovering addict. We fight for our lives every day in ways most people would never understand" - Unknown

HOW TO SUPPORT YOURSELF

These are resources (information and support groups) available in HRM and online for those affected by a loved one's substance use

- "Affected Others" group program: self-refer at 1-855-822-1122
- AL-ANON support program: access at al-anonmaritimes.ca
- AL-ATEEN support for young people: access at al-anon.org
- Families Matter in Mental Health: register at ssns.ca or by phone at 902-465-2601
- Families for Addiction Recovery (support groups and education): access at farcanada.org
- Facebook groups: "The Addict's Mom", "TAM Canada", and "Parents of Children Struggling with Drugs and Alcohol"
- Resources for families: access at cathytaughinbaugh.com
- Guides for partners and parents: access at the20minuteguide.com
- Free online toolkit: access at addictionthenextstep.com