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GUIDELINES

TRANSFORMING
NURSING THROUGH
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Clinical Best
Practice Guidelines

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Engaging Clients Who Use Substances

RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
autorisés de l'Ontario

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Engaging Clients Who Use Substances

Greetings from Doris Grinspun,

Chief Executive Officer, Registered Nurses' Association of Ontario

The Registered Nurses' Association of Ontario (RNAO) is delighted to present the first edition of the clinical best practice guideline *Engaging Clients Who Use Substances*. Evidence-based practice supports the excellence in service that health professionals are committed to delivering every day. RNAO is delighted to provide this key resource.

We offer our heartfelt thanks to the many stakeholders who are making our vision for best practice guidelines a reality, starting with the Government of Ontario, for recognizing RNAO's ability to lead the program and for providing multi-year funding. For their invaluable expertise and leadership, I wish to thank Dr. Irmajean Bajnok, Director of the RNAO International Affairs and Best Practice Guidelines Centre, and Dr. Monique Lloyd, Associate Director. I also want to thank the co-chairs of the expert panel, Wayne Skinner (Deputy Clinical Director in the Addictions Program at the Centre for Addiction and Mental Health) and Dr. Caroline O'Grady (Assistant Professor, School of Nursing, York University) for their exquisite expertise and stewardship of this Guideline. Thanks also to RNAO staff Sabrina Merali, Tasha Penney and Glynis Gittens for their intense work in the production of this Guideline. Special thanks to the members of the expert panel for generously providing the time and expertise to deliver a rigorous and robust clinical resource. We couldn't have done it without you!

Successful uptake of best practice guidelines requires a concerted effort from educators, clinicians, employers, policy-makers and researchers. The nursing and health-care community, with their unwavering commitment and passion for excellence in client care, have provided the expertise and countless hours of volunteer work essential to the development and revision of each best practice guideline. Employers have responded enthusiastically by nominating best practice champions, implementing guidelines, and evaluating their impact on patients and organizations. Governments at home and abroad have joined in this journey. Together, we are building a culture of evidence-based practice.

We ask you to share this Guideline with your colleagues from other professions, because we have so much to learn from one another. Together, we must ensure that the public receives the best possible care every time they come in contact with us – making them the real winners in this important effort!

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How to Use this Document

This nursing Best Practice Guideline (BPG)[G]* is a comprehensive document that provides resources for evidence[G]-based nursing practice. It is not intended to be a manual or "how to" guide, but rather a tool to guide best practices and enhance decision making for nurses working with clients who use substances[G]. The Guideline should be reviewed and applied in accordance with both the needs of the individual organizations or practice settings, and the needs and preferences of the client[G]. In addition, the Guideline provides an overview of appropriate structures and supports for providing the best possible evidence-based care.

Nurses, other health-care providers[G], and administrators who lead and facilitate practice changes will find this document invaluable for developing policies, procedures, protocols, educational programs and assessments, interventions, and documentation tools. Nurses and other health-care providers in direct care will benefit from reviewing the recommendations and the evidence that supports them. We particularly recommend that practice settings adapt these guidelines in formats that are user-friendly for daily use.

If your organization is adopting this Guideline, we recommend that you follow these steps:

a) Assess your nursing and health-care practices using the recommendations in this Guideline,

b) Identify which recommendations will address needs or gaps in services, and

c) Develop a plan for implementing the recommendations. (implementation resources, including the RNAO's *Toolkit: Implementation of Best Practice Guidelines* (2nd ed.) (RNAO, 2012a) are available at www.RNAO.ca).

We are interested in hearing how you have implemented this Guideline. Please contact us to share your story.

* Throughout this document, terms marked with a superscript G ([G]) can be found in the Glossary of Terms (**Appendix A**).

Purpose and Scope

Best practice guidelines are systematically developed statements designed to assist nurses and the interprofessional team[G] to make decisions about appropriate health care (Field & Lohr, 1990). This Guideline provides evidence-based recommendations for nurses and other members of the interprofessional team across all care settings who are assessing and providing interventions[G] to individuals who use substances and may be at risk for or experiencing a substance use disorder[G].

In June 2010, RNAO convened four focus groups with 20 experts representing all sectors of health care who specialize in assessing substance use and intervening with individuals at risk for or experiencing a substance use disorder. The focus groups provided participants with the opportunity to discuss key strengths, potential gaps, and needs in the assessment[G], intervention, and management of substance use and substance use disorders. The resulting discussion provided direction for the development of this Guideline.

In October 2010, an expert panel consisting of an interprofessional team was convened and established the purpose and scope of this Guideline. The purpose of this Guideline is to provide nurses and the interprofessional team across all care settings with evidence-based recommendations related to assessment and interventions for individuals aged 11 years and older who use substances and may be at risk for or experiencing a substance use disorder. The expert panel further delineated that all individuals who use substances, regardless of a diagnosis of a substance use disorder, require support in decreasing risky behaviours from their substance use. The expert panel adopted the definition of a substance use disorder found in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM–5*; American Psychiatric Association [APA], 2013), which defines a substance use disorder as "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (APA, 2013, p. 483). For the purposes of this Guideline, the term "substance use disorder" will be used to indicate those at risk for problems associated with substance use, as well as those who meet the *DSM-5* criteria for a substance use disorder.

This Guideline provides best practice recommendations in three main areas:

- Practice recommendations[G] are directed primarily to nurses and other health-care providers in the interprofessional team who provide care for youth and adults across all practice settings.
- Education recommendations[G] are directed to those responsible for nursing and staff education, such as educators, quality improvement teams, managers, administrators, and academic institutions.
- System, organization, and policy recommendations[G] apply to a variety of audiences, depending on the recommendation. Audiences include managers, administrators, policy-makers, nursing regulatory bodies, and government bodies.

For optimal effectiveness, recommendations in these three areas should be implemented together.

The scope of this Guideline includes effective assessment and management interventions that can be utilized with individuals aged 11 and older who use substances and may be at risk for or are experiencing a substance use disorder. Also included are education, organization, and policy recommendations for improving access to care for these individuals.

Because assessment tools and management interventions for children under 11 years of age can differ significantly from those used with adolescents, adults, and older adults, the scope of this Guideline excludes children under 11 years of age. A comprehensive review of non-substance use disorders within the broader category of addictions

(e.g., gambling, shopping, eating disorders, internet/technology, sex, etc.) is also outside the scope of this Guideline, as assessment and management interventions can vary according to each particular disorder. Assessment – and management interventions specific to tobacco-related disorders have been excluded, as these are covered in RNAO Best Practice Guidelines pertaining to tobacco cessation (RNAO, 2007a). While the panel was cognizant of the relationship between substance use and mental health (i.e., concurrent disorder[G]), due to the complexities involved in working with this population, an exploration of this topic is beyond the scope of this Guideline. And, finally, while pharmacological interventions – including medication to treat withdrawal[G]/detoxification[G], substitution[G], maintenance overdose prevention, and abstinence[G] supports – are an important consideration when working with clients with substance use disorders, such interventions have been excluded from the comprehensive review due to the complexities associated with individual clients' characteristics and the nature of their substance use disorders.

This Guideline is designed to apply to all practice settings and across all domains of nursing practice – including clinical, administration, and education – to help nurses become more comfortable, confident, and competent when caring for clients who use substances and may be at risk for or experiencing a substance use disorder. It focuses on the core competencies and the evidence-based strategies that nurses and members of the interprofessional team require to assess and treat clients who use substances. Delivering effective care to such clients requires coordination between health-care providers, as well as open communication between health-care providers and their clients. In addition, clients' individual needs and preferences should be acknowledged, and the personal and environmental resources available should be considered.

Various factors will affect the successful implementation of the recommendations in this Guideline across settings. Individual nurses' skills and knowledge, and their professional judgment, are shaped over time by education and experience, and thus individual competencies vary. In all cases where the care needs of a client lie outside of the scope of a nurse's professional knowledge, the nurse should consult with other members of the interprofessional team (College of Nurses of Ontario [CNO], 2011). Governmental legislation, organizational policies and procedures, and the client population will also affect implementation of this Guideline.

A reference list and appendices (including a glossary of terms, a description of how this Guideline was developed, and details of our literature search) follow the main Guideline. See **Appendix A** for a glossary of terms. See **Appendices B and C** for the guideline development process and the process for the systematic review and search strategy. The remaining appendices include resources related to the screening, assessment, and management of substance use and substance use disorders.

Summary of Recommendations

PRACTICE RECOMMENDATIONS		LEVEL OF EVIDENCE
1.0 Assessment	Recommendation 1.1: Screen all clients to determine whether they use substances.	V
	Recommendation 1.2: For clients who use substances, use universal screening questions and/or an appropriate screening tool to determine the level of support required.	V
	Recommendation 1.3: Conduct a comprehensive assessment with all clients who screen positive for substance use, as appropriate based on the nurses' knowledge, skill, time, setting and resources.	V
2.0 Planning	Recommendation 2.1: Build collaborative relationships with clients through the use of motivational interviewing techniques to develop the plan of care.	Ia
3.0 Implementation	Recommendation 3.1: Use brief intervention to collaborate with clients identified as at risk for or experiencing a substance use disorder.	Ia
	Recommendation 3.2: Advocate for and support access to combined pharmacological and psychosocial interventions, as appropriate, and promote the appropriate use of combined interventions to improve well-being and health outcomes.	Ia
	Recommendation 3.3: Engage youth and adolescents at risk for or experiencing a substance use disorder using family-based therapies until recovery, as appropriate.	Ia
4.0 Evaluation	Recommendation 4.1: Reassess the effectiveness of the plan of care until the client's goals are met.	V

EDUCATION RECOMMENDATIONS		LEVEL OF EVIDENCE
5.0 Education	Recommendation 5.1: Integrate theory and clinical practice opportunities regarding care of clients at risk for or experiencing a substance use disorder into the undergraduate education of nurses and other health-care providers.	V
	Recommendation 5.2: Health-care providers participate in continuing education to enhance their ability to assess and work with clients at risk for or experiencing a substance use disorder.	Ib
	Recommendation 5.3: Nurses practice reflectively to enhance their awareness of their current and evolving attitudes, perceptions and biases, and values and beliefs when working with clients at risk for or experiencing a substance use disorder.	V

SYSTEM, ORGANIZATION AND POLICY RECOMMENDATIONS		LEVEL OF EVIDENCE
6.0 System, Organization and Policy	Recommendation 6.1: Advocate for improved health outcomes by: ■ Increasing access to integrative and collaborative care for clients at risk for or experiencing a substance use disorder; and ■ Reducing health inequities by dedicating resources to preventing, treating, and supporting the recovery of individuals at risk for or experiencing a substance use disorder.	V
	Recommendation 6.2: Organizations integrate prevention, assessment, and management of substance use and substance use disorders as a strategic clinical priority across all care settings.	V
	Recommendation 6.3: Organizations integrate components of harm reduction and the social determinants of health into comprehensive, multi-faceted approaches to addressing substance use disorders.	V
	Recommendation 6.4: Organizations use knowledge translation processes and multi-faceted strategies to integrate best practices in the assessment and management of substance use and substance use disorders across all practice settings.	V

Interpretation of Evidence

Levels of evidence are assigned to study designs to rank how well particular designs are able to eliminate alternate explanations of the phenomena under study. The higher the level of evidence, the greater the likelihood that the relationships presented between the variables are true. Levels of evidence do not reflect the merit or quality of individual studies.

Levels of Evidence

Ia	Evidence obtained from meta-analysis[G] or systematic reviews[G] of randomized controlled trials, and/or synthesis of multiple studies primarily of quantitative research.
Ib	Evidence obtained from at least one randomized controlled trial[G].
IIa	Evidence obtained from at least one well-designed controlled study[G] without randomization.
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study[G], without randomization.
III	Synthesis of multiple studies primarily of qualitative research[G].
IV	Evidence obtained from well-designed non-experimental observational studies, such as analytical studies[G] or descriptive studies[G], and/or qualitative studies.
V	Evidence obtained from expert opinion or committee reports, and/or clinical experiences of respected authorities.

Adapted from the Scottish Intercollegiate Guidelines Network (2011) and Pati (2011).

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Declarations of interest that might be construed as constituting an actual, potential or apparent conflict were made by all members of the Registered Nurses' Association of Ontario expert panel, and members were asked to update their disclosures regularly throughout the guideline development process. Information was requested about financial, intellectual, personal and other interests and documented for future reference. No limiting conflicts were identified.

Further details are available from the Registered Nurses' Association of Ontario.

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Stakeholder Acknowledgement

As a component of the guideline development process, the Registered Nurses' Association of Ontario is committed to obtaining feedback from nurses from a wide range of practice settings and roles, knowledgeable administrators and funders of health-care services, and stakeholder[G] associations. Stakeholders representing diverse perspectives were solicited* for their feedback, and the Registered Nurses' Association of Ontario wishes to acknowledge the following individuals for their contribution in reviewing this Nursing Best Practice Guideline.

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*Stakeholder reviewers are individuals who have expertise in the subject matter of the guideline or are representatives of organizations involved in implementing the guideline or are affected by its implementation. Reviewers may be nurses and other point-of-care health-care providers, nurse executives, administrators, research experts, members of the interdisciplinary team, educators, nursing students, or patients. RNAO aims to solicit stakeholder expertise and perspectives representing a diversity of health-care sectors, roles within nursing and other professions (e.g., clinical practice, research, education, and policy) and geographic locations.

Stakeholder reviewers for RNAO guidelines are identified in two ways. First, stakeholders are recruited through a public call issued on the RNAO website (http://rnao.ca/bpg/get-involved/stakeholder). Second, key individuals and organizations with expertise in the guideline topic area are identified by the RNAO guideline development team and expert panel and are directly invited to participate in the review.

Reviewers are asked to read a full draft of the guideline and participate in the review prior to its publication. Stakeholder feedback is submitted on-line by completing a survey questionnaire. The stakeholders are asked the following questions about each recommendation:

- Is this recommendation clear?
- Do you agree with this recommendation?
- Does the evidence support this recommendation?
- Does this recommendation apply to all roles, regions and practice settings?

The survey also includes opportunity to include comments and feedback for each section of the guideline.

Survey submissions received are compiled and feedback is summarized by the RNAO guideline development team. The RNAO expert panel reviews and considers all feedback and, if necessary, modifies the guideline content and recommendations prior to publication to address the feedback received.

Stakeholder reviewers have given consent to the publication of their names and contact details in this guideline.

Background

Substance Use and Substance Use Disorders

Substance use refers to the ingestion or administration of psychoactive substances – such as alcohol, tobacco, caffeine, illegal drugs, medications, solvents, and glues – that can be beneficial or harmful depending on the substance used and the quantity, frequency, method, and context of use (Ministry of Health Promotion, 2010; Rassool, 2010). The use of psychoactive substances is a cultural behaviour that has been occurring since the beginning of recorded human history (Ministry of Health Promotion, 2010). Not all substance use results in problematic behaviour or effects; however, in certain situations and depending on the type of substances consumed, substance use may lead to physical and psychological health problems in individuals, regardless of their socio-economic status or their geographical location.

A *substance use disorder*, in accordance with the *DSM–5*, is defined as "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (APA, 2013, p. 483). The diagnosis and classification criteria (see **Appendix D**) for a substance use disorder, also commonly referred to as an "addiction," are based on pathological patterns of behavior that include impaired control, social impairment, risky use, and pharmacological criteria (APA, 2013). For the purposes of this Guideline, the term "substance use disorder" will be used.

The three most commonly used psychoactive substances in Canada are alcohol, cannabis, and tobacco (Health Canada, 2014). Globally, Canada has the second highest level of prescription opioid use (e.g., morphine, codeine, oxycodone), and national prevalence rates of prescription opioids associated with substance use disorder are steadily increasing (National Advisory Committee on Prescription Drug Misuse, 2013). Among individuals aged 35 years and younger, cannabis, stimulants, and hallucinogens have been reported as the most common substances of choice (Pirie, Jesseman, Di Gioacchino, & National Treatment Indicators Working Group, 2014).

Although substance use disorders can occur at any age, they often begin in adolescence (Ministry of Health and Long Term Care, 2011). Young people between the ages of 15 and 24 years of age are three times more likely to have a substance use disorder than individuals over the age of 24 (Ministry of Health and Long Term Care, 2011). Statistics also indicate a gap in the number of individuals with a substance use disorder and the number who are accessing services to manage their substance use disorders (Pirie et al., 2014). In 2012, 4.4 percent of Canadians met the criteria for a substance use disorder, yet only 0.4 percent accessed publicly funded substance use intervention services, suggesting the need for better identification and management services (Pirie et al., 2014).

Development of a Substance Use Disorder

Substance use disorders result from a complex interaction of multiple factors. Risk factors include genetics, biological or physiological vulnerability (e.g., physical and mental illness, genetic predisposition to developing a substance use disorder, post-traumatic stress disorder), external psychosocial factors (e.g., stressors, trauma, social and family[G] situations), and internal factors (e.g., coping skills, and lack of resiliency) (Ministry of Health Promotion, 2010; RNAO, 2009). In addition, marginalization due to issues pertaining to the social determinants of health (such as social status, culture[G], social environment, and income) can add further complexity (Ministry of Health Promotion, 2010; RNAO, 2009).

Figure 1 illustrates the process of developing a substance use disorder. A substance use disorder is often, though not always, characterized by dependence and withdrawal. Dependence has two aspects: physical and psychological.

Rather than as separate, these can be thought of as two aspects of the same process. *Physical dependence* occurs when an individual develops *tolerance* to a substance, so that he or she requires an increased amount of the substance to achieve the desired effects, which often include "feeling normal" (APA, 2013; RNAO, 2009). *Psychological dependence* may occur with physical dependence, and is characterized by a pattern of compulsive substance use and craving – or an intense desire – for the substance due to the reinforcing effects of the substance (RNAO, 2009). Craving can occur at any time, but is more likely to be triggered by an environmental cue that is associated with previous use (APA, 2013).

Physical withdrawal symptoms, such as nausea, vomiting, palpitations, and tremors, may occur if the individual suddenly discontinues using the substance (RNAO, 2009). For this reason, individuals with a substance use disorder may continue to use substances to avoid the negative, debilitating feelings of withdrawal rather than to experience the feelings of euphoria that were associated with the initial experience of use (RNAO, 2009). In addition to physical withdrawal symptoms, sudden cessation of a substance can lead to psychological withdrawal symptoms, such as anxiety, irritability, or mood lability (APA, 2013; RNAO, 2009).

Figure 1: Process of Developing a Substance Use Disorder

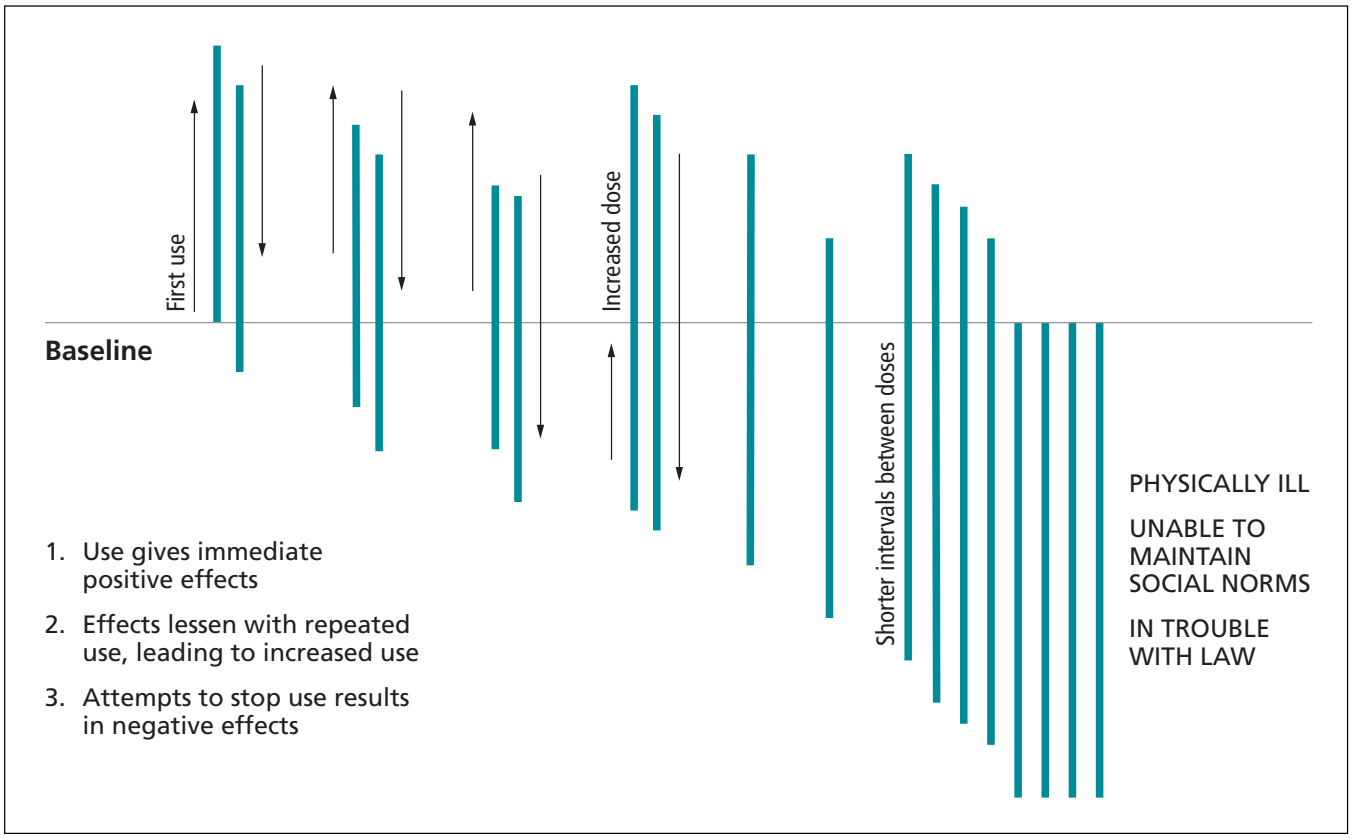


Figure 1. Adapted from M. Dykeman, personal communication, July 24, 2014.

A common misconception is that psychological dependence is not as serious as physical dependence (RNAO, 2009). However, it is important to note that a substance use disorder can occur without evidence of physical dependence (tolerance or withdrawal) and/or psychological dependence, depending on the substance consumed (APA, 2013). For example, opioids, alcohol, and nicotine have been shown to cause both physical (i.e., withdrawal) and psychological (i.e., craving) dependence, while cocaine causes only psychological dependence.

Societal Costs of Substance Use Disorders

Figure 1 illustrates some possible consequences of a substance use disorder for the individual, including physical illness, inability to maintain social norms, and negative interactions with the justice system. In Canada, the overall societal cost of substance use disorders in 2002 was estimated to be $39.8 billion, representing a cost of $1,267 for every Canadian (Ministry of Health Promotion, 2010; Rehm et al., 2006). This societal cost not only includes the direct costs of health care but also accounts for enforcement, research, prevention, and the indirect costs of lost productivity in the home and/or at work for individuals experiencing a substance use disorder (Ministry of Health Promotion, 2010; Rehm et al., 2006). Evidence demonstrates that significant morbidity, injury, and mortality resulting from substance use disorders could be reduced for future generations by implementing effective assessment, intervention, and prevention strategies for substance use disorders (Ministry of Health Promotion, 2010).

Stigma and Discrimination

Stigma[G] is defined as "a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation that results from experience or reasonable anticipation of an adverse social judgment about a person or group" (Martin & Johnston, 2007, p. 8). Unlike many other conditions, substance use disorders are often treated as a moral and criminal issues rather than as a health concern; clients with a substance use disorder are more likely to be perceived by health-care providers as having personal control over their illness and, therefore, are more likely to be held responsible and blamed (Livingstone, Milne, Fang, & Amari, 2012). Stigma contributes to a host of adverse outcomes for people at risk for or with a substance use disorder, including poor mental and physical health, barriers to engagement[G] or completion of substance use interventions, delayed recovery[G] or reintegration processes, and increased involvement in risky behaviour (Livingstone et al., 2012).

Prejudices are fostered by negative stereotypes, which are associated with stigmatization and create the conditions for discrimination[G]. The Ontario *Human Rights Code* (Government of Ontario, 2012) prohibits discrimination against individuals on a number of protected grounds in protected social areas (e.g., employment; accommodation; goods, services, and facilities). The protected grounds include but are not limited to age, ancestry, place of origin, colour, race, citizenship, ethnic origin, creed, sex, sexual orientation, gender identify, gender expression, marital status, family status, and disability; the "disability" ground covers a range of conditions, including physical disabilities, mental health issues, and severe substance abuse and dependence. For example, an employer who refuses to promote an employee due to the perception that the employee has experienced a substance use disorder in the past may be contravening provincial law by not providing equal opportunity and management services to the employee, as required by the Ontario *Human Rights Code* (Ontario Human Rights Commission [OHRC], 2011).

Discrimination is problematic for ethical, professional, and legal reasons, as it contravenes the Ontario *Human Rights Code*. It is important for health-care providers to be cognizant of their attitudes and behaviour when working with clients who use substances; to understand the ethical, professional, and legal implications of discrimination; and to engage in reflective practice in order to provide appropriate care to all clients.

Guiding Frameworks

The following frameworks were used to guide the literature review and the development of recommendations. They provide fundamental prerequisite knowledge and form the basis of each of the recommendations included in this guideline. It is recommended that nurses and other health-care providers receive adequate education and training with respect to these frameworks and apply them in their daily practice.

Social Determinants of Health

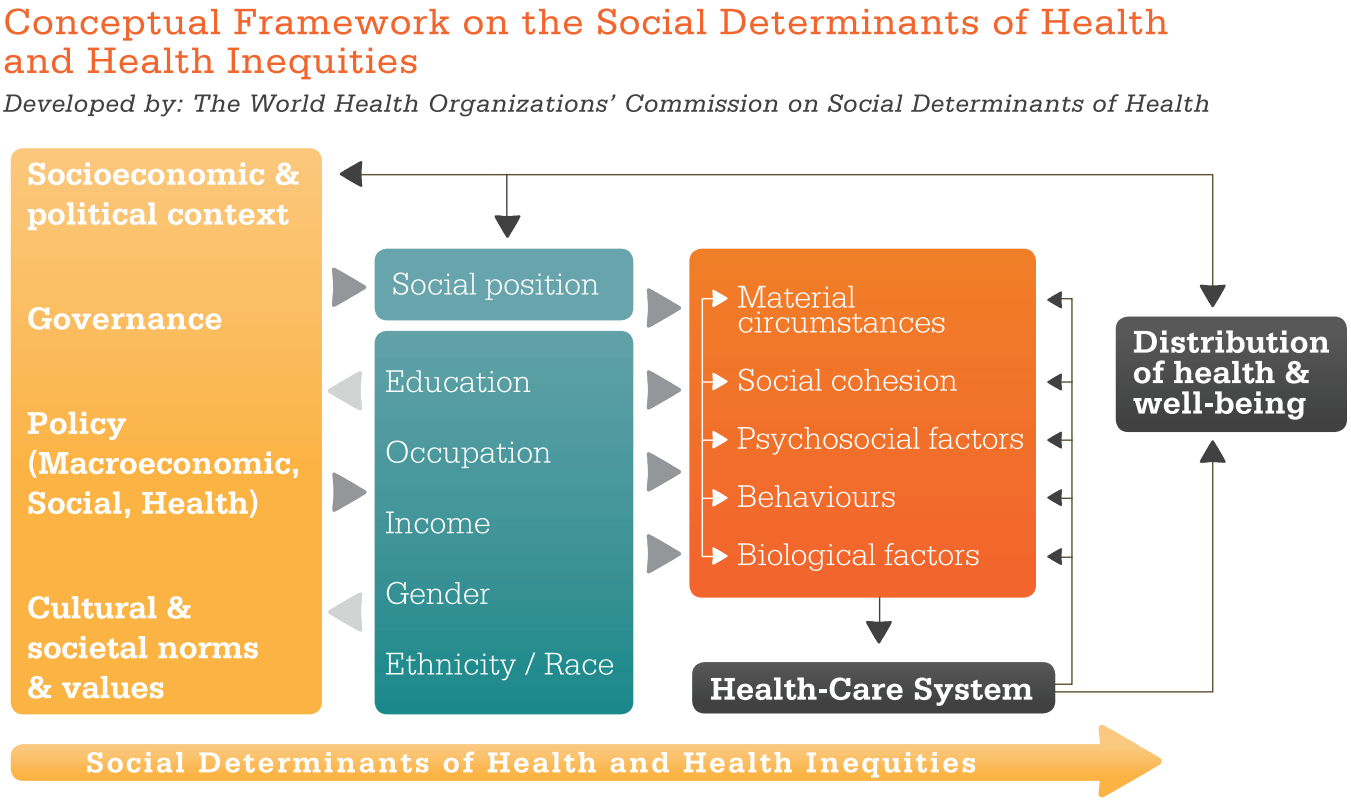
Ethical nursing practice endeavours to address broad aspects of the social determinants of health that are associated with the distribution of health and well-being (Canadian Nurses Association [CNA], 2009). The World Health Organization (WHO) defines the social determinants of health as:

> The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at the global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries. (WHO, 2014, "What are social determinants of health", para. 1)

The social determinants of heath include income and social status, education, biology and genetics, and health services, among other determinants. Health inequities – the differences in the health of individuals that result largely from the social determinants – are socially produced (and therefore modifiable), systemic in their distribution across the population, and unfair (National Collaborating Centre for Determinants of Health, 2013).

The goal for nurses when working with clients is to achieve health equity. *Health equity* means that all people can achieve their full health potential and not be disadvantaged from achieving this potential as a result of their social position or other socially determined circumstances (National Collaborating Centre for Determinants of Health, 2013). Figure 2, which provides a conceptual framework for the social determinants of health and health inequities, shows the broad categories of factors that shape health outcomes, and that nurses and others must address to achieve equitable distribution of health and health outcomes. The structural factors seen in the gold box on the far left side are the overarching systemic factors that affect equitable distribution of health and health outcomes (Nelson, 2012; WHO, 2014).

Figure 2: Conceptual Framework on the Social Determinants of Health and Health Inequities



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The Commission on the Social Determinants of Health, established by WHO to support countries in addressing the social factors that lead to poor health and health inequities, recommended the following three principles of action:

- Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
- Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.
- Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health (Commission on Social Determinants of Health [CSDH], 2008).

Nurses must recognize the significance of the social determinants of health, and must individually and collectively advocate for and work toward eliminating health inequities (CNA, 2009). When working collaboratively with clients who use substances, nurses must acknowledge the social determinants that affect their clients' health and well-being, including their income and social status, their social support networks, their education, and their personal coping skills (Public Health Agency of Canada [PHAC], 2001). Nurses have a responsibility to incorporate their knowledge of health determinants into their assessment, plans, and interventions when working with clients who use substances. **Appendix E** lists 14 social determinants of health identified in the Canadian context with which nurses should be familiar.

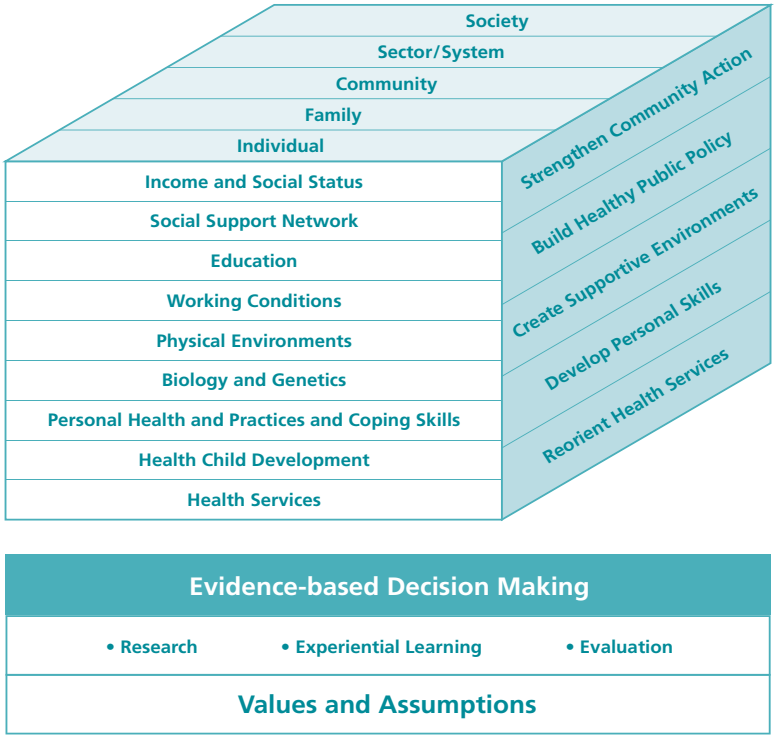
Population Health Promotion Model

Population health promotion[G] aims to improve the health of the entire population and to reduce health inequities among population groups (Hamilton and Bhatti, 1996). Consequently, this model of care addresses a broad range of factors and conditions that influence health (Hamilton and Bhatti, 1996). The relationship between population health and health promotion[G] is depicted by the Population Health Promotion Model (see Figure 3). This model illustrates how the health of a population can be improved through health promotion interventions and strategies that act on the factors and conditions that determine health (Hamilton and Bhatti, 1996). The model consists of three major components, each of which is represented on one of the visible sides of the cube:

1. Social determinants of health (shown on the front facing side),
2. Comprehensive action strategies (shown on the right side), and
3. Levels of action (shown on the top side).

A population health promotion approach should be used to create comprehensive initiatives in communities aimed at preventing and reducing the risk for substance use through building resilient communities (Hamilton and Bhatti, 1996; Health Canada, 2008). Nurses should apply the principles of population health promotion to plan, implement, and evaluate substance-use-prevention initiatives. **Appendix F** provides some examples of prevention-based strategies that nurses and other health-care providers can employ to prevent and reduce the risk of substance use in communities and help build resilient communities.

Figure 3: Population Health Promotion Model



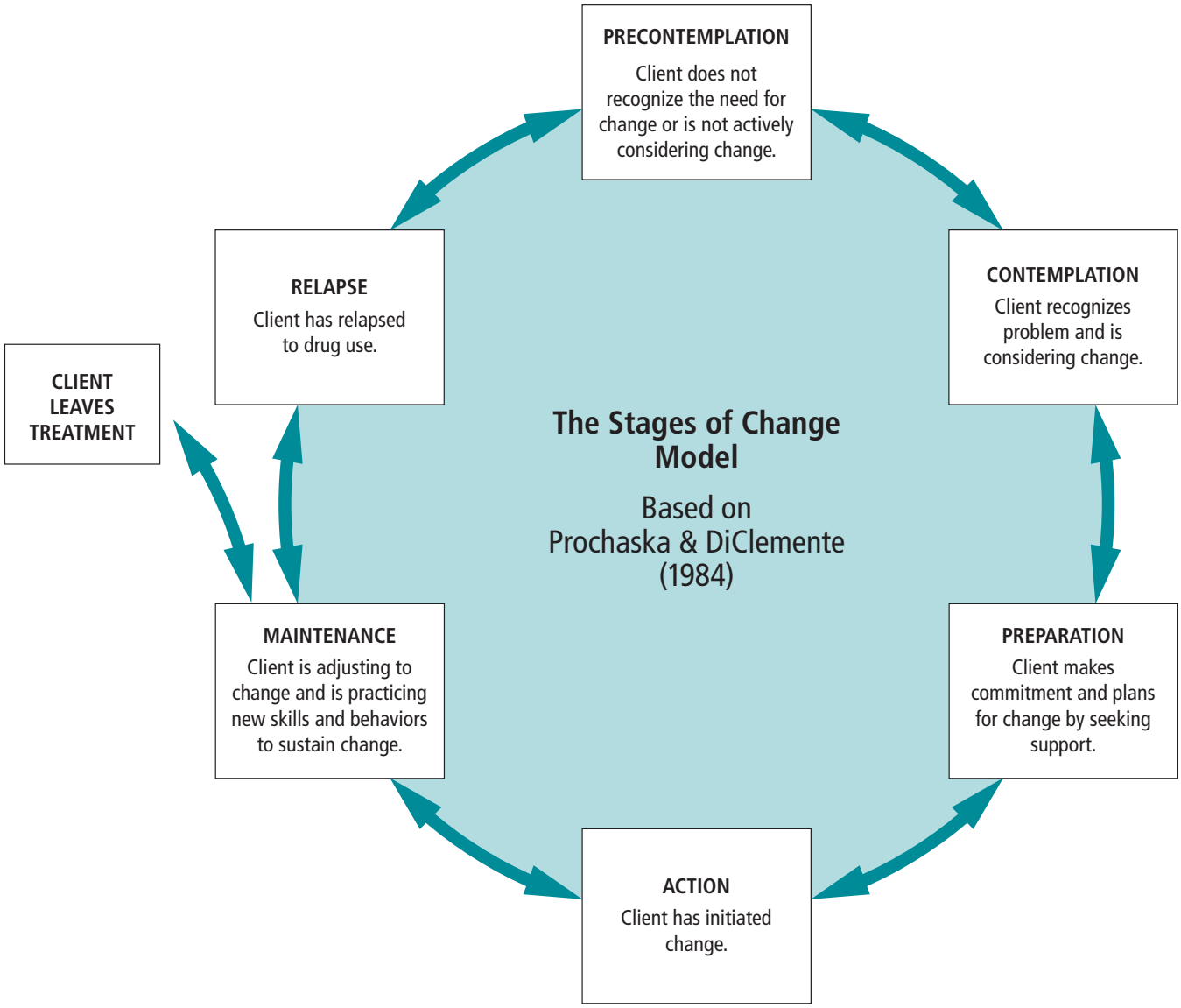
Population Health Promotion Model

Reprinted from, *Population Health Promotion: An Integrated Model of Population Health and Health Promotion*, by Hamilton and Bhatti, 1996. Public Health Agency of Canada, 2001. Reprinted with permission from the Minister of Health, 2014.

Transtheoretical Model of Change

The Transtheoretical Model (TTM) of Change was developed by Prochaska and DiClemente (1984) to describe the process of behaviour change. The TTM, reproduced in Figure 4, illustrates behavioural change as a progression through a series of five stages (Prochaska & DiClemente, 1984). The process of change is non-linear and is unique for each individual. The model helps practitioners assess and identify the stage that a particular individual is at with respect to change, enabling stage-appropriate engagement and intervention strategies (Prochaska & DiClemente, 1984). Nurses should use the TTM to assess, plan, and design interventions in collaboration with clients who use substances. Specific guiding questions that clinicians can use at each stage of the TTM are listed in **Appendix G**. Using the TTM, health-care providers can collaborate with individual clients to address their specific needs in the change process (Prochaska & DiClemente, 1984).

Figure 4: Transtheoretical Model of Change



Adapted from "Screening and Assessment Practices," by L. Sibley, 2014, *Fundamentals of Addiction: A Practical Guide for Counsellors*, p. 172, by M. Herie and W. Skinner (Eds.). Copyright 2014 by the Centre for Addiction and Mental Health. Adapted with permission.

Harm Reduction

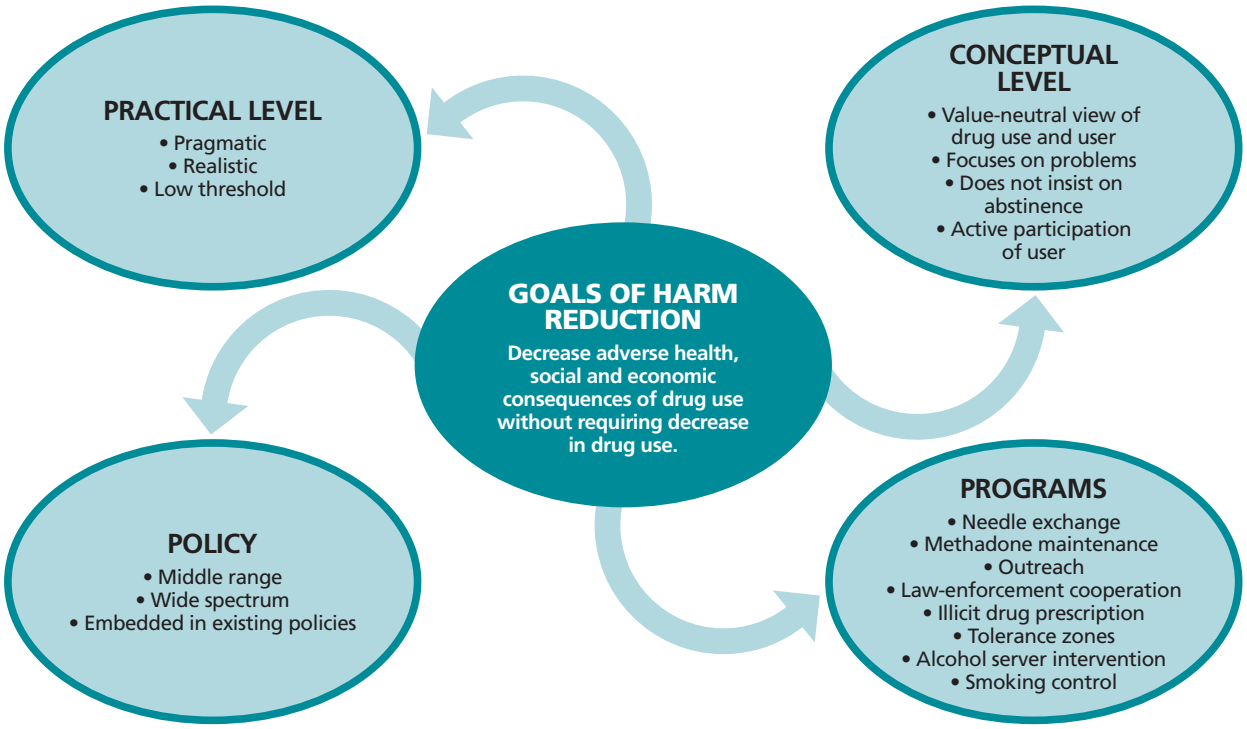
Harm reduction[G] refers to practices, programs, and policies that aim to reduce the adverse health, social, and economic consequences of substance use without requiring individuals to abstain from substance use (CNA, 2011; Rassool, 2010). Harm reduction:

- Is an alternative to the disease causation model of substance use;
- Accepts that at any given time some people are not ready to choose abstinence;
- Accepts that substance use occurs in society and works to minimize its harmful effects;
- Accepts that people who are substance-dependent should have a voice in the creation of programs and policies designed to serve them;
- Values patient autonomy; and
- Does not exclude abstinence as an option (Beirness, Jesseman, Notarandrea, & Perron, 2008; CNA, 2011).

Harm reduction acknowledges that substance use is a complex phenomenon that encompasses a continuum of behaviours, and aims to minimize the harmful effects of substance use (CNA, 2011; Rassool, 2010). The approach calls for non-judgmental provision of care, and advocates for equal access to resources and services for care. Furthermore, harm reduction strives to provide care within the communities that clients live in and in the areas and conditions where substances are used, rather than in contexts that are removed from these settings (Rassool, 2010). Harm reduction recognizes the realities of poverty, racism, social isolation, past trauma, and other social inequalities that affect a person's vulnerability and capacity to deal effectively with substance-related harm, but does not attempt to minimize or ignore the dangers associated with such use (Rassool, 2010). Figure 5 illustrates the goals, guiding principles, and some of the programs that may be associated with harm reduction.

Nurses should integrate principles of harm reduction when working with clients who use substances and when treating those at risk for or experiencing a substance use disorder. Before using this approach with clients, nurses must understand the principles of harm reduction and must be aware of and address their own attitudes and biases. Applying a harm reduction framework allows nurses to tailor their approach in order to meet clients "where they are," establish goals collaboratively with the client, and develop a client-centered plan of care, while building trust and autonomy in the nurse–client relationship (RNAO, 2009).

Figure 5: Harm Reduction Model



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Trauma-Informed Approaches to Care

Trauma is defined as an experience that overwhelms an individual's capacity to cope (Canadian Centre on Substance Abuse [CCSA], 2012). Whether it is experienced early in life or later in life, trauma can be devastating (CCSA, 2012). Trauma can result from a number of negative experiences, including: abuse or neglect during childhood, disrupted attachment in early life, violence, accidents, natural disasters, war, sudden unexpected loss, and other life events that are outside of one's control (CCSA, 2012). Such experiences can interfere with individuals' sense of safety, self, and self-efficacy, as well as their ability to regulate emotions and develop and maintain positive relationships (CCSA, 2012).

Trauma is pervasive and can be life-changing, especially for those who have faced multiple traumatic events, repeated experiences of abuse, or prolonged exposure to abuse (CCSA, 2012; Klinic Community Health Centre, 2008; National Child Traumatic Stress Network, 2008). Individuals who have experienced trauma are at greater risk for developing a substance use disorder (Macy & Goodbourn, 2012). Trauma is a *response* to an overwhelmingly negative experience and, for many persons with trauma histories, substance use is an attempt to cope with trauma symptoms (CCSA, 2012).

Nurses should utilize a trauma-informed perspective to care when assessing and treating all clients who use substances, even when trauma is not suspected in clients. In trauma-informed services, it is not necessary for the client to disclose his or her trauma, and is it not expected that the clinician will treat the client's trauma (CCSA, 2012). Rather, a trauma-informed perspective results in a particular approach and acknowledges how common trauma is among clients who use substances, and the manifestations of trauma in their lives. The result is the creation of a culture of non-violence, learning, and collaboration. Table 1 sets out the four key principles of trauma-informed approaches as outlined by the Canadian Centre on Substance Abuse (2012).

Table 1: Key Principles of Trauma-Informed Approaches

1. Trauma awareness	All services taking a trauma-informed approach begin with building awareness among staff and clients of: how common trauma is; how its impact can be central to one's development; the wide range of adaptations people make to cope and survive; and the relationship of trauma with substance use, physical health and mental health concerns. This knowledge is the foundation of an organizational culture of trauma-informed care.
2. Emphasis on safety and trustworthiness	Physical and emotional safety for clients is key to trauma-informed practice because trauma survivors often feel unsafe, are likely to have experienced boundary violations and abuse of power, and may be in unsafe relationships. Safety and trustworthiness are established through activities such as: welcoming intake procedures; exploring and adapting the physical space; providing clear information about the programming; ensuring informed consent; creating crisis plans; demonstrating predictable expectations; and scheduling appointments consistently. The needs of service providers are also considered within a trauma-informed service approach. Education and support related to vicarious trauma experienced by service providers themselves is a key component.
3. Opportunity for choice, collaboration and connection	Trauma-informed services create safe environments that foster a client's sense of efficacy, self-determination, dignity and personal control. Service providers try to communicate openly, equalize power imbalances in relationships, allow the expression of feelings without fear of judgment, provide choices as to treatment preferences, and work collaboratively. In addition, having the opportunity to establish safe connections – with treatment providers, peers and the wider community – is reparative for those with early/ongoing experiences of trauma. This experience of choice, collaboration and connection is often extended to client involvement in evaluating the treatment services, and forming consumer representation councils that provide advice on service design, consumer rights and grievances.
4. Strengths-based and skill building	Clients in trauma-informed services are assisted to identify their strengths and to further develop their resiliency and coping skills. Emphasis is placed on teaching and modelling skills for recognizing triggers, calming, centering and staying present. In her Sanctuary Model of trauma-informed organizational change, Sandra Bloom described this as having an organizational culture characterized by 'emotional intelligence' and 'social learning.' Again, parallel attention to staff competencies and learning these skills and values characterizes trauma-informed services.

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Cultural Competence and Cultural Safety

Culture is a process that happens between individuals and groups within communities that shapes personal identity and confers social meaning and significance (CNA, 2008). In providing client-centred care, the nurse should reflect upon the client's and their own cultural perspectives and consider how these different perspectives may affect the caring relationship (CNO, 2009). In clients who use substances, these differences can affect the way in which substance use is discussed and managed within the nurse-client relationship (RNAO, 2009). When working with clients from different cultural backgrounds, it is important to remember that there is not one right approach, rather each client situation should be treated uniquely. In caring for clients who use substances, nurses should conduct individualized assessments and plan nursing care in collaboration with the client. Assessments and plan of care should focus on the client's needs (CNA, 2008).

Cultural competence[G] is the application of knowledge, skills, attitudes, and personal attributes required by nurses to provide appropriate care and services in relation to the cultural characteristics of their client, be it the individual, family, group, or community (RNAO, 2009). Nurses demonstrate cultural competence by being able to: (1) develop an awareness of one's self without letting it have an undue influence on those from other backgrounds; (2) demonstrate knowledge and understanding of the client's culture; (3) accept and respect cultural differences; and (4) adapt care to be congruent with the client's culture (International Council of Nurses, 2007). Nurses should seek to develop a greater understanding of other cultures and enhance their ability to ask culturally relevant questions when working with clients from different cultures. An important part of this process is self-reflection regarding one's own cultural beliefs, and ongoing interactions with colleagues and clients from other cultures (CNO, 2009). In applying the concept of cultural competence in practice, nurses must ensure that it is not used to stereotype or categorize people in ways that may cause stigmatization or marginalization (RNAO, 2009).

Cultural competence is necessary for the delivery of culturally appropriate care. The College of Nurses of Ontario (2009) has outlined the core tenets of the provision of care that is culturally appropriate, as shown in Table 2.

Table 2: Core Tenets of Providing Culturally Appropriate Care

- Individual assessments are necessary to identify relevant cultural factors within the context of each situation for each client;
- An individual's culture is influenced by many factors such as race, gender, religion, ethnicity, socio-economic status, sexual orientation and life experience. The extent to which particular factors influence a person will vary;
- Culture is dynamic. It changes and evolves over time as individuals change over time;
- Reactions to cultural differences are automatic, often subconscious and influence the dynamics of the nurse-client relationship;
- A nurse's culture is influenced by personal beliefs and by nursing's professional values;
- The nurse is responsible for assessing and responding appropriately to the client's cultural expectations and needs.

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Cultural safety[G] includes cultural awareness[G] (acknowledgement of difference), cultural sensitivity[G] (recognition of the importance of respecting difference), and cultural competence (skills, knowledge, and attitudes of practitioners) (RNAO, 2007b). Cultural safety addresses inequities in power structures by shifting power from the health-care provider to the client. Health-care providers must engage in reflection on the cultural, historical, structural differences, and power relationships that exist in order to provide clients with services that are culturally safe (Health Canada, 2011). Providers engaging with clients require excellence in relational practice to ensure that a respect for the client's culture is reflected in practice. Cultural safety extends beyond the nurse–client relationship to encompass the health-care environment, including service design, policy, human resources, service delivery, and the achievement of health outcomes that are meaningful and culturally relevant (National Advisory Committee on Prescription Drug Misuse, 2013).

Recovery Perspective

Recovery is a paradigm that is conceptualized and understood as a process that is unique to each individual. It is not defined as an endpoint, but rather as a journey that is rooted in the cornerstones of dignity, hope, empowerment, and resilience (Forchuck, 2003; Jacobson & Curtis, 2000). A number of definitions and frameworks that articulate the concept of recovery have emerged from several spheres, including the psychosocial rehabilitation movement, addictions, mental health, and social activism (Anthony, 1993; Jacobson & Curtis, 2000; Jacobson & Greenley, 2001).

The recovery perspective guides how nurses engage with clients along the spectrum of substance use. The overarching themes of dignity, hope, resilience, relationships, creating meaning of one's life, and self-efficacy in each person's unique and evolving journey are the guiding principles of the recovery perspective (Deegan, 1988; Forchuk, 2003; Jacobson, 2012; Jacobson & Curtis, 2000). The perspective acknowledges that recovery is a long-term process of internal change, and that these internal changes are processed through various stages (Substance Abuse and Mental Health Service Administration [SAMHSA], 2005). Recovery involves an ongoing process of refining oneself and learning to accept one's vulnerabilities; overcoming stigma and discrimination; regaining hope, control, and responsibility in one's life; and becoming engaged in meaningful social activities and community citizenship (Snow, 2010). By adopting a recovery perspective, nurses and other health-care providers acknowledge that recovery is a client-driven process that typically occurs outside of or following professional care, and which reinforces the client's long-term participation in management of their care (SAMHSA, 2005). It is imperative that nurses and health-care providers adopt a recovery-based perspective when working with clients who are experiencing issues with their substance use.

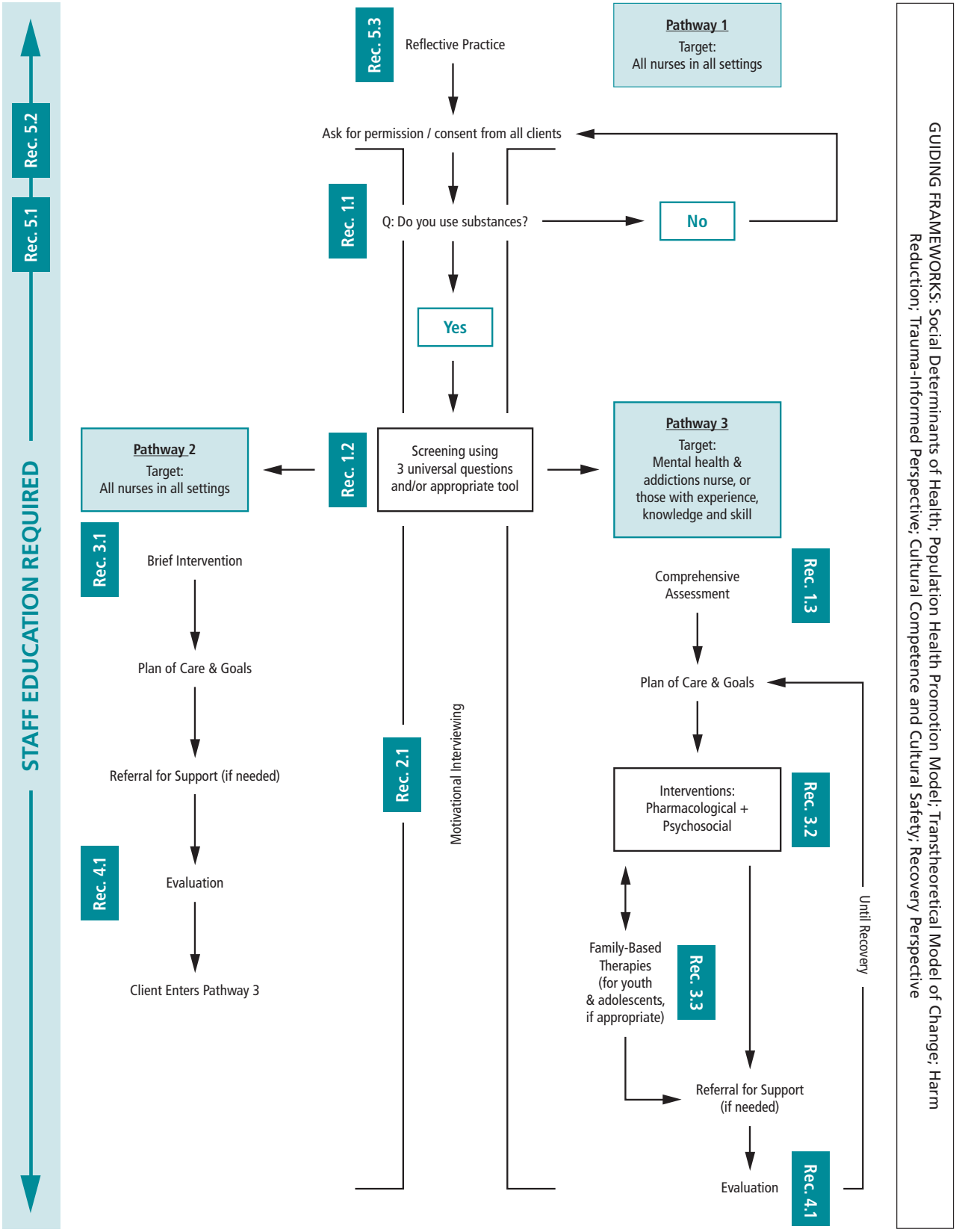
Algorithm for Engaging Clients Who Use Substances

The expert panel has developed an algorithm that depicts all of the practice and education recommendations in this Guideline that should be implemented across all practice settings (see Figure 6). The algorithm may be implemented in a stepwise approach or it may be abridged. The decision will depend on the health-care environment (e.g., emergency department, community health centre, mental health setting etc.), client factors (e.g., suspected risk or known substance use disorder), and nurse factors (e.g., knowledge and skill).

A nurse can complete all phases of the screening, assessment, intervention, and evaluation algorithm or involve other health-care providers as required. **Pathway 1** – encompassing screening of all clients to determine whether they use substances – is applicable to all nurses and other health-care providers across all practice settings, to initiate discussion regarding substance use. If a client screens positive for substance use, nurses or other health-care providers should further investigate using universal screening[G] questions or an appropriate tool to determine the level of support for care. **Pathway 2** – encompassing brief intervention[G], plan of care and goals, and referral for support – is applicable to nurses and other health-care providers across all practice settings who may have limited time, knowledge, and resources related to substance use. It outlines the minimal support required for all clients who use substances. **Pathway 3** – encompassing comprehensive assessment[G], plan of care and goals, interventions, and evaluation – is applicable to those nurses and other health-care providers who have specific knowledge, skill, time, and resources to work more closely to screen, assess, and intervene with clients who use substances. Pathway 3 can occur across all care settings, but occurs primarily in mental health and addictions practice settings.

RECOMMENDATIONS

Figure 6: Algorithm for Engaging Clients Who Use Substances



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Practice Recommendations

1.0 ASSESSMENT

RECOMMENDATION 1.1:

Screen all clients to determine whether they use substances.

RECOMMENDATION 1.2:

For clients who use substances, use universal screening questions and/or an appropriate screening tool to determine the level of support required.

Level of Evidence = V

Discussion of Evidence:

Screening is a formal process of testing to identify clients, at a particular period in time, who warrant more careful assessment to confirm or disconfirm potential risks for or diagnosis of a substance use disorder (Feldstein & Miller, 2007; Newton et al., 2011). Administering standardized screening instruments in a variety of practice settings (e.g., emergency departments, primary health-care settings, acute care settings, long-term care) has been shown to reduce substance use among clients; improve access to early interventions, thereby decreasing harms to clients' health and leading to positive client outcomes; and reduce health-care costs to the system (Burns, Gray, & Smith, 2010; Newton et al., 2011). All health-care providers across the continuum of care should be able to identify and carry out a basic screen and assessment with all clients to identify substance use and any potential physical or psychological health risks related to this use (National Institute for Health and Care Excellence [NICE], 2007). Standardized, appropriate screening tools[G] should be brief, easy to administer, appropriate for the target population, cost-effective, and reliable in identifying clients who require further assessment (Burns et al., 2010; Dhalla, Zumbo, & Poole, 2011; Health Canada, 2002; Lanier & Ko, 2008; Newton et al., 2011).

Initial Screening

The expert panel recommends that nurses conduct an initial screen with all clients to determine substance use (Figure 6). If a client does not use substances, the expert panel recommends that the nurse (a) provide health education teaching and positive validation for healthy behaviours, and (b) continue to screen for substance use, using the screening and assessment algorithm depicted in Figure 6 periodically. The timeframe for re-screening will depend on the practice setting and the frequency of contact with clients. The expert panel therefore recommends that nurses discuss the timeframe for re-screening with the client and utilize their own clinical judgment or repeat screening during all new episodes of care or as the client's situation changes.

Further Screening with Clients Who Use Substances

Clients who use substances may be at risk for developing associated problems from their substance use as well as be at risk for developing a substance use disorder. The expert panel recommends that nurses screen clients who identify as positive for substance use further, using either the universal screening questions or an appropriate screening tool, to identify those who are at risk for or experiencing a substance use disorder (Figure 6). Nurses should use their clinical judgment and expertise when deciding whether to use the universal screening questions or an appropriate screening tool with a particular client; a nurse may not see a clear clinical rationale for conducting a universal screen prior to utilizing an appropriate screening tool at every clinical encounter. Furthermore, a nurse may not have the knowledge or resources necessary to conduct a screen with an appropriate screening tool, but may be able to complete a universal screen and refer the client for further assessment.

Screening for substance use allows the nurse to (a) determine whether the client is consuming substances, (b) identify the frequency and amount of substance use, (c) identify problematic substance use that may result in risky behaviours or a substance use disorder, and (d) facilitate health education teaching. Nurses across the continuum of care should be aware of the health risks associated with substance use (e.g., cancer, myocardial infarction, etc.), and integrate screening and health education teaching into their care.

Universal Screening Questions

The purpose of universal screening is to identify whether a clients substance use is placing them at risk for various problems and may warrant further screening with an appropriate focused tool (see Figure 6) (Health Canada, 2002; SAMHSA, 2005). Universal screening requires minimal time and effort on the part of the nurse, and can take place either during initial contact or as part of ongoing assessment with the client. It is therefore recommended that nurses ask the following three universal questions to screen all clients for substance use on initial contact across all settings (Health Canada, 2002, p. 32):

1. Have you ever had any problems related to your use of alcohol or other drugs? (Yes/no)
2. Has a relative, friend, doctor or other health-care provider been concerned about your drinking or other drug use or suggested cutting down? (Yes/no)
3. Have you ever said to another person "No, I don't have [an alcohol or drug] problem," when around the same time, you questioned yourself and felt, "Maybe I do have a problem"? (Yes/no)

A positive response (i.e., when a client answers "yes" to any of the above questions) indicates the need for further investigation (Health Canada, 2002).

NOTE: If there are no positive responses to any of the universal screening questions, the expert panel recommends that the nurse provide health education teaching using brief intervention and positive validation for healthy behaviours and continue to screen for substance use using the screening and assessment algorithm depicted in pathway 2 in Figure 6 periodically. The timeframe for re-screening will depend on the practice setting and the frequency of contact with clients. The expert panel therefore recommends that nurses discuss the timeframe for re-screening with the client and determine the timeframe based on their clinical judgment or repeat screening during all new episodes of care or as the client's situation changes.

Appropriate Screening Tool

The expert panel recommends that an appropriate screening tool be utilized either following or instead of the universal screening questions, depending on the nurse's clinical expertise and judgment, the practice setting, and the time and resources available. **Appendix H** lists commonly used screening tools based on the specific substance(s) used, the client population being screened, and the clinical setting where tool is being utilized. The nurse plays an important role in administering the screen in collaboration with clients to identify potential risks associated with the client's substance use and to ensure that the findings are acted upon and communicated to the interprofessional team. Some of the tools listed in **Appendix H** take less than ten minutes to complete and do not require specialized training to administer (APA, 2006; Mdege & Lang, 2011). If a health-care provider is unfamiliar with the screening tools, the expert panel recommends that the provider seek appropriate support from an expert or administer the universal screening questions instead.

Other Considerations

Because screening tools vary according to the substance used, the characteristics of the target population to be screened, and the clinical setting, one single screening tool cannot be recommended for use with all clients in all situations. Rather, the expert panel recommends that health-care providers take a critical approach in determining the most appropriate tool in each situation and how best to use the tool based on the unique characteristics of each client and the clinical setting. When selecting and using a screening tool, health-care providers should observe the following guidelines:

- Nurses and other health-care providers should be familiar with the tools they are using;
- If the nurse or other health-care provider are unfamiliar with the appropriate tools, the provider should use the three universal screening questions listed above;
- Nurses and other health-care providers should assess the client's stage of change when conducting screening to help guide further interventions;
- Nurses and other health-care providers should demonstrate cultural competency when selecting and using particular screening tools;
- Due to the sensitive nature of the questions, when completing a screen with clients, nurses and other health-care providers should administer the tools with sensitivity and confidentiality; and
- Nurses and other health-care providers should use therapeutic communication skills to maintain client safety and build rapport with all clients, especially those from vulnerable populations[G].

RECOMMENDATION 1.3:

Conduct a comprehensive assessment with all clients who screen positive for substance use, as appropriate based on the nurses' knowledge, skill, time, setting and resources.

Level of Evidence = V

Discussion of Evidence:

The expert panel recommends that a comprehensive assessment be conducted with all clients who are identified as at risk for or experiencing a substance use disorder based on the universal and/or other appropriate screening tool. A comprehensive assessment should only be conducted by nurses' who have the appropriate knowledge, skill, time, and resources available (see Pathway 3, Figure 6). For nurses' in practice settings who may have limited time, knowledge, and resources related to substance use, please refer to Recommendation 3.1. The purpose of a comprehensive assessment is to obtain information about relevant aspects of an individual's substance use and the individual's perceptions, goals, strengths, motivations, and needs, in order to best facilitate planning and interventions for the management of their substance use (APA, 2006; SAMHSA, 2005). The comprehensive assessment is important because it leads to specific nursing interventions or referral to a specialist for diagnosis of substance use disorder or interventions for support. The assessment can also help the nurse or specialist to determine the level of care the client requires (e.g., case management or education sessions).

Table 3 identifies key areas for comprehensive assessment that nurses and other health-care providers should include when conducting an assessment with clients at risk for or experiencing a substance use disorder. If a health-care provider is unfamiliar with the key areas for comprehensive assessment listed in Table 3, the expert panel recommends that the provider seek out appropriate support from an expert.

When working with clients from vulnerable populations, it is important for nurses to consider the clients' unique needs in terms of access to care (e.g., culture, stigma), biological concerns (e.g., chronic pain, infections, aging, pregnant and postpartum, concurrent disorders), and risk for marginalization (e.g., working in the sex trade, incarceration) in order to provide ethical, respectful, and culturally sensitive care. Substance use can increase a client's risk for infection due to poor hygiene, poor living conditions and high risk behaviours (i.e. unprotected sex, sharing crack pipes or other drug paraphernalia) (CNA, 2011). Due to the increased health risks associated with substance use, the expert panel recommends that when conducting assessments, nurses be aware of potential infections that may result from intravenous (IV) drug use or high-risk behaviour including:

- Localized and systemic infections or abscesses;
- Cellulitis;
- Human immunodeficiency virus (HIV);
- Hepatitis B;
- Hepatitis C;
- Infective endocarditis; and
- Osteomyelitis.

See **Appendix I** for specific screening, assessment, and intervention considerations when working with various vulnerable populations.

Table 3: Key Areas for Comprehensive Assessment

Client's Goals	■ Reasons for seeking care ■ Immediate and long-term goals related to health-care concerns (i.e., physical and mental health) ■ Perceived obstacles to and supports in achieving current goals ■ Discussion of the impact of the client's substance use goals on his/her other health-care goals ■ Client's values and beliefs about the best outcome for himself/herself ■ Readiness and stage of change regarding substance use
Demographic & Socio-Economic Information	■ Age ■ Gender: sexual orientation and gender identity and/or gender expression ■ Cultural and ethnic background ■ Education/employment/income ■ Housing ■ Relationships ■ Legal: past or current involvement with the justice system ■ Circle-of-care supports: health-care providers, family, and other social supports ■ Cultural and diversity needs ■ Spirituality
Substance Use History	■ Substances used by client ■ Age of first use of each substance ■ Pattern of use (e.g., amount, frequency, duration of use, etc.) ■ Route of substance use (e.g., IV, smoking, snorting, etc.) ■ Withdrawal symptoms associated with substance use ■ Tolerance to substances ■ Substances of concern, as identified by the client ■ Access and use of harm reduction strategies (e.g., safer drug use education) and/or supplies (e.g., clean needles) ■ Triggers of substance use ■ Adverse consequences related to use ■ Increasing loss of control over use ■ Periods of abstinence and factors that supported abstinence ■ Past history of seeking help for substance use

Physical Health History and Medical Conditions	■ Diagnosed health conditions past and present ■ Medication: past and current (include over-the-counter medications and alternative/complementary medications) ■ Interventions and procedures ■ Experiences with interventions and services ■ Chronic pain ■ History of seizures ■ Dental issues ■ Sexually transmitted infections
Potential infections (resulting from IV drug use and/or high-risk behaviour)	■ Localized and systemic infections or abscesses ■ Cellulitis ■ HIV ■ Hepatitis B ■ Hepatitis C ■ Infective endocarditis, ■ Osteomyelitis
Mental Health History	■ History of mental health problems ■ Current mental health concerns ■ Current and past interventions for mental health problems (pharmacological and non-pharmacological) ■ Experiences with interventions and services for mental health problems ■ Trauma (emotional, physical, and psychological) ■ History of self-harm ■ Suicide attempts or thoughts of suicide ■ Feelings of anxiety or depression ■ Current ability to cope with emotions ■ Resilience and hopefulness
Family History of Substance Use and Mental Health Concerns	■ Information about relatives who have or have had issues due to substance use or a substance use disorder, and how they have managed (e.g., medications and therapies, current health status, etc.) ■ Information about relatives who have or have had mental health concerns, and how they have managed (e.g., medications and therapies, current health status, etc.)
Resilience and Strengths	■ Client-identified personal strengths and sources of resilience ■ Client-identified needs and supports to enhance resilience and strengths

(APA, 2006; SAMHSA, 2005)

2.0 PLANNING

RECOMMENDATION 2.1:

Build collaborative relationships with clients through the use of motivational interviewing techniques to develop the plan of care.

Level of Evidence = Ia

Discussion of Evidence:

Building collaborative relationships is essential when working with clients at risk for or experiencing a substance use disorder. Collaborative relationships between the health-care provider and the client allow for the creation of a therapeutic environment that fosters client well-being and autonomy throughout the process of recovery. Motivational interviewing[G] (MI) is an evidence-based counselling approach that is client-centered, non-directive, and non-judgmental, and which nurses can use in order to develop collaborative and empathic relationships with all clients in all practice settings.

As shown in Figure 6, MI should be used during screening, assessment, intervention, and evaluation when working with clients who use substances across practice settings. Through utilizing the MI approach, health-care providers work collaboratively with clients as they gain a deeper understanding of the client's needs, capabilities, and goals (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). The main goal of MI is to help the client examine and resolve ambivalence[G] in order to elicit and strengthen motivation for change (Lundahl et al., 2010; Rubak, Sandbaek, Lauritzen, & Christensen, 2005; Smedslund et al., 2011). When conducting MI, health-care providers employ a broad collection of techniques to help clients explore and resolve their ambivalence about behavioural change. Through counselling and the development of a collaborative relationship, the health-care provider assists clients to become more aware of the implications of changing or not changing (Lundahl et al., 2010). Health-care providers can use the MI approach when providing care – in particular, when creating the plan of care, which supports clients in setting their personal goals.

One systematic review of RCTs and one systematic review which included RCTs and controlled trials demonstrated MI to be 10 to 20 percent more effective in eliciting change and reducing substance use compared to no intervention (Lundahl et al., 2010; Smedslund et al., 2011). In a meta-analysis, Lundahl et al. (2010) found that MI approaches assisted with client improvement and increased client engagement in the interventions provided. Client engagement in MI leads to improvements on measures of readiness and motivation toward change, particularly with clients who are reluctant or ambivalent toward change (Dunn, Deroo, & Rivara, 2001; Rubak et al., 2005). Research has also shown that MI can be more effective in helping clients change their behaviours than traditional advice-giving alone (Rubak et al., 2005). MI can be effective even in brief encounters of only 15 minutes (Lundahl et al., 2010; Rubak et al., 2005). Individuals who have participated in MI intervention demonstrate enhanced retention in interventions and sustained positive outcomes beyond the initial intervention (Lundahl et al., 2010).

At the heart of MI is the nurse's ability to form empathic connections and collaborative relationships with clients that are free from judgment. For this reason, an emphasis on partnership, acceptance, compassion, and evocation is considered more important than the use of any particular skill or technique (Miller & Rollnick, 2013). Before conducting MI with clients, nurses should seek appropriate education and training, and incorporate the principles, techniques, and skills of MI into their daily practice.

3.0 IMPLEMENTATION

RECOMMENDATION 3.1:

Use brief intervention to collaborate with clients identified as at risk for or experiencing a substance use disorder.

Level of Evidence = Ia

Discussion of Evidence:

Brief intervention (BI) can be used effectively with clients at risk for or experiencing a substance use disorder to identify current or potential problems and motivate clients to change their behaviour. BI is applicable to nurses and other health-care providers across all practice settings who may have limited time, knowledge, and resources related to conduct a comprehensive assessment (see Pathway 2, Figure 6). BI is an evidence-based practice designed for use by health-care providers across settings to motivate clients to reduce or abstain from substance use (APA, 2006; McQueen, Howe, Allan, Mains, & Hardy, 2011). It is a time-limited intervention that seeks to identify individuals at risk for or experiencing a substance use disorder through screening and uses motivational feedback to help clients examine the benefits and drawbacks of behaviour change (APA, 2006; McQueen et al., 2011). BI as a client-centered approach respects the client's choice and autonomy in the formation of the care plan. The frequency, number, and length of BI sessions that individual clients receive varies, but the literature most commonly reports one to four sessions of 5- to 30-minutes in duration with a trained nurse or health-care provider (APA, 2006; McQueen et al., 2011).

The evidence suggests that even one short episode of BI is efficacious in improving outcomes (McQueen et al., 2011; Sullivan, Tetrault, Braithwaite, Turner, & Fiellin, 2011). BI is effective in motivating clients to change and encouraging those with more severe problems to consider referrals to specialized intervention services. It has been shown to decrease alcohol intake, risky drinking practices, and injury frequency (Nilsen, Aalto, Bendtsen, & Seppa, 2006). Two systematic reviews of RCTs and controlled trials demonstrated benefits to delivering BI in general hospital and primary-care settings to individuals who use alcohol (McQueen et al., 2011; Sullivan et al., 2011). In these studies, BI showed a greater reduction in alcohol consumption and decreased mortality rates compared to control groups (who did not receive BI) at six and nine months follow-up (McQueen et al., 2011), and was associated with 1.4 fewer standard drinks per week compared to control groups (Sullivan et al., 2011). Although these studies demonstrate the effectiveness of BI in the reduction of alcohol consumption, the expert panel recommends that brief intervention be used with all clients at risk for or experiencing a substance use disorder.

As illustrated in Figure 6, all nurses across all practice settings should be able to use brief interventions with clients at risk for or experiencing a substance use disorder. BI is an approach for which specialized training is available, and nurses should seek appropriate education and training, and develop a plan to incorporate BI into their clinical practice, before utilizing BI with clients.

Tools and guides for BI, particularly within the context of SBIRT (Screening, Brief Intervention, and Referral to Treatment) protocols, are available for use by clinicians. A sample SBIRT tool is provided in **Appendix J**.

RECOMMENDATION 3.2:

Advocate for and support access to combined pharmacological and psychosocial interventions, as appropriate, and promote the appropriate use of combined interventions to improve well-being and health outcomes.

Level of Evidence = Ia

Discussion of Evidence:

An integrated approach combining pharmacological and psychosocial interventions allows clinicians to address clients' physiological as well as their psychosocial needs (APA, 2006). The effectiveness of pharmacotherapy for treating substance use may be limited unless delivered in combination with psychosocial therapies (APA, 2006). While pharmacological therapies act rapidly to reduce physiological withdrawal and cravings, they do not address psychosocial symptoms that may be present during stabilization, detoxification, and recovery (Amato, Minozzi, Davoli, & Vecchi, 2011). Psychosocial interventions effect change through focusing on motivation, coping skills, and social relationships (APA, 2006).

Systematic reviews of RCTs and controlled trials demonstrated positive results for reducing substance use when combined pharmacological and psychosocial interventions where utilized (Amato et al., 2011; Kelly, Daley, & Douaihy, 2012). Combined pharmacological and psychosocial interventions have also been shown to result in increased client motivation and educational opportunities, and a supportive, health-promoting relationship between practitioner and client (APA, 2006). Promoting the use of combined pharmacological and psychosocial interventions is therefore an important part of the care that nurses provide in collaboration with clients at risk for or experiencing a substance use disorder. It is important that the clinician collaborate with the client, consider the client's choice, and respect their autonomy when deciding on management approaches and making decisions.

Pharmacological Considerations

Pharmacotherapy can play an important role in the management of withdrawal/detoxification, substitution, and overdose prevention[G], and can help support abstinence in clients with a substance use disorder. While a description of specific pharmacological interventions are beyond the scope of this Guideline, health-care providers should consider the use of pharmacotherapy as part of a combined intervention when working with clients who use substances or have a substance use disorders. In general, with respect to pharmacological management, nurses should ensure that: 1) pharmacotherapy options are considered in management planning; 2) clients have access to appropriate pharmacotherapy; and 3) pharmacotherapy is administered safely.

1) Pharmacotherapy Options

Nurses should engage the interprofessional team to ensure that a full range of pharmacological options is considered for the client. Drugs in the following six categories of pharmacological agents are used in the management of clients who use substances or have a substance use disorder:

- Medications to treat overdose and withdrawal;
- Medications to decrease the reinforcing effects of abused substances;

- Agonist maintenance therapies[G];
- Antagonist therapies[G];
- Abstinence-promoting and relapse prevention therapies; and
- Medications to treat co-morbid psychiatric conditions (APA, 2006).

The expert panel recommends that nurses refer to evidence-based resources, journals, and manuals for more information on the pharmacological management of clients with substance use disorders.

2) Access

Ensuring appropriate pharmacotherapy requires an analysis of the financial and availability issues surrounding the client's access to pharmacological management. Financial barriers that may impede or prohibit a client's access to medication may include: absence of a drug plan, lack of coverage under the client's drug plan for certain medications used to treat substance use, and additional fees associated with certain medications that the client cannot afford. The expert panel recommends that nurses determine whether individual clients can afford the cost of the medication and, if not, identify community supports that can assist the client in receiving financial support for drug coverage.

Availability issues should also be considered prior to starting a client on medication. These include: (i) whether the client's pharmacy carries medications that are commonly used to treat substance use disorders, such as methadone and suboxone (buprenorphine/naloxone), (ii) the hours of operation of the client's local pharmacy, and (iii) whether the pharmacy delivers medication, especially in situations when a medication is administered daily and a client is unable to access the pharmacy (e.g., as a result of hospitalization, limited mobility, etc.). Nurses in Ontario should consult the Ministry of Health and Long-Term Care website for information about the programs and supports that may help clients in the province access financial support for drug coverage (http://www.health.gov.on.ca/en/public/programs/drugs/). Practitioners in other jurisdictions should obtain jurisdiction-specific information from the relevant governmental websites.

3) Safe Administration

Nurses play an essential role in ensuring safe medication administration. When working with clients with a substance use disorder, the nurse's ability to ensure safe administration may be affected by factors such as client intoxication, clients in withdrawal, and clients who present late or who frequently miss appointments (RNAO, 2009). Nurses who administer medications should have an understanding of the nature of substance use disorders. When administering a dose of medication to a client, every nurse should assess the appropriateness of the medication following the eight rights of medication administration (CNO, 2014, p. 6):

1. The right client,
2. The right medication,
3. The right reason,
4. The right dose,
5. The right frequency,
6. The right route,
7. The right site, and
8. The right time.

Nurses should also manage any adverse patient reactions to medication and document information concerning medication administration and client safety (CNO, 2014; RNAO, 2009). Nurses must advocate with clients for the ability of the client to choose to self-administer medication, provided the client is able competently to do so. In this case, the nurse also has a responsibility to ensure that the client has the knowledge, supplies necessary and clinical support necessary to self-administer medication.

The expert panel recommends that nurses seek out organizational support from a trained expert (e.g., an addictions specialist, a nurse educator, etc), if they are unfamiliar with the pharmacotherapy choices, access options and administering protocols.

Psychosocial Interventions

The choice of psychosocial intervention is often made jointly by the nurse and client, taking into account considerations such as the effectiveness and accessibility of the intervention, and the client's own preferences and goals (NICE, 2007). Psychosocial interventions cover a range of approaches that help clients develop coping skills and increase motivation, manage symptoms of withdrawal, enhance supports and improve functioning, and provide positive reinforcement (APA, 2006). Psychosocial interventions can also support clients in addressing underlying issues with respects to the social determinants of health (e.g., housing, financial support, etc), especially in marginalized and vulnerable populations. These interventions can occur in multiple settings of fixed locations, but also include modalities such as mobile vans and outreach programs. In some cases, nurses may be the clinicians administering the psychosocial intervention, depending on their clinical practice, level of training, and the type of psychosocial intervention specified. However, if the nurse does not have the clinical expertise or skill for the particular psychosocial intervention, the expert panel recommends that referral to a specialist is made for further support. See **Appendix K** for types of psychosocial interventions used to support clients at risk for or experiencing a substance use disorder.

RECOMMENDATION 3.3:

Engage youth and adolescents at risk for or experiencing a substance use disorder using family-based therapies until recovery, as appropriate.

Level of Evidence = Ia

Discussion of Evidence:

Systematic reviews of RCTs show support for the efficacy and effectiveness of family-based therapies for youth and adolescents at risk for or experiencing a substance use disorder, demonstrating a promising approach to adolescent focused interventions (Austin, Macgowan, & Wagner, 2005; Waldron & Turner, 2008). Family-based therapies should be used in conjunction with the combined pharmacological and psychosocial interventions described in Recommendation 3.2.

Family-based therapies utilize a collection of therapeutic approaches that aim to address substance use by working with youth and one or more family member(s) in therapeutic interactions and alliances (Austin et al., 2005, SAMHSA, 2004). The concept of family and what it encompasses is defined by the youth (Simpson, 2010). Family-based approaches highlight the importance of recognizing and addressing the biopsychosocial integrity of the family, as defined by the client and the family (Simpson, 2010). This can include recognizing and addressing the multiple pathways to substance

use, such as biological factors (e.g., genetic predisposition); psychological processes (e.g., coping mechanisms); and social, cultural, and religious influences (e.g., peer pressure).

Engaging clients in family-based therapies increases adherence to interventions and promotes better outcomes (APA, 2006). Through such therapy, the client and their family can address interpersonal and family interactions, which can promote positive behaviours that can support the client's recovery (APA, 2006). Family-based interventions are best indicated in situations where the interactions of the client's family can affect the client's plan of care (e.g., where a family frequently engages in conflicts or disputes, which can affect the client's substance use) and when family members need help adjusting to the client's individual and family goals, attitudes, and behaviours (APA, 2006).

Family-based therapies are *not* recommended in situations where the youth does not wish to involve the family, where there is no family engagement or support, where there is previous history of abuse or neglect, and where the client's adherence to care would be affected during the course of family therapy (e.g., risk of relapse with family involvement). The expert panel recommends that nurses collaborate with youth who use substances and/or is experiencing a substance use disorder to continue to provide interventions in accordance with Recommendation 3.2 when family-based therapies are not recommended.

Nurses who utilize family-based therapies seek to address the relevant developmental, family, social, community, and cultural needs of the young person (Austin et al., 2005). The nurse's role in delivering family-based therapies includes counselling, promotion of self-care activities, developing strengths and resources, providing supportive therapy, education, health teaching, and ultimately, building resiliency in youths and their families (Simpson, 2010). Nurses also address adolescents' substance use and related problems by enhancing family function through building skills related to communication and conflict resolution (Austin et al., 2005). Interventions may include developing contracts to reinforce behaviours associated with abstinence from drugs, implementing skill-based interventions and training, developing communication skills, and facilitating access to education and training opportunities that can help the young person develop the skills necessary to obtain employment or attend school (SAMHSA, 2014a). The expert panel recommends integrating harm reduction techniques into health teaching with youth and families, if abstinence is not the goal of care.

Family-based therapies include many intervention approaches, which are influenced by family systems theory as well as principles from cognitive behavioural therapy (CBT), attachment theory, development theory, and social ecological theory (Austin et al., 2005). One example of a family-based therapy is the Multidimensional Family Therapy (MDFT), which has demonstrated clinically significant improvements in substance use among youth and adolescents (Austin et al., 2005; Waldron & Turner, 2008). More information on MDFT can be found in **Appendix K**. Before utilizing family-based therapies in collaboration with clients, nurses should seek appropriate education and training, and incorporate the skills required into their daily practice.

4.0 EVALUATION

RECOMMENDATION 4.1:

Reassess the effectiveness of the plan of care until the client's goals are met.

Level of Evidence = V

Discussion of Evidence:

The literature indicates that continual reassessment and evaluation of the plan of care is an essential component when working with clients who use substances. This requires collaboration between nurses, the client, and other health-care providers. Such collaboration supports nurses to maintain and strengthen therapeutic alliances[G] with clients and also motivates clients toward change based on their established goals of care (APA, 2006).

Assessment and evaluation of the plan of care should be done with clients at every clinical visit as an ongoing process of seeking current information regarding the management of their care (APA, 2006; SAMHSA, 2005). Ongoing evaluation of the plan of care allows the health-care provider to assess client engagement and motivation in treatment, as well as the client's progress toward achieving the treatment goals (SAMHSA, 2005). When evaluating the client's progress, it is more important that nurses assess improvements with respect to the underlying factors that affect the client's substance use (e.g., behavioural and social factors) than the client's abstinence from substance use.

Ongoing evaluation of the plan of care must assess the client's perspectives on his or her progress in treatment; this includes re-examining the client's goals, adherence to the treatment plan and retention, and safety (i.e., no negative effects to the client's physical and psychological health) (APA, 2006; SAMHSA, 2005). **Appendix L** outlines some specific components that may be evaluated to assess the effectiveness of the plan of care. Findings from the evaluation should be used to adjust the existing plan of care and the strategies used with the client to improve outcomes over the course of treatment.

Education Recommendations

5.0 EDUCATION

RECOMMENDATION 5.1:

Integrate theory and clinical practice opportunities regarding care of clients at risk for or experiencing a substance use disorder into the undergraduate education of nurses and other health-care providers.

Level of Evidence = V

Discussion of Evidence:

The expert panel recommends that educational institutions that provide training for nurses and other health-care providers improve upon the existing curriculum to better integrate the study of substance use disorders and care into their curriculum at the undergraduate level. In addition, entry-to-practice nurses should receive practicum opportunities that allow them to develop the skills, knowledge, and confidence necessary to work with clients at risk for or experiencing a substance use disorder. The expert panel recommends that curriculum and practicum opportunities should integrate, but not be limited to, components related to the guiding frameworks, motivational interviewing, and brief intervention.

Findings from studies and recent reports demonstrate that health-care providers lack training on screening, assessment, and intervention approaches for clients at risk for or experiencing a substance use disorder at both the undergraduate and graduate levels (Cameron et al., 2006; Campbell-Heider et al., 2009; Kelleher & Cotter, 2009; Monks, Topping, & Newell, 2013; National Advisory Committee on Prescription Drug Misuse, 2013; O'Gara et al., 2005; Rassool, Villar-Luis, Carraro, & Lopes, 2006). The lack of integration of mental health and addictions theory-based courses and practicum opportunities in nursing schools demonstrates a disproportionate underinvestment in education and training, given the extent of substance use problems and associated costs to individuals, communities, the health-care system, and society as a whole.

Empirical literature and an environmental scan conducted by The Canadian Federation of Mental Health Nurses in 2009 demonstrated variability and lack of standardization in Mental Health and Addictions curricula – in particular, theory-based courses and practicum opportunities – across schools of nursing (Chang & Yang, 2013; Cund, 2013; Mollica, Hyman, & Mann, 2011; Tognazzini, Davis, Kean, Osborne, & Wong, 2009). It is important to note that, in practice, the provision of care for clients who use substances is negatively affected by a lack of confidence, low self-efficacy, and perceptions of inadequate skill on the part of health-care providers (Griffiths, Stone, Tran, Fernandez, & Ford, 2007; Nilsen et al., 2006; O'Gara et al., 2005; Rassool et al., 2006). Clinically based experiences are an important determinant in students' attitudes, beliefs, and knowledge, and their skill and confidence in intervening with clients who are at risk for or experiencing a substance use disorder (Cund, 2013; Rassool & Oyefeso, 2007; Tognazzini et al., 2009). Therefore, mandatory theory-based courses and practicum opportunities in mental health settings working with clients who use substances should be considered.

RECOMMENDATION 5.2:

Health-care providers participate in continuing education to enhance their ability to assess and work with clients at risk for or experiencing a substance use disorder.

Level of Evidence = Ib

Discussion of Evidence:

Health-care providers across the continuum of care should possess the knowledge and skills to provide safe, competent, and ethical care to clients who are at risk for or experiencing a substance use disorder (CCSA, 2014). In particular, the expert panel recommends health-care providers participate in training in the key areas related to the guiding frameworks (e.g., harm reduction, trauma-informed perspectives, cultural safety, etc.) and therapeutic relationships (e.g., MI) in order to build collaborative relationship with clients.

There is a clear need for tailored professional education and training opportunities for nurses and health-care providers across the continuum of care pertaining to assessment and interventions for clients who use substances (CCSA, 2014; Nilsen et al., 2006). A lack of professional development opportunities related to substance use, combined with negative attitudes and mistrust of clients with substance use disorders, negatively affects the quality of care such clients receive (Monks et al., 2013). A recent RCT showed evidence that nurses who engaged in professional development education and training had increased knowledge, self-efficacy, and clinical skills when responding to clients who were experiencing problems related to their alcohol use (Tsai et al., 2011). This finding was further substantiated by other studies supporting the effectiveness of continuing education programs for substance use disorders with respect not only to building knowledge and skills, but also decreasing nurses' negative attitudes about working with clients with such disorders (Chang & Yang, 2013; Kennedy et al., 2013).

The expert panel emphasizes that exposing nurses to clinical learning environments, including clinical supervision[G] and coaching, can help nurses to incorporate best practices related to screening, assessment, and intervention in their work with clients who use substances (RNAO, 2006). Furthermore, such tailored professional education, clinical supervision, and coaching opportunities should be supported by the organization in collaboration with advanced practice nurse educators and the interprofessional team. **Appendix M** includes a list of resources that nurses and other health-care professionals can refer to for more information when working with clients who use substances.

The Competencies for Canada's Substance Abuse Workforce, developed by the CCSA (2014), is an educational resource that sets out the core competencies required by any professional (in the health-care system but also in other areas, such as the justice system) to work effectively with individuals who use substances. The expert panel recommends that organizations use this resource to identify gaps in knowledge and skills among health-care providers, and to assist in tailoring continuing educational programs. The Competencies for Canada's Substance Abuse Workforce (CCSA, 2014) can be accessed at: http://www.ccsa.ca/Eng/topics/Workforce-Development/Workforce-Competencies/Pages/default.aspx

RECOMMENDATION 5.3:

Nurses practice reflectively to enhance their awareness of their current and evolving attitudes, perceptions and biases, and values and beliefs when working with clients at risk for or experiencing a substance use disorder.

Level of Evidence = V

Discussion of Evidence:

The expert panel recommends that nurses working with clients at risk for or experiencing a substance use disorder engage in reflective practice in order to remain aware of their evolving attitudes, perceptions and biases, and values and beliefs concerning such clients and substance use behaviour. These are learned elements that develop over time and that affect how nurses view, respond to, and care for clients who use substances. When nurses reflect on the how their personal values and beliefs affect their relationships with clients, their ability to deliver client-centred care is enhanced (CNA, 2008). Furthermore, engaging in personal reflection, learning, and support results in the provision of a higher quality of care to the diverse communities that nurses serve (CNO, 2009).

Studies show that a significant proportion of health-care providers hold negative or stereotypical views of individuals with a substance use disorder, which compromises the quality of care such clients receive (Natan, Beyil, & Neta, 2009; Skinner, Feather, Freeman, & Roche, 2007). For example, when treating a client who has a substance use disorder and who is also suffering from another condition or illness (e.g., chronic pain or cancer), health-care providers may choose not to prescribe certain pharmacological interventions or offer certain services (e.g., a needle exchange) as a result of their own negative or stereotypical beliefs. This perpetuates stigma and, ultimately, has a negative effect on client care (Livingstone et al., 2012). For people with a substance use disorder, stigma contributes to a host of adverse outcomes, including poor mental and physical health, barriers to engagement or completion of substance use interventions, delayed recovery or reintegration processes, and increased involvement in risky behaviour (Livingstone et al., 2012). Nurses must be cognizant of their attitudes and behaviour that can affect client care, and engage in reflective practice in order to work effectively with all clients.

System, Organization and Policy Recommendations

6.0 SYSTEM, ORGANIZATION AND POLICY

RECOMMENDATION 6.1:

Advocate for improved health outcomes by:

- Increasing access to integrative and collaborative care for clients at risk for or experiencing a substance use disorder; and
- Reducing health inequities by dedicating resources to preventing, treating, and supporting the recovery of individuals at risk for or experiencing a substance use disorder.

Level of Evidence = V

Discussion of Evidence:

The expert panel asserts that all levels of government should demonstrate leadership and commitment to improving health outcomes through supportive, integrative, and collaborative care for individuals at risk for or experiencing a substance use disorder. Furthermore, government and policy-makers must work toward decreasing health inequities in order to prevent substance use disorders, through the development of evidence-informed strategies and policies.

Access to Integrative and Collaborative Management Services

Benefits of improved collaboration and coordination across the system will include a reduction in avoidable visits to emergency rooms and hospitalizations, reduced wait times for community- and hospital-based services, and improved access to community supports, helping to address the needs of clients in a more timely manner (Ministry of Health and Long Term Care, 2011).

Timely access to integrated, high-quality, client-centered care is critical to the recovery of clients experiencing a substance use disorder (Ministry of Health and Long Term Care, 2011). In order to increase early identification and management opportunities, substance use care must be integrated within all areas of the health-care system, including primary care, hospitals, home- and long-term care, public health, and supportive services (Ministry of Health and Long Term Care, 2011; RNAO, 2014a). For example, an acute care unit might ensure that a universal screen is conducted and documented for each client at admission, and that the appropriate referrals and appointments for specialist consults are made in a timely fashion for clients who are identified as at risk. Another example of integration would be ensuring that individuals seeking care for a mental illness and a substance use disorder do not have to go to separate programs for each health concern but can receive care for both within a single program.

In 2011, the Ontario Ministry of Health and Long-Term Care released the ten-year "Open minds, healthy minds: Ontario's comprehensive mental health and addiction strategy." The report set out key system-level strategies that will strengthen and integrate mental health and addiction services in the province, including:

- Improving mental health and well-being for all Ontarians by laying the foundation for good mental health (e.g., by identifying mental health needs early and providing programs and services for youth in their home communities; reducing stigma through the promotion of equity, diversity, physical activity, healthy eating, and self-esteem

programs; developing parenting and peer support programs for families; implementing mental health literacy and cross-sectoral training on early identification for educators; implementing programs in schools to facilitate early identification and referrals for interventions and enhancing mental health resources in schools);

- Creating healthy, resilient, inclusive communities (e.g., by implementing more mental health promotion and anti-stigma practices; acknowledging that the mental health and addictions services sector should reflect diversity; recognizing the housing challenges faced by those with mental health and addictions issues; developing policy guidelines and tools aimed at supporting individuals experiencing substance use disorders to access health, housing, and employment resources);
- Enhancing early intervention (e.g., by developing best practices for early identification and management, and developing standardized role and competencies for health professionals); and
- Increasing access to support centres across the province (e.g., by building community-based mental health and addiction support services in easily accessible locations, and improving transitions services between different sectors, such as between the youth and adult systems).

Reducing Health Inequities

Despite positive developments in terms of increased supports and access to services that address the prevention and management of substance use disorders, the expert panel recommends that further government action is required to address the root causes of such disorders. Health inequities create barriers such as poverty, isolation, and discrimination, which marginalize individuals and make them more vulnerable to developing a substance use disorder. The expert panel recommends that governments take the following steps to enhance the current system:

- Implement effective leadership and investment by all levels of government for intersectoral action on the determinants of health, such as planning and implementing strategies to address poverty, affordable housing, and inclusive communities (Standing Senate Committee on Social Affairs, Science and Technology, 2009; WHO, 2010);
- Improve the conditions of daily life by addressing the immediate needs of individuals for food, safe shelter, and income security, including increasing social assistance rates so that they reflect the actual cost of living (Muntaner, Ng, & Chung, 2012; RNAO, 2010a; CSDH, 2008);
- Maintain and enforce strong human rights legislation to protect against discrimination on protected grounds, including disability status (Canadian Mental Health Association Ontario, 2014; Ontario Human Rights Commission, 2014);
- Implement a universal, publically funded and administered pharmacare program for all Canadians (Gagnon, 2014; Morgan, Daw, & Law 2013); and
- Invest in an integrated mental health and addictions service system in Ontario, including financial and human resources to address substance use on an ongoing basis across all care settings. This would include:
  - Ensuring that individuals across Ontario can access screening and management services locally in a timely way (Ontario Mental Health and Addictions Alliance, 2014);
  - Funding of systems that recognize the importance of trauma in people at risk for substance use disorders and the integration of trauma-informed approaches to care (SAMHSA, 2014b);
  - Funding and regulatory support for the integration of harm-reduction strategies across all practice settings (e.g., supervised injection services, increased access to naloxone programs, etc.) (CNA, 2011); and
  - Ensuring the existence of accountability mechanisms to ensure that all health and social service organizations, as well as the criminal justice system, provide safe and high-quality care and management for individuals with substance use disorders.

To support the integrated system outlined above, the expert panel recommends that sustainable revenue be generated through progressive taxation. It would be important for government to invest a portion of the profits from the sale of legalized substances, particularly alcohol, in initiatives aimed at the prevention, early identification, and management of substance use disorders (Ministry of Health and Long-Term Care, 2011).

RECOMMENDATION 6.2:

Organizations integrate prevention, assessment, and management of substance use and substance use disorders as a strategic clinical priority across all care settings.

Level of Evidence = V

Discussion of Evidence:

Organizations must recognize that all clients have the right to timely, high-quality, and integrated care when it comes to prevention, identification, and management of substance use and substance use disorders across all clinical care settings (Ministry of Health and Long Term Care, 2011; Nilsen et al., 2006). Currently, of the 4.4 percent of Canadians identified as having a substance use disorder, only 0.4 percent accesses publicly funded services (Pirie et al., 2014). For clients accessing clinical services for substance use disorders, care can be fragmented (i.e., substance use disorders are not assessed or treated during routine care, such as during a doctor's visit) and spread across different care settings, meaning that clients may have to visit multiple clinical locations rather than receive services in a single setting (Ministry of Health and Long Term Care, 2011). This increases wait times and results in a decreased quality of care to clients.

Addressing substance use as a clinical priority across organizations will ensure that clients who are at risk for or experiencing a substance use disorder will receive services in a timely, coordinated system that provides promotion, prevention, early intervention, and community support and management programs (Ministry of Health and Long Term Care, 2011). Furthermore, providing integrated care will help decrease wait times, decrease the cost per person of accessing mental health and addiction services, decrease repeat emergency department visits or unplanned hospital readmissions, result in better mental health outcomes for clients, enhance the quality of life for people with substance use disorders, and develop a workforce better trained to support clients who use substances. This in turn will reduce stigma and discrimination against individuals with substance use disorders (Ministry of Health and Long Term Care, 2011).

Evidence suggests that integrating best practices to address substance use more effectively in health-care settings is best approached as a long-term process (Wits, Knibbe, & van de Mheen, 2005). To achieve this, organizations will require:

- Buy-in from leadership and management in terms of understanding the critical importance of addressing the prevention, assessment, and management of substance use as a strategic priority;
- Standards, policies, and procedures that prevent, assess, and treat substance use;
- A positive organizational climate, developed through the support of all staff (management and front-line staff) in addressing substance use disorders (Babor, Higgins-Biddle, Dauser, Higgins, & Burleson, 2005; Howard & Holmshaw, 2010; Nilsen et al., 2006; RNAO, 2012; Wits et al., 2005). For example, developing a dedicated committee that will address substance use across the organization will help develop an organizational climate that supports positive change in addressing substance use disorders (Babor et al., 2005; RNAO, 2012);
- The development of a core working group, including individuals with lived experience that will integrate prevention, assessment, and management of substance use and substance use disorders across all care settings within the organization;
- The provision of adequate physical, human, and financial resources (Babor et al., 2005; RNAO, 2012; Wits et al., 2005) (e.g., adequate dollars allocated to substance use prevention and management, dedicated staffing to address substance use prevention and management, time allotted for staff to attend training, etc.); and
- Continuous quality improvement initiatives to evaluate substance use and substance use disorder prevention, assessment, and management processes and outcomes.

It is recommended, when addressing substance use disorders as a clinical priority, that organizations create long-term, sustainable plans that address the needs of clients who are at risk for or experiencing a substance use disorder.

RECOMMENDATION 6.3:

Organizations integrate components of harm reduction and the social determinants of health into comprehensive, multi-faceted approaches to addressing substance use disorders.

Level of Evidence = V

Discussion of Evidence:

To support positive health outcomes for clients at risk for or experiencing a substance use disorder, the expert panel recommends that organizations integrate principles of harm reduction and the social determinants of health into comprehensive approaches that address substance use. These principles recognize the realities of social inequalities that affect individuals' vulnerability to and their capacity to deal effectively with substance use disorders while also aiming to minimize the dangers associated with substance use (Rassool, 2010). Through the development of comprehensive organizational approaches that address substance use, organizations should develop a workforce that is trained to identify and advocate against social injustices that affect the health of clients at risk for or experiencing a substance use disorder (CSDH, 2008).

Comprehensive, multi-faceted organizational approaches that include components of education, clinical supports, and resources are successful in supporting nurses and the interprofessional team (Babor et al., 2005; Nilsen et al., 2006; Wits et al., 2005). Successful, system-wide change in clinical practice requires careful planning, comprehensive implementation, and ongoing evaluation and quality improvement supports (RNAO, 2012; Stanley, Worrall, Lunsford, Couillard, & Norcross, 2007).

To create a comprehensive, multi-faceted approach, organizations should:

- Engage individuals with lived experiences with substance use in the development of their approach, where appropriate;
- Establish policies and procedures to assess and treat all clients at risk for or experiencing a substance use disorder that incorporate principles of harm reduction and the social determinants of health (Groves et al., 2010);
- Establish and integrate principles of harm reduction and the social determinants of health into all new and existing programs that address substance use across the organization (e.g., needle exchange programs, naloxone overdose prevention programs) (CNA, 2011);
- Be consistent in the use of screening and assessment tools within interprofessional teams and settings;
- Integrate screening and assessment tools into documentation processes (Groves et al., 2010);
- Develop standardized tools for documenting and communicating the assessment of and management plans for substance use and substance use disorders (Groves et al., 2010);
- Receive support from substance use disorder specialists within the organization regarding implementation initiatives (Groves et al., 2010);
- Develop referral networks to facilitate further supports for clients at risk for or experiencing a substance use disorder (Bernstein, et al., 2009);
- Provide education on substance use and substance use disorders, including information related to harm reduction and the social determinants of health, and support for ongoing professional development and new staff

orientation. Education (i.e., theory, clinical supervision, and coaching opportunities) should be supported by the organization in collaboration with advanced practice nurse educators and the interprofessional team; and
- Participate in ongoing quality improvement initiatives to evaluate assessment and management processes and outcomes, and ascertain further needs of the organization (Armstrong & Holmes, 2005).

RECOMMENDATION 6.4:

Organizations use knowledge translation processes and multi-faceted strategies to integrate best practices in the assessment and management of substance use and substance use disorders across all practice settings.

Level of Evidence = V

Discussion of Evidence:

The expert panel recommends that health-care organizations utilize multiple knowledge transfer strategies to increase health-care providers' knowledge and skills regarding substance use and substance use disorders (Caley, Riemer, & Weinstein, 2010; Nordqvist, Johansson, Lindqvist, & Bendtsen, 2006; Seale et al., 2005; Tran, Stone, Fernandez, Griffiths, & Johnson, 2009; Tsai et al., 2011). Ensuring ongoing knowledge transfer opportunities helps increase health-care providers' awareness of substance use and substance use disorders, fosters positive attitudes, and enhances the skills and knowledge practitioners need to identify and care for clients who use substances, positively increasing screening and intervention rates for such clients (Groves et al., 2010; RNAO, 2009). Promoting knowledge transfer through professional development also fosters positive work environments that are conducive to implementing evidence-based guidelines (RNAO, 2009). Having a nursing workforce that is knowledgeable about current evidence in the assessment and management of substance use disorders enhances the quality and continuity of care that clients receive within the organization (RNAO, 2009).

Uptake of best practices associated with caring for clients with a substance use disorder is enhanced when organizations apply the following knowledge translation strategies:

- Using Best Practice Guidelines (RNAO, 2012a);
- Providing clinical supervision and coaching opportunities to all staff on a regular basis (McKenna, Thom, Howard, & Williams, 2010; Nilsen et al., 2006; Rassool & Oyefeso, 2007; RNAO, 2006);
- Providing interactive, educational workshops (e.g., motivational interviewing, harm reduction, addressing social determinants of health, etc.) on best practices related to substance use and substance use disorders that provide opportunity for discussion and reflection (Aalto, Pekuri, & Seppa, 2005; Babor et al., 2005; Seale et al., 2005; Stanley et al., 2007; Tsai et al., 2011);
- Developing Champions who specialize in assessment and management of substance use and its related issues – clinical staff (e.g., nurse educators) who have had specialized training in substances, screening, assessment and interventions, who integrate best practices, and act as a resource for staff in specific practice settings – within the organization to support best practices uptake and implementation (Babor et al., 2006; Bernstein et al., 2009; Groves et al., 2010; RNAO, 2012); and
- Providing access to self-directed learning opportunities, including web-based learning and videos (Daly, Kermode, & Reilly, 2009; Stanley et al., 2007).

Research Gaps and Future Implications

The Registered Nurses' Association of Ontario (RNAO) expert panel, in reviewing the evidence for this Guideline, identified the priority areas for research set out in Table 4. They are broadly categorized into practice, outcome, and health-system research.

Table 4: Priority Practice, Outcomes and Health-System Research Areas

CATEGORY	PRIORITY RESEARCH AREA
Practice research	Effective primary-prevention strategies in the development of resiliency to, risk reduction for, and the problems associated with substance use.
	Validation of screening tools and intervention options for older adults who use substances, clients with polysubstance abuse disorders, and clients with concurrent disorders.
	Effective screening tools and interventions for substance use disorders across diverse cultures.
	Clinical utility, feasibility, and effectiveness of applying screening instruments in busy primary health-care settings.
Outcomes research	Educational programs and practicum opportunities for nurses and other health-care providers that are effective in developing the skills required to assess and manage substance use in clients.
	Effectiveness of formal (i.e., program led by a health-care provider) versus informal (i.e., peer-led) interventions for clients with a substance use disorder.
	Outcomes of health-care providers working within interprofessional teams to manage care of clients who use substances.
Health-system research	Organizational and government policies that improve accessibility to and utilization of substance use management services.
	Effective care delivery models that support assessment and interventions for individuals who use substances.
	Effectiveness of government taxation interventions for reducing alcohol consumption and associated health issues.
	The impacts of social determinants of health on clients' recovery from substance use disorders (e.g., housing first approaches).

The above table, though not exhaustive, is an attempt to identify and prioritize the research needed with respect to substance use and substance use disorders. Many of the recommendations are based on quantitative and qualitative research evidence. Other recommendations are based on expert opinion or grey literature sources. Further substantive research is required to validate some of these recommendations. Increasing the research evidence will lead to improved practice and outcomes for clients who are at risk for or experiencing a substance use disorder.

Implementation Strategies

Implementing guidelines at the point of care is multi-faceted and challenging; it takes more than awareness and distribution of guidelines to get people to change how they practice. Guidelines must be adapted for each practice setting in a systematic and participatory way, to ensure recommendations fit the local context (Harrison, Graham, Fervers, & van den Hoek, 2013). The Registered Nurses' Association of Ontario's (RNAO) *Toolkit: Implementation of Best Practice Guidelines* (2nd ed.) (2012a) provides an evidence-informed process for doing this (see **Appendix N**).

The *Toolkit* is based on emerging evidence that successful uptake of best practice in health care is more likely when:

- Leaders at all levels are committed to supporting guideline implementation;
- Guidelines are selected for implementation through a systematic, participatory process;
- Stakeholders for whom the guidelines are relevant are identified and engaged in the implementation;
- Environmental readiness for implementing guidelines is assessed;
- The guideline is tailored to the local context;
- Barriers and facilitators to using the guideline are assessed and addressed;
- Interventions to promote use of the guideline are selected;
- Use of the guideline is systematically monitored and sustained;
- Evaluation of the guideline's impact is embedded in the process; and
- There are adequate resources to complete all aspects of the implementation.

The *Toolkit* (RNAO, 2012a) uses the "Knowledge-to-Action" framework (Straus, Tetroe, Graham, Zwarenstein, & Bhattacharyya, 2009) to demonstrate the process steps required for knowledge inquiry and synthesis. It also guides the adaptation of the new knowledge to the local context and implementation. This framework suggests identifying and using knowledge tools, such as guidelines, to identify gaps and to begin the process of tailoring the new knowledge to local settings.

RNAO is committed to widespread deployment and implementation of our Best Practice Guidelines (BPGs). RNAO uses a coordinated approach to dissemination, incorporating a variety of strategies including: 1) the Nursing Best Practice Champion Network®, which develops the capacity of individual nurses to foster awareness, engagement, and adoption of BPGs; 2) nursing order sets[G] which provide clear, concise, actionable intervention statements derived from the BPGs' practice recommendations that can be readily embedded within electronic medical records, but may also be used in paper-based or hybrid environments; and 3) the Best Practice Spotlight Organization® (BPSO®) designation, which supports implementation at the organization and system levels. BPSOs focus on developing evidence-based cultures with the specific mandate to implement, evaluate, and sustain multiple RNAO BPGs. In addition, we offer capacity-building learning institutes on specific guidelines and their implementation annually (RNAO, 2012a).

Information about RNAO implementation strategies can be found at:

- RNAO Best Practice Champions Network: www.RNAO.ca/bpg/get-involved/champions
- RNAO's nursing order sets: http://rnao.ca/bpg/initiatives/nursing-order-sets
- RNAO Best Practice Spotlight Organizations: www.RNAO.ca/bpg/bpso
- RNAO capacity-building learning institutes and other professional development opportunities: www.RNAO.ca/events

Evaluating and Monitoring this Guideline

As you implement the recommendations in this Guideline, we ask you to consider how you will monitor and evaluate their implementation and impact.

Table 5 is based on a framework outlined in the Registered Nurses' Association of Ontario's *Toolkit: Implementation of Best Practice Guidelines* (RNAO, 2012a) and illustrates some specific indicators for monitoring and evaluating implementation of this Guideline.

Table 5: Structure, Process, and Outcome Indicators for Monitoring and Evaluating This Guideline

TYPE OF INDICATOR		
STRUCTURE	**PROCESS**	**OUTCOME**
These indicators refer to the supports and resources required for a health system, health service organization or academic institution that enable the successful implementation of the Guideline, *Engaging Clients Who Use Substances* into practice.	These indicators evaluate whether best practices directed at the education, training, and practice of health-care professionals to improve engagement with clients who use substances have been implemented.	These indicators evaluate the impact of implementing the Guideline recommendations on health-care organizations, health-care professionals and client outcomes.
Establishment of a system-level committee to review best practices related to assessing and managing clients who use substances. System-wide integration of policies consistent with best practices and Guideline recommendations for supporting clients who use substances. Organizations establish assessment and management of substance use disorders as a strategic clinical priority. Availability of adequate financial resources to support and implement Guideline recommendations.	Percentage of undergraduate nursing students who participated in clinical/practical opportunities related to care of clients who use substances. Percentage of newly hired nurses who attended an orientation session related to best practices for supporting clients who use substances. Percentage of nurses who attended continuing education/training sessions related to the care of clients who use substances. Percentage of nurses who completed an annual performance review.	New graduates / nursing staff/ other health-care providers report satisfaction with education and training received. New graduates / nursing staff are able to articulate the guiding frameworks related to care of clients who use substances. New graduates / nursing staff demonstrate the knowledge and skill to work with clients who use substances, using Motivational Interviewing techniques. Nursing staff and other health-care providers report increased confidence in effectively assessing and managing clients who use substances.

TYPE OF INDICATOR		
STRUCTURE	**PROCESS**	**OUTCOME**
Organizations adopt and implement evidence-based policies and procedures that support screening for all clients, as well as assessment, intervention and referral for clients who use substances. Organizational programs that address substance use disorders integrate principles of harm reduction and address the social determinants of health. Organizational availability of educational resources for nurses and other health-care professionals related to management of clients who use substances, prior to, during and after Guideline implementation. Organizations provide professional development activities related to assessment and management of clients who use substances for all health-care providers (e.g., in-services, clinical training/orientation, development of policies and procedures, development of documentation forms). Organizations adopt and provide appropriate documentation protocols/ standards/tools for conducting comprehensive assessment. Units, programs, services or teams implement appropriate substance use screening tools.	Percentage of clients screened for substance use on admission or initial contact. Percentage of clients who screened positive for substance use who were subsequently screened for the risk for or presence of a substance use disorder using an appropriate tool. Percentage of clients who screened positive for substance use, who subsequently received a comprehensive assessment. Percentage of clients who screened positive for substance use, who received brief intervention during their care. Percentage of clients at risk for or with a diagnosed substance use disorder who are provided combined pharmacological and psychosocial interventions. Percentage of clients with an individualized substance use plan of care with evidence that the plan of care is assessed for effectiveness at each visit. Percentage of clients who have been referred for treatment based on comprehensive assessment.	Percentage of nurses who demonstrate self-reflection related to the care of clients who use substances in most recent performance evaluation. Demonstrated cost efficiency and effectiveness of management of clients who use substances. Percentage of clients at risk for or with a diagnosed substance use disorder who have participated in developing an individualized plan of care. Percentage of clients at risk for or with a diagnosed substance use disorder who achieve or maintain desired self-management goals. Percentage of youth and adolescent clients at risk for or with a diagnosed substance use disorder who receive family-based therapy during their care. Percentage of clients who are satisfied with the care they received related to management of their substance use disorder.

TYPE OF INDICATOR		
STRUCTURE	**PROCESS**	**OUTCOME**
Units, programs, services or teams provide training programs on motivational interviewing and brief intervention for nursing staff. Mandatory, annual performance review process for all nursing staff that emphasizes reflective practice and continuing professional development. Availability of educational resources for undergraduate nursing and allied health programs, which are consistent with best practices for assessing and managing clients who use substances. Incorporation of theory and clinical/practical opportunities related to the management of clients who use substances into basic and interprofessional curricula for nurses and other health-care professionals.		

Other RNAO resources for the evaluation and monitoring of Best Practice Guidelines:

- Nursing Quality Indicators for Reporting and Evaluation (NQuIRE®) were designed for RNAO's Best Practice Spotlight Organizations® (BPSO®) to systematically monitor the progress and evaluate the outcomes of implementing RNAO best practice guidelines in their organizations. NQuIRE® is the first international quality improvement initiative of its kind consisting of a database of quality indicators derived from recommendations of selected RNAO clinical Best Practice Guidelines. Please visit http://rnao.ca/bpg/initiatives/nquire for more information.
- Nursing order sets embedded within electronic medical records provide a mechanism for electronic data capture of process indicators. The ability to link structure and process indicators with specific client outcome indicators aids in determining the impact of BPG implementation on specific client health outcomes. Please visit http://rnao.ca/ehealth/nursingordersets for more information.

Process for Update and Review of the Guideline

The Registered Nurses' Association of Ontario (RNAO) commits to updating its Best Practice Guidelines as follows:

1. Each nursing BPG will be reviewed by a team of specialists in the topic area every five years following publication of the previous edition.
2. The International Affairs and Best Practice Guidelines (IaBPG) Centre staff regularly monitor for new systematic reviews, randomized controlled trials, and other relevant literature in the field.
3. Based on that monitoring, staff may recommend an earlier revision period. Appropriate consultation with members of the original expert panel and other specialists and experts in the field will help inform the decision to review and revise the guidelines earlier than planned.
4. Three months prior to the review milestone, the staff commences planning of the review by:
   a) Inviting specialists in the field to participate on the expert panel. It will be comprised of members from the original expert panel as well as other recommended specialists and experts.
   b) Compiling feedback received and questions encountered during the implementation, including comments and experiences of Best Practice Spotlight Organizations® and other implementation sites regarding their experience.
   c) Compiling new clinical best practice guidelines in the field and conducting a systematic review of the evidence.
   d) Developing a detailed work plan with target dates and deliverables for developing a new edition of the Guideline.
5. New editions of guidelines will be disseminated based on established structures and processes.

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Appendix A: Glossary of Terms

Abstinence: Not using any substances at any time (SAMHSA, 2005).

Agonist maintenance therapies: "An agonist is a substance that mimics the actions of a neurotransmitter or hormone to produce a response when it binds to a specific receptor in the brain. Opioid drugs, for example heroin and methadone, are agonists that produce responses such as 'liking,' analgesia and respiratory depression" (NICE, 2008, p. 302).

Ambivalence: "The simultaneous presence of competing motivations for and against change" (Miller and Rollnick, 2013, p.405).

Analytical studies: Analytical studies test hypotheses about exposure-outcome relationships. The investigators do not assign an intervention, exposure, or treatment but do measure the association between exposure and outcome over time, using a comparison group (Centers for Disease Control and Prevention, 2013). Analytical study designs include case-control studies and cohort studies.

Cohort study: An observational study in which a defined group of people (the cohort) is followed over time either prospectively or retrospectively (The Cochrane Collaboration, 2005).

Case-control study: A study that compares people with a specific disease or outcome of interest (cases) to people from the same population without that disease or outcome (controls) (The Cochrane Collaboration, 2005).

Antagonist therapies: "In contrast to the action of an agonist, an antagonist, such as naltrexone, binds to a specific receptor in the brain but does not activate it. Therefore, if an agonist, for example heroin or methadone, is present and activating the receptor, taking naltrexone will counteract the activation, resulting in withdrawal" (NICE, 2008, p. 302).

Appropriate Screening Tools: An appropriate screening tool is a clinical screening tool that is specific to substance(s) used, the client population and the clinical setting where the screening is occurring. Refer to **Appendix H** for a list of commonly use appropriate screening tools.

Assertive community treatment (ACT): A form of intervention that typically employs intensive outreach activities, continuous 24-hour responsibility for the client's welfare, active and continued engagement with clients, a high intensity of services, and the provision of care by multidisciplinary teams. ACT emphasizes shared decision making with the client as essential to the client's engagement process.

Assessment: A basic assessment for a client who is at risk for or experiencing a substance use disorder consists of gathering key information and engaging in a process with the client that enables the counsellor to understand the client's readiness for change, problem areas, mental health, disabilities, and strengths. An assessment typically involves a clinical examination of the functioning and well-being of the client and includes a number of tests and written and oral exercises.

Best practice guideline: Systematically developed statements to assist practitioner and client decisions about appropriate health care for specific clinical (practice) circumstances (Field & Lohr, 1990).

Brief intervention (BI): Brief intervention is a technique used by health-care providers to express empathy for the client and offer feedback in order to increase the client's motivation to make changes related to his or her substance use. Most clients receive between one and four 5- to 30-minute sessions with a trained nurse or health-care provider (APA, 2006; McQueen et al., 2011; NICE, 2007).

Client: A client is a person with whom the nurse is engaged in a therapeutic relationship. In most circumstances, the client is an individual but may also include family members and/or substitute decision-makers (group or community) (CNO, 2013).

Clinical supervision: "A reflective process that permits supervisees to explore and examine the part they play in the complexities of events within the therapeutic relationship as well as the quality of practice" (Kelly, Long, & McKenna, 2001, p. 12). It is an opportunity for personal and professional growth that does not involve penalties or judgment (RNAO, 2006).

Comprehensive assessment: A comprehensive assessment is a bio/psycho/social/spiritual nursing assessment of a client that "includes a health history and physical examination; considers the psychological, emotional, social, spiritual, ethnic, and cultural dimensions of health; attends to the meaning of the client's health-illness experience; and evaluates how all of this affects the individual's daily living" (Lasiuk, 2010, p. 174).

Concurrent disorder: The concurrent disorder population refers to those individuals who are experiencing at least one diagnosable mental disorder along with at least one substance use disorder (Health Canada, 2002).

Controlled study: A clinical trial in which the investigator assigns an intervention, exposure, or treatment to participants who are not randomly allocated to the experimental and comparison or control group (The Cochrane Collaboration, 2005).

Culture: Culture refers to the shared and learned values, beliefs, norms and ways of life of an individual or group. It influences thinking, decisions and actions (CNO, 2013; RNAO, 2012b, p.84).

Cultural awareness: Cultural awareness is "the first step towards achieving cultural safety. It can be built by observing activities and how people participate in them, and involves being able and willing to recognize or acknowledge and accept difference within a population" (National Collaborating Centre for Aboriginal Health, 2013).

Cultural competence: Cultural competence is the "application of knowledge, skill, attitudes and personal attributes required by nurses to provide appropriate care and services in relation to cultural characteristics of their clients. Cultural competence includes valuing diversity, knowing about cultural mores and traditions of the population being served, and being sensitive to these while caring for the individual" (CNA, 2004).

Cultural competence recognizes the significant impact of cultural values and beliefs, as well as power and hierarchy often inherent in client interactions, particularly between clients from marginalized groups and practitioners (RNAO, 2007b).

Cultural safety: Cultural safety includes cultural awareness (acknowledgement of difference), cultural sensitivity (recognition of importance of respecting difference), and cultural competence (skills, knowledge, and attitudes of practitioners) (RNAO, 2007b).

Cultural sensitivity: Cultural sensitivity refers to an awareness, understanding, and attitude toward culture, and places the focus on the self-awareness and insight of the health-care provider (RNAO, 2007b).

Descriptive studies: Studies that generate hypotheses and describe characteristics of a sample of individuals at one point in time. The investigators do not assign an intervention, exposure, or treatment to test a hypothesis, but merely describe the who, where, or when in relation to an outcome (Centers for Disease Control and Prevention, 2013; The Cochrane Collaboration, 2005). Descriptive study designs include cross-sectional studies.

Cross-sectional study: A study measuring the distribution of some characteristic(s) in a population at a particular point in time (also called a survey) (The Cochrane Collaboration, 2005).

Detoxification: The "process of safely and effectively withdrawing a person from an addictive substance, usually carried out under medical supervision" (Austin & Boyd, 2010, p. 996).

"Detoxification is the process by which an individual is withdrawn from the effects of a psychoactive substance. As a clinical procedure, the withdrawal process should be supervised and carried out in a safe and effective manner, such that withdrawal symptoms are minimized. Typically, the individual is clinically intoxicated or already in withdrawal at the outset of detoxification. Detoxification may involve the administration of medication, the dose of which is calculated to relieve withdrawal symptoms without inducing intoxication, and is gradually tapered off as the individual recovers" (NICE, 2008, p. 302).

Discrimination: The Ontario *Human Rights Code* states that "every person has the right to equal treatment with respect to services, goods and facilities without discrimination on the grounds of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status, or disability" (Government of Ontario, 2012, s. 1).

Education recommendations: Statements of educational requirements and educational approaches/strategies for the introduction, implementation, and sustainability of the best practice guideline.

Engagement: A client's commitment to and maintenance of treatment in all of its forms. A successful engagement program helps clients view the treatment facility as an important resource.

Evidence: Evidence is information that comes closest to the facts of a matter. The form it takes depends on context. The findings of high-quality, methodologically appropriate research provides the most accurate evidence. Because research is often incomplete and sometimes contradictory or unavailable, other kinds of information are necessary supplements to, or stand-ins, for research. The evidence-base for a decision is the multiple forms of evidence combined to balance rigour with expedience while privileging the former over the latter (RNAO, 2014a, p. 66).

Family: Whomever the client defines as being his or her family. Family members can include parents, children, siblings, partners, neighbours, and significant people in the client's community (RNAO, 2010b, p. 57).

Formal intervention: The provision of an intervention with clients that is initiated and delivered by a health-care provider.

Harm reduction: "'Harm Reduction' refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community" (International Harm Reduction Association, 2010, p. 1).

Health-care provider: In this BPG, health-care provider refers to the regulated and unregulated individuals who provide care for clients at risk for or identified with a substance use disorder and their families.

Health promotion: "The process of enabling people to increase control over, and to improve their health. It not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental, political and economic conditions so as to alleviate their impact on public and individual health" (PHAC, 2010).

Informal intervention: The provision of an intervention with clients that is initiated and delivered by a layperson. This intervention is peer-based and may include volunteer, unpaid facilitation by the peer.

Interprofessional team: A team made up of individuals from different professions working together to reach a common goal and who share decision making to achieve that goal. The goal in health care is to work in collaboration with clients and their families to provide treatment that reflects their goals and values. An interprofessional team typically includes one or more physicians, nurses, social workers, spiritual advisors, personal support workers, and volunteers. Other disciplines may be part of the team, as resources permit and as appropriate (Ferris et al., 2002).

Interventions: Encompasses the specific treatment strategies, therapies, or techniques that are used to treat one or more disorders.

Meta-analysis: A systematic review of randomized controlled trials that uses statistical methods to analyze and summarize the results of the included studies (The Cochrane Collaboration, 2005).

Motivational interviewing (MI): An evidence-based, client-centered, non-directive counselling method for enhancing a client's intrinsic motivation to change (Smedslund et al., 2011).

Nursing order sets: A group of evidence-based interventions that are specific to the domain of nursing; it is ordered independently by nurses (i.e., without a physician's signature) to standardize the care provided for a specific clinical condition or situation (in this case, a substance use disorder).

Overdose prevention: The goals of overdose prevention programs are to prevent ill consequences and death by overdose amongst individuals who use substances. Overdose prevention programs provide education, training and medication (e.g., "take-home kits") for client's who use substances and are at risk for overdose situations. For example, provision of Naloxone programs to individuals who use substances to prevent overdose situations.

Practice recommendations: Statements of best practice directed at the practice of health-care providers that are ideally evidence-based.

Qualitative research: Research that uses an interactive and subjective approach to investigate and describe phenomena (e.g., lived experience) and to give them meaning. The nature of this type of research is exploratory and open-ended. Analysis involves the organization and interpretation of non-numerical data (e.g., Phenomenology, Ethnography, Grounded Theory, Case Study, etc.) (Speziale & Carpenter, 2007).

Quasi-experimental study: A study that lacks randomization and a control group and therefore is not considered a "true" experimental design (e.g., a randomized controlled trial). The investigator controls the assignment to the intervention, exposure, or treatment by using some criterion other than random assignment (e.g., pre-post design) (Polit, Beck, & Hungler, 2001).

Randomized controlled trial (RCT): An experiment in which the investigator assigns an intervention, exposure, or treatment to participants who are randomly allocated to either the experimental group (receives intervention) and the comparison (conventional treatment) or control group (no intervention or placebo) (The Cochrane Collaboration, 2005). The participants are followed and assessed to determine the efficacy of the intervention. Includes double-blind, single-blind, and non-blind trials.

Recovery: "Recovery involves a process of growth and transformation as the person moves beyond the acute distress often associated with a mental health problem or illness and develops new-found strengths and new ways of being" (Mental Health Commission of Canada, 2009).

Stakeholder: An individual, group, or organization with a vested interest in the decisions and actions of organizations and who may attempt to influence decisions and actions (Baker et al., 1999). Stakeholders include all individuals or groups who will be directly or indirectly affected by the change or solution to the problem.

Stigma: "A social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation that results from experience or reasonable anticipation of an adverse social judgment about a person or group" (Martin & Johnston, 2007, p. 8).

Substance: For the purposes of this BPG, a substance is a chemical that has psychoactive properties (e.g., drugs and/or alcohol). Canada's federal *Controlled Drugs and Substances Act* classifies drugs into four categories: hallucinogens, depressants, stimulants and anabolic steroids. These drugs may have the potential to be used safely and not become problematic. However, there is the potential for the drug to be abused, leading to a substance use disorder (Sunshine Coast Drug Guide, 2010).

Substance use disorder: "A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (APA, 2014, p.483).

In this BPG, the term "substance use disorder" refers to individuals who are at risk for problems associated with substance use, as well as those who meet the DSM-5 criteria for a substance use disorder.

Substitution: To change a client's drug of choice to a drug that has less risk associated with its use (e.g., methadone or Buprenorphine) (RNAO 2009).

Systematic review: A review of a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise relevant research, and to collect and analyze data from the studies that are included in the review (The Cochrane Collaboration, 2005).

System, organization and policy recommendations: Statements of conditions required for a practice setting that enables the successful implementation of the best practice guideline. The conditions for success are largely the responsibility of the organization, although they may have implications for policy at a broader governmental or societal level.

Therapeutic alliance: A type of relationship between client and clinician in which both are working cooperatively toward the same goals, with mutual respect and understanding; also called a "helping alliance." It is the bond of trust formed between client and clinician during therapeutic work that makes healing possible.

Universal screening: The initial screen of all individuals to identify potential or actual risk or harm resulting from substance use.

Vulnerable populations: Vulnerable populations are groups who have an increased susceptibility and higher burden of illness and adverse health outcomes due to disparities in accessing resources that support health. Examples of vulnerable population groups may include, but are not limited to: aboriginal populations, single mothers experiencing poverty, people experiencing homelessness, and refugees (Alberta Health Services, 2012; Beiser & Stewart, 2005).

Withdrawal: A substance-specific syndrome that occurs due to the reduction or cessation of substance use that has been heavy or prolonged. Withdrawl can cause significant distress or impairment in social, occupational or other areas of functioning (APA, 2013).

Appendix B: Guideline Development Process

The Registered Nurses' Association of Ontario (RNAO) has made a commitment to ensure that this Best Practice Guideline is based on the best available evidence. In order to meet this commitment, a monitoring and revision process has been established for each Guideline every five years.

For this new Guideline, RNAO assembled a panel of experts who represent a range of sectors and practice areas. A systematic review of the evidence, which captured relevant literature published between 2005 and 2014, was based on the purpose and scope of this Guideline and supported by the following three questions:

1. What are the most effective methods of assessment for substance use disorders for individuals aged 11 years and older?
2. What are the most effective interventions for individuals aged 11 years and older with a substance use disorder?
3. What education and policy considerations may best facilitate nurses' care of individuals with a substance use disorder?

The RNAO expert panel's mandate was to develop an evidence-based Best Practice Guideline that will provide nurses and other health-care providers with current best practices for engaging clients who use substances. The recommendations in this Guideline aim to bridge the identified gap between current practice and evidence-based practice.

This edition (2015) is the result of the expert panel's work to integrate the most current and best evidence into the recommendations and provide supporting evidence.

Appendix C: Process for Systematic Review and Search Strategy

Guideline Review

The Registered Nurses' Association of Ontario (RNAO) guideline development team's project coordinator searched an established list of websites for guidelines and other relevant content published between 2005 and 2014. This list was compiled based on knowledge of evidence-based practice websites, recommendations from the literature, and key websites related to substance use disorder. Detailed information about the search strategy for existing guidelines, including the list of websites searched and inclusion criteria, is available online at www.RNAO.ca. Guidelines were also identified by members of the RNAO expert panel.

Members of the expert panel critically appraised 16 international guidelines using the *Appraisal of Guidelines for Research and Evaluation Instrument II* (Brouwers et al., 2010). From this review, the following five guidelines were selected to inform the recommendations and discussions of evidence:

American Psychiatric Association. (2006). *Practice guideline for the treatment of patients with substance use disorders* (2nd ed.). Retrieved from http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf

Health Canada. (2002). *Best practices: Concurrent mental health and substance use disorders.* Retrieved from http://www.hc-sc.gc.ca/hc-ps/alt_formats/hecs-sesc/pdf/pubs/adp-apd/bp_disorder-mp_concomitants/bp_concurrent_mental_health-eng.pdf

Health Canada. (2008). *Best practices, early intervention, outreach and community linkages for youth with substance use problems.* Retrieved from http://publications.gc.ca/collections/collection_2012/sc-hc/H128-1-08-531-eng.pdf

National Institute for Health and Care Excellence. (2007). *Drug misuse, psychosocial interventions.* Retrieved from http://www.nice.org.uk/guidance/CG51

Substance Abuse and Mental Health Services Administration (SAMHSA). (2005). *Substance abuse treatment for persons with co-occurring disorders.* Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK64197/pdf/TOC.pdf

Systematic Review

A comprehensive search strategy was developed by the RNAO research team and a health sciences librarian, based on inclusion and exclusion criteria created with the RNAO expert panel. A search for relevant articles published in English, between 2005 and 2014, was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), Cochrane Central Register of Controlled Trials (CENTRAL), Cochrane Database of Systematic Reviews (CDSR), Database of Abstracts of Reviews of Effects (DARE), Embase, MEDLINE, PsycINFO, and Applied Social Sciences Index and Abstracts (ASSIA). In addition to this systematic search, panel members were asked to review personal libraries for key articles not found through the above search strategies.

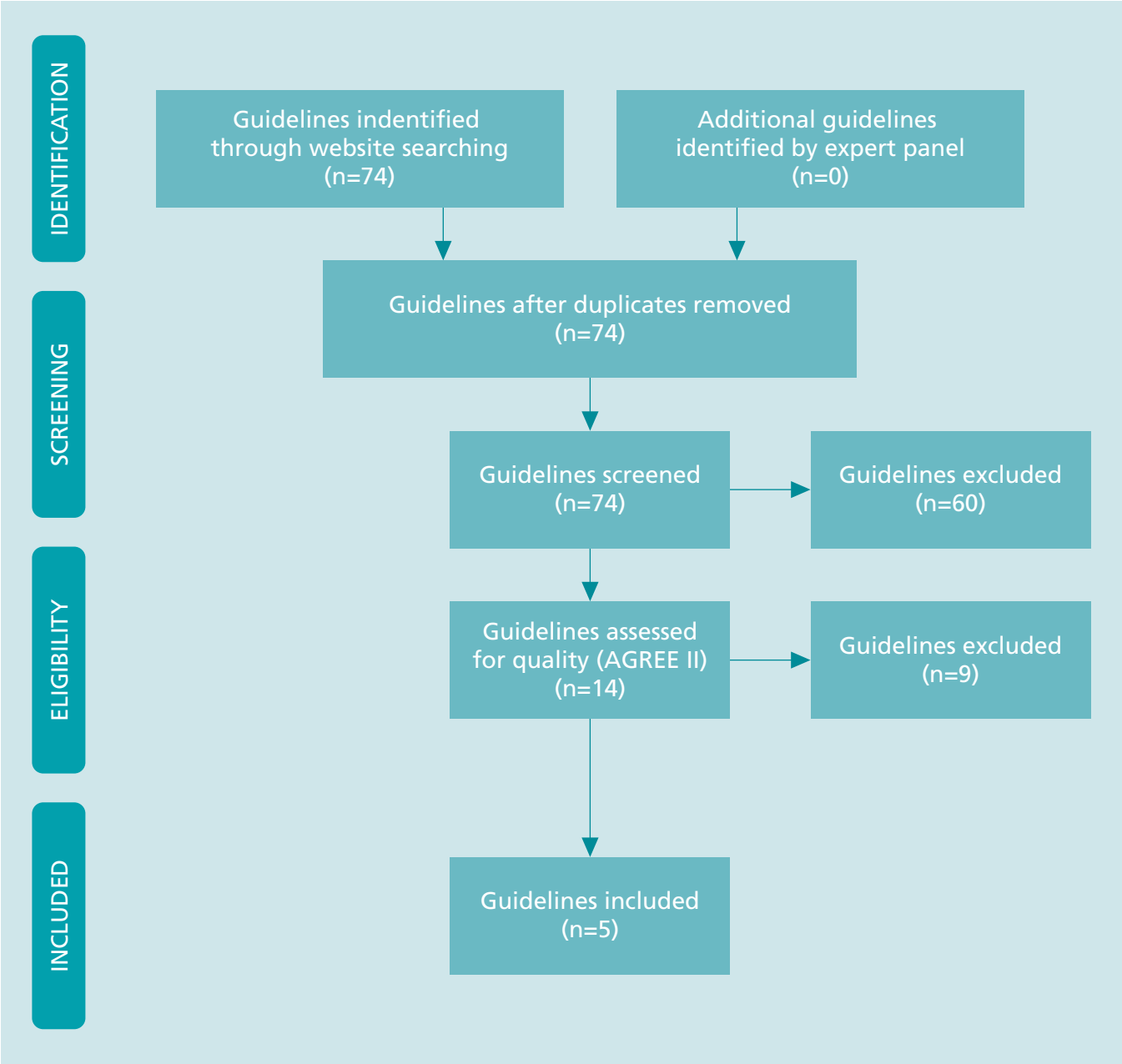
Detailed information about the search strategy for the systematic review, including the inclusion and exclusion criteria as well as search terms, is available online at http://rnao.ca/substanceuse

Once articles were retrieved, the records were divided equally between two teams of research associates (RA), comprised of two RAs each (three RAs are nurses holding master's degrees; one RA is an epidemiologist holding a master's degree). Each member of the team independently assessed the eligibility of their studies according to established inclusion/exclusion criteria. The RNAO's Best Practice Guideline program manager, involved in supporting the RNAO expert panel, resolved disagreements between RAs within each team.

Quality appraisal scores for 24 articles (a random sample of 10% of articles eligible for data extraction and quality appraisal) were independently assessed by each RA. Acceptable inter-rater agreement (kappa statistic, K=0.71) justified proceeding with quality appraisal and data extraction by dividing the remaining studies equally between the RAs (Fleiss, Levin, & Paik, 2003). A final summary of literature findings was completed. The comprehensive data tables and summary were provided to all RNAO expert panel members for review and discussion.

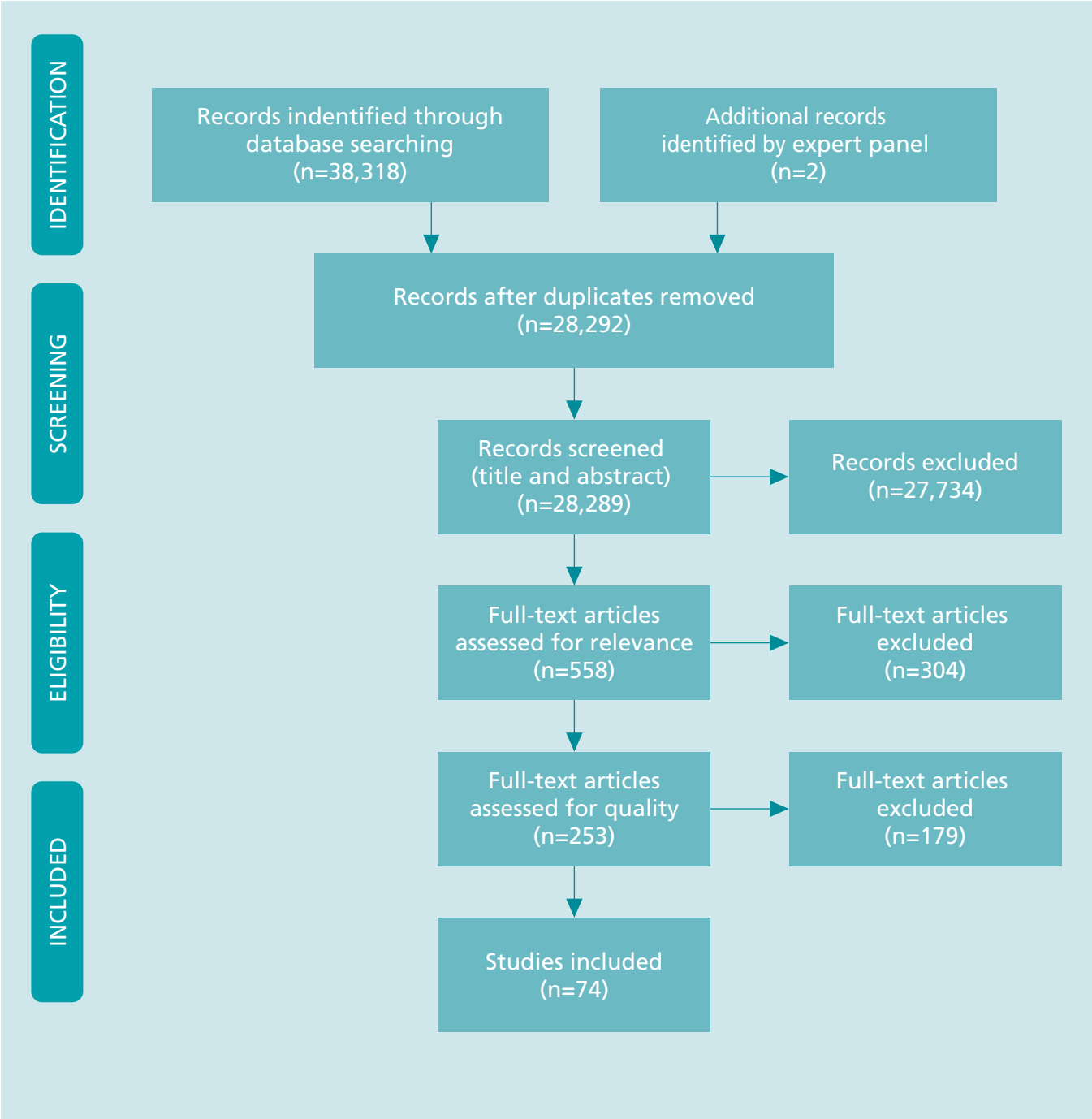
A complete Bibliography of all full text articles screened for inclusion is available at http://rnao.ca/substanceuse

Guideline Review Process Flow Diagram



Flow diagram adapted from D. Moher, A. Liberati, J. Tetzlaff, D. G. Altman, and The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *BMJ 339*, b2535, doi: 10.1136/bmj.b2535

Article Review Process Flow Diagram



Flow diagram adapted from D. Moher, A. Liberati, J. Tetzlaff, D. G. Altman, and The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *BMJ 339*, b2535, doi: 10.1136/bmj.b2535

Appendix D: Classification Criteria for Substance Use Disorders

This appendix summarizes the diagnostic criteria for substance use disorders found in the *DSM-5*. Criteria are grouped under the following headings: impaired control, social impairment, risky use, and pharmacological criteria. In the *DSM-5*, substance use disorders are measured on a continuum from mild, moderate and severe dependent on the amount of criterion present. The table below provides a summary of each criterion that contributes to the development of a substance use disorder.

IMPAIRED CONTROL

- Increase in substance use or over longer period of time than originally intended
- Unsuccessful desire stated to regulate or reduce substance use. Great deal of time obtaining, using or recovering from effects of substance
- Craving: urge for drug at any time of day, especially in environments where drug was previously obtained or used

SOCIAL IMPAIRMENT

- Failure to fulfill major role obligations due to substance use (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school, neglect of children or household)
- Problems (social and interpersonal in nature) occur (persistent or recurrent) and are caused or aggravated by effects of substance use
- Activities once considered important to the individuals (e.g., social, occupational or recreational) are reduced or discontinued due to substance use

RISKY USE

- Recurrent use of substances in situations where it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
- Repeated substance use, even though physical and or psychological problems (caused or exacerbated by substance use) persist

PHARMACOLOGICAL EFFECTS

- Increased amount of substance consumed to achieve desired effects and /or diminished effect with use of the same amount of substance (Tolerance)
- Occurrence of withdrawal marked by reduced blood and tissue concentrations of substances used; individual increases amount of substance used to relieve symptoms

For more information on diagnostic criteria for substance use disorders, please refer to:

American Psychiatric Association (APA). (2013). *Diagnostic and Statistical Manual of Mental Disorders* 5th edition, by the American Psychiatric Association, 2013, pp. 483-484.

Appendix E: Social Determinants of Health Examples

This appendix lists the 14 social determinants of health identified in the Canadian context to help explain why some Canadians are healthier than others (Mikkonen & Raphael, 2010). The determinants, in alphabetical order, are:

- Aboriginal status
- Disability
- Early childhood development
- Education
- Employment and working conditions
- Food insecurity
- Health services
- Gender
- Housing
- Income and income distribution
- Racialized status
- Social exclusion
- Social safety net
- Unemployment and job security

1. Mikkonen & Raphael. (2010). *Social determinants of health: The Canadian facts.* Retrieved from http://www.thecanadianfacts.org/The_Canadian_Facts.pdf

Appendix F: Sample Prevention-Based Strategies

This appendix describes examples of prevention-based strategies, based on the Population Health Promotion Model proposed by Hamilton and Bhatti (1996) that nurses and other health-care providers can employ to prevent, reduce the risk of and the problems associated with substance use in communities. The action strategies in the left-hand column are derived from Hamilton and Bhatti (1996), while the sample interventions in the right-hand column are adapted from the Ministry of Health Promotion *Prevention of Substance Misuse Guidance Document* (2010).

STRATEGY	SAMPLE INTERVENTIONS
Developing personal skills	■ Work with community partners (e.g., schools, law enforcement, community agencies) to provide health education teaching to those at risk and to address concerns (e.g., risk reduction techniques, prevention techniques) ■ Develop educational outreach programs that engage youth and parents to develop resilience building skills
Creating supportive environments	■ Establish community programs that utilize a harm reduction approach (e.g., needle exchange, non-abstinence-based approaches, mobile outreach vans and clinics) ■ Work with establishments that serve alcohol to have breathalyzers available and provide access to safe modes of transportation ■ Establish Safer Bars programs that conduct a bar risk assessment and provide staff training on safe drinking levels, liability and legal issues, and violence prevention techniques
Strengthening community action	■ Conduct a situational assessment with community partners to understand the local community context ■ Work on health promotion programming that includes access to community resources related to substance use disorders ■ Provide opportunities for accessible and equitable recreation and leisure activity ■ Provide opportunities for civic engagement among youth at risk for a substance use disorder ■ Create social marketing campaigns regarding harm reduction and substance use prevention techniques
Building healthy public polices	■ Partner with local communities and liquor control boards to ensure safe and socially responsible access to alcohol (e.g., cost and availability) ■ Advocate for zero tolerance laws regarding blood alcohol content levels ■ Advocate for policies that promote principles of harm reduction (e.g., needle exchange programs, safe injection sites, etc.)

1. Hamilton, N and T. Bhatti. 1996. *Population Health Promotion: An Integrated Model of Population Health and Health Promotion.* Retrieved from http://www.phac-aspc.gc.ca/ph-sp/php-psp/php3-eng.php#Developing

2. Ministry of Health Promotion. (2010). *Prevention of substance misuse guidance document.* Retrieved from http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guidance/PreventionOfSubstanceMisuse.pdf

Appendix G: Guiding Questions for Transtheoretical Model of Change

This appendix provides examples of guiding questions for each of the stages of change in the Transtheoretical Model of Change, developed by Prochaska and DiClemente (1984). The guiding questions below are compiled from Herie & Skinner (2010) and Rassool (2010). Further additions have also been made by the expert panel. Clinicians can use them when working with clients who use substances to develop action-based goals and a plan of care to address clients' unique needs in the change process.

UTILIZING THE STAGES OF CHANGE IN NURSING PRACTICE

Assessing and Listening for Readiness to Change – Ask:
1) Tell me about your substance use.
2) How important is it for you to make changes?
3) How confident are you that you could make changes to your substance use?

Stage: *Precontemplation*
Assessing and Listening for Precontemplation – Ask:
1) Tell me about your substance use?
2) Tell me about a typical day. Where does your drug use fit in?
3) What are the reasons that you take substance X?

Stage: *Contemplation*
Assessing and Listening for Contemplation – Ask:
1) What concerns do you have about your use of substance X?
2) What are the pros and cons of substance use from your perspective?
3) Create a decisional balance sheet: "What do you like/hate about substance X?"
4) How does your current substance use fit in with how you see yourself in two, three, five years?
5) What might happen if nothing was to change?

Stage: *Preparation*
Supporting the Person in Preparation – Consider:
1) Review decisional balance sheet: discuss medications, counseling options
2) Explore harm reduction strategies & coping strategies
3) Review commitment to change

Stage: *Action*
Supporting the Person in Action – Consider:
1) Remember that change is a process not an event
2) Plan for slips and lapses

Stage: *Maintenance*
Supporting the Person in Maintenance – Consider:
1) Review accomplishments and provide positive reinforcement
2) Explore stimulus control, reinforcement management & counter conditioning
3) Talk about ongoing harm reduction strategies and barriers

Stage: *Relapse Prevention*
Relapse Prevention – Plan:
1) Safety planning: identify triggers, coping strategies, support systems, dealing with different levels of distress
2) Chain analysis after relapse
3) Teach coping and social skills

Compiled by the RNAO expert panel, 2015.

References: Herie & Skinner (2010), and Rassool (2010).

Appendix H: Commonly Used Screening Tools

The tools included in the table below are commonly used in various clinical settings to screen certain client populations for use of the specific substance(s) listed. The tools support health-care providers in obtaining specific clinical information about the client's substance use, which informs the assessment and development of the care plan in conjunction with the client. It is important to note that the tools listed below are not diagnostic in nature.

Certain tools are particularly recommended for use with certain populations. Where available, this information is included in the "Population" column.

Please note that if the health-care provider is unfamiliar with a particular tool, the expert panel recommends that the provider seek out appropriate support from his or her organization, consult with an expert, and/or follow Recommendation 1.1 and administer the universal screen.

The RNAO expert panel selected the following tools from the evidence-based literature; the list is not exhaustive.

SCREENING TOOL	INDICATION FOR USE	POPULATION	CLINICAL SETTING	URL/REFERENCE
The Alcohol Use Disorders Identification Test (AUDIT)	Alcohol	■ General adult population ■ Pregnant women ■ Youth/adolescents ■ Individuals with severe mental health issues	■ Primary care ■ Emergency settings	http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf
The Alcohol Use Disorders Identification Test – Consumption Questions	Alcohol	■ General adult population ■ Pregnant women	Primary care	http://www.hiv.va.gov/provider/manual-primary-care/alcohol-misuse-tool1.asp
TWEAK (Tolerance, Worried, Eye Opener, Amnesia, C(k)ut Down)	Alcohol	■ General adult population ■ Pregnant women	Primary care	http://www.unodc.org/ddt-training/treatment/VOLUME%20A/Volume%20A%20-%20Module%201/5.Screening%20and%20Assessment%20Tools,%20Assist/9.TWEAK.pdf
T-ACE (Tolerance, Annoyance, Cut Down, Eye Opener)	Alcohol	■ General adult population ■ Pregnant women	*Not specified*	http://www.michigan.gov/documents/mdch/T-ACEScreeningTool_412228_7.pdf
Fast Alcohol Screening Test (FAST)	Alcohol	■ General adult population	Emergency department	http://www.effectivepi.co.uk/files/FAST%20&%20other%20AUDIT%20questions_EPI%20version%20Mar%2009.pdf
Short Michigan Alcohol Screening Test (SMAST)	Alcohol	■ General adult population	*Not specified*	http://smchealth.org/sites/default/files/docs/1309587945SHORTMICHIGANALCOHOLSCREENINGTEST.pdf

SCREENING TOOL	INDICATION FOR USE	POPULATION	CLINICAL SETTING	URL/REFERENCE
CAGE (Cut, Annoyed, Guilty, Eye Opener)	Alcohol	■ General adult population ■ Concurrent disorders population	In-patient populations	http://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/CAGE%20Substance%20Screening%20Tool.pdf
Paddington Alcohol Test (PAT)	Hazardous and harmful alcohol use	Adult population at risk for hazardous alcohol use	Emergency department	http://www.cmaj.ca/content/suppl/2002/04/04/164.3.323.DC1/0323a.pdf
Standardized Mini-Mental State Examination	Alcohol problems and cognitive functioning	Older adults	*Not specified*	http://www.health.gov.bc.ca/pharmacare/adti/clinician/pdf/ADTI%20SMMSE-GDS%20Reference%20Card.pdf
Michigan Alcoholism Screening Test-Geriatric Version (MAST-G)	Alcohol	Older adults	*Not specified*	http://www.sbirttraining.com/sites/sbirttraining.com/files/MAST-G.pdf
Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G)	Alcohol problems and cognitive functioning	Older adults	*Not specified*	http://consultgerirn.org/uploads/File/trythis/try_this_17.pdf Blow, F.C., Brower, K.J., Schulenberg, J.E., Demo-Dananberg, L.M., Young, J.P., & Beresford, T.P. (1992). The Michigan Alcoholism Screening Test – Geriatric Version (MAST-G): A new elderly-specific screening instrument. *Alcoholism: Clinical and Experimental Research, 16*, 372.

SCREENING TOOL	INDICATION FOR USE	POPULATION	CLINICAL SETTING	URL/REFERENCE
CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble)	Substance use, including alcohol	Youth and adolescents	*Not specified*	http://www.integration.samhsa.gov/clinical-practice/sbirt/adolescent_screening,_brieft_intervention_and_referral_to_treatment_for_alcohol.pdf
CAGE-AID (CAGE Adapted to Include Drugs)	Substance use dependence and alcohol	■ General adult population ■ Concurrent disorders population	In-patient populations	http://www.ncdhhs.gov/mhddsas/providers/DWI/dualdiagnosis/CAGE-AID.pdf
Drug Abuse Screening Test (DAST)	Substance use	■ General adult population ■ Psychiatric population ■ Adolescents	■ Psychiatric settings ■ General hospital settings	http://www.np.edu.sg/ss/studentcare/resources/Documents/Drug%20Abuse%20Screening%20Test%20(DAST).pdf
ASSIST (Alcohol, Smoking and Substance Involvement Screening Test)	Substance use, including alcohol and tobacco	■ General adult population	Primary care	http://whqlibdoc.who.int/publications/2010/9789241599382_eng.pdf

SCREENING TOOL	INDICATION FOR USE	POPULATION	CLINICAL SETTING	URL/REFERENCE
Severity of Dependence Scale (SDS)	Substance use dependence (cannabis, cocaine, amphetamines, benzodiazepines, and alcohol)	■ General adult populations ■ Specific user populations identified as either: individuals who use cannabis, regular users of cocaine, or clients with schizophrenia ■ Youth/adolescents	*Not specified*	http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/InstrumentPDFs/67_SDSS.pdf http://www.who.int/substance_abuse/research_tools/severitydependencescale/en/ https://ncpic.org.au/media/1580/severity-of-dependence-scale.pdf
Addiction Severity Index (ASI)	Substance use	Adults with concurrent disorders	*Not specified*	Health Canada. (2002). *Best practices: Concurrent mental health and substance use disorders*, http://www.hc-sc.gc.ca/hc-ps/alt_formats/hecs-sesc/pdf/pubs/adp-apd/bp_disorder-mp_concomitants/bp_concurrent_mental_health-eng.pdf http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/InstrumentPDFs/04_ASI.pdf
GAIN-SS	Substance use, internalizing disorders, externalizing disorders, and crime/violence	■ General adult population ■ Individuals aged 10 to 17	All practice settings, especially primary care	http://www.gaincc.org/GAINSS

Appendix I: Considerations for Vulnerable Populations

The chart below contains information that nurses and other health-care providers should keep in mind when working with individuals from certain populations. Members of these groups may be at increased risk for a substance use disorder, and assessments and interventions that take their specific needs and circumstances into consideration may result in better outcomes. This list, while not exhaustive, was informed by the literature and expert panel consensus.

POPULATION	SPECIAL CONSIDERATIONS
Concurrent Disorders[1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12]	The term *concurrent disorder* refers to individuals experiencing at least one diagnosable mental disorder along with at least one substance use disorder (Health Canada, 2002). In Canada, more than half of individuals seeking help for a substance use disorder also have a mental illness (CCSA, 2009). Individuals with concurrent disorders are some of the most challenging individuals to engage in and retain over the duration of care (Hunt, Siegfried, Morley, Sitharthan, & Cleary, 2013). Individuals with low levels of substance use and compounding severe mental illness can experience a number of harmful effects, including: a worsening of psychiatric symptoms, a decrease in compliance with interventions, increased risk of suicidal and self-harming behaviours, decreased physical health, decreased social supports, decreased financial resources, increased use of acute care services including emergency room visits and psychiatric admissions, and increased involvement with the criminal justice system (Donald, Dower, & Kavanagh, 2005; Hunt et al., 2013). The utilization of multi-faceted care plans that include both psychosocial and pharmacological approaches aids in decreasing negative mental health effects and promotes positive care outcomes in individuals with concurrent disorders (Kelly et al., 2012). Furthermore, integrated pharmacological and psychosocial intervention appraoches significantly improve mental health, reduce substance use, improve access to services, allow for individualization of care, increase retention in care and compliance with interventions, and promote positive social adjustment (Donald et al., 2005; Drake, O'Neal, & Wallach, 2008). (See the discussion of evidence under Recommendation 3.2 for further information regarding combined pharmacological and psychosocial interventions.) The psychosocial interventions found to be most effective with this population include motivational interviewing and brief intervention (Hunt et al., 2013; Kelly et al., 2012; Kaner, Brown, & Jackson, 2011), cognitive behavioural therapy (Hides, Samet, & Lubman, 2010; Gregory, 2011), Twelve-Step Facilitation (Miller, Bogenschutz, & Villarreal, 2006; SAMHSA, 2005), case management including Assertive Community Treatment[G] (Fries & Rosen, 2011; Kelly et al., 2012), and contingency management (Kelly et al., 2012). Further information on psychosocial interventions can be found in **Appendix K**.

POPULATION	SPECIAL CONSIDERATIONS
First Nations, Inuit, and Métis[13, 14, 15]	First Nations, Inuit and Métis populations have been and continue to be affected by a range of social, historical, and cultural factors, including but not limited to colonization and the legacy of colonization; oppression; loss of culture (including language); intergenerational trauma resulting from residential schools and the associated physical, emotional, and spiritual abuse; family dislocation; and lack of access to adequate education, housing, social, and health services. These factors have negatively impacted the health and well-being of First Nations, Inuit, and Métis people, and have placed them at an increased risk for substance use disorders (Assembly of First Nations [AFN], 2011; Health Canada, 2011). Issues pertaining to substance use and mental health are among the top priorities for First Nations communities and leaders, both on and off reserve. This is clearly articulated in the First Nations Information Governance Centre's (2012) national longitudinal health survey of First Nations communities, in which 82.6 percent of respondent communities identified the misuse of alcohol and drugs on-reserve as their primary concern for community wellness. Furthermore, First Nations communities demonstrate higher-than-average percentages of drug use and chemical dependency compared to the Canadian population as a whole (AFN, 2011). When working with individuals from First Nations, Inuit, and/or Métis communities, it is vital to approach health and wellness in ways that are holistic and strengths-based, and integrate cultural practices into care. The goal of achieving wellness is essential and should promote balance of mental, physical, emotional, and spiritual well-being, taking into consideration culture as the central component. Culturally specific interventions that address the needs and interconnectedness of the mind, body, spirit, and emotions should be considered. This creates a necessary foundation that allows nurses and other health-care providers to support the diverse needs of First Nations, Inuit, and Métis people in ways that are culturally competent and culturally safe. Please refer to http://rnao.ca/substanceuse, for a synopsis of substance use issues in First Nation communities created by the National Native Addictions Partnership Foundation.
Homeless, Under-housed, and Transient Populations[16, 17]	Nurses should view every encounter with a homeless client as an opportunity to assess for substance use. Due to stigma and other barriers, many homeless patients may not be screened for a substance use disorder when engaging with health-care providers. Case management, establishing therapeutic communities, and alternative housing programs have been shown to be effective in engaging, retaining, and reducing substance use among homeless populations (Kertesz, Crouch, Milby, Cuisimano, & Schumacher, 2009; Vanderplasschen, Wolf, Rapp, & Broekaert, 2007). Alternative housing approaches, commonly known as "housing first" approaches, should be considered, as they have been shown to produce better addiction and mental health outcomes than approaches that do not use a housing first approach (Kertesz et al., 2009).

POPULATION	SPECIAL CONSIDERATIONS
Immigrant and Newcomers to Canada[18, 19, 20]	Shifts in global population trends are resulting in increasing numbers of individuals from diverse ethnic groups immigrating to North America (SAMHSA, 2005). Cultural barriers that impede the care of immigrants and newcomers with a substance use disorder may include: stigma regarding disclosure of problematic substance use, lack of openness to involve external service providers due to trust issues, cost and limited accessibility to care, and language barriers (Lim, 2008). When creating a substance use disorder care plan for immigrant/newcomer clients, nurses should discuss the client's cultural beliefs and needs with the client in a respectful way, to ensure that they are included in the care plan (SAMHSA 2005). Each culture has specific communication styles, family role expectations, social norms, and, most importantly, health beliefs, which should be considered when collaborating with the client in planning care (RNAO, 2007b). The expert panel suggests that when working with clients from diverse populations, nurses should assess the following: the client's role in the family, based on their culture; the client's religious/spiritual beliefs and religious influence; the client's language of origin (first or primary language, and the need for an interpreter); the client's style of communication, which can be culturally driven; the client's beliefs about health and healing (e.g., traditional cultural beliefs, folk medicine, prayers, healers, alternative therapies, etc.). Clinicians can help address barriers faced by newcomers by providing outreach services to these populations, providing services in the client's preferred language, and increasing the sensitivity of service providers to the values and culture of specific ethnic groups (Health Canada, 2008). Ultimately, the incorporation of clients' cultural needs into the care plan is essential in improving acceptance of care, adherence to interventions, and the outcomes of care (SAMHSA, 2005).
Incarcerated Women[21, 22, 23]	Incarcerated individuals are at higher risk for developing a substance use disorder (Ministry of Health Promotion, 2010). When working with incarcerated women with a history of substance use, nurses should provide individualized care in an environment separate from the general prison population (Finfgeld-Connett & Johnson, 2011). Two systematic reviews demonstrated that the development of trust-based relationships between health-care providers and incarcerated women can increase engagement in therapy, and is linked with women's ability to meet their individual goals (Adams, Leukefeld, & Peden, 2008; Finfgeld-Connett & Johnson, 2011). Management approaches that include linkages between prison and community-based treatment, and integrated approaches that incorporate empowerment, community mentoring by successful peer role models, and the use of MI techniques are effective in supporting the recovery of incarcerated women from a substance use disorder (Adams et al., 2008). The two systematic reviews concluded that women with a substance use disorder who are engaged in intervention programs while completing their prison sentence emerge with better self-esteem, improved problem-solving and coping skills, and an enhanced ability to establish supportive relationships with family outside of prison (Adams et al., 2008; Finfgeld-Connett & Johnson, 2011).

POPULATION	SPECIAL CONSIDERATIONS
Lesbian, Gay, Bisexual, Transgendered, Two-Spirited, Intersex, Queer, Questioning, or Asexual (LGBTTIQQA) [18, 19, 24]	Health Canada (2008), APA (2006), and SAMHSA (2005) indicate that individuals in the LGBTTIQQA population are at increased risk for a substance use disorder due to factors related to wide-spread marginalization and discrimination, ranging from insensitivity to violence (Health Canada, 2008). The discrimination and marginalization that individuals from the LGBTTIQQA population experience can make sharing their specific concerns and needs with family members, friends, and other supports difficult, especially for youth who are dealing with their emerging sexual identity and the associated challenges. The use of support groups, assistance from support agencies, the provision of accurate health information, and the promotion of positive community linkages are important considerations when working with individuals from the LGBTTIQQA population. Health Canada, the APA, and SAMHSA note that the research that has been conducted on substance use within the LGBTTIQQA population is limited, and that more is needed to identify and address the unique needs of this population.
Older Adults [25, 26, 27]	Alcohol, prescription medications, and over-the-counter medications are the most commonly misused substances among older adults (Royal College of Psychiatrists, 2011; SAMHSA/CSAT, 1998). Nurses should use appropriate screening tools when assessing for substance use disorders in this population. In terms of screening, the SMAST-G and MME help identify problems with alcohol use and cognitive functioning, respectively, and have been developed and validated with older adult populations (Royal College of Psychiatrists, 2011; SAMHSA/CSAT, 1998). Although the other screening tools mentioned in **Appendix H** are helpful, certain adjustments must be made when applying them to the older adult population, who may not exhibit withdrawal symptoms in the same way as younger populations (Seeking Solutions, 2004). When initiating care with older adults, health-care providers must recognize that detoxification may require a longer timeframe due to potential physical and psychiatric co-morbidities, and age related physiological changes (e.g., water ratio, metabolism, etc.) (Royal College of Psychiatrists, 2011; SAMHSA/CSAT, 1998; Seeking Solutions, 2004). Pharmacological interventions in older adults also require closer monitoring, due to physiological and psychological changes. For example, nutritional status should be monitored closely in older adults who use alcohol, as there is increased risk of nutritional deficiencies (e.g., thiamine) (Royal College of Psychiatrists, 2011). Finally, effective case management is essential when working with older adults, as their social networks may be limited as a result of their substance use, physical limitations, and/or loss of family members and friends (Seeking Solutions, 2004).

POPULATION	SPECIAL CONSIDERATIONS
Pregnant and Postpartum Women[24, 28, 29, 30]	According to the APA (2006), the management of substance use disorders in pregnant women is vital due to the multiple complications that can result for both the mother and the developing fetus. Pregnant women using substances have an increased risk for diseases, disorders, and complications such as HIV, hepatitis, anemia, tuberculosis, hypertension, pre-eclampsia spontaneous abortions, abruptio placentae, and early and prolonged labour (APA, 2006). The fetus is at higher-than-average risk for birth defects, impaired growth and development, prematurity, low birth weight, and stillbirth (APA, 2006; Milligan et al., 2010). Post-delivery, the neonate may experience withdrawal symptoms due to maternal substance use, and long-term issues may include behavioural problems, learning disabilities, and future substance use issues (Milligan et al., 2010). Nurses are ideally positioned to intervene with women to reduce substance use during the preconception, pregnancy, and postpartum periods. Nurses conducting prenatal visits should screen all clients using appropriate screening tools and provide brief interventions for support (see **Appendix H and Appendix J**). Despite the limited number of screening tools available, it is important that nurses screen and offer follow-up support to clients who engage in substance use during pregnancy and in the postpartum period (Burns et al., 2010). Home visiting programs during pregnancy and/or after birth for women experiencing substance use disorders have been shown to be beneficial for both the mother and the infant. Benefits include: increased enrolment in and attendance for drug and alcohol management services, a reduction in non-voluntary child foster care, and improved contraception use (Turnbull & Osborn, 2012). It is important for nurses and other health-care providers across the continuum of care to work with women during pregnancy and in the postpartum period to provide culturally appropriate, sensitive management options for substance use disorders.
Sex Trade Workers[24, 31, 32]	Sex trade workers are at high risk for problem substance use, victimization, and discrimination (Health Canada, 2006). The establishment and maintenance of trust over multiple sessions with individual sex trade workers plays an important role in effective outreach (Health Canada, 2006). Education should be provided to this population on safe substance use administration, safe sex practices, and methods to decrease the risk of contraction of blood-borne pathogens. Screening using blood tests should be made available to screen for sexually transmitted diseases, and periodic skin testing for tuberculosis should be performed (APA 2006). Access to basic requirements that determine health, including housing and health services, is critical when managing care of client's with substance use disorders in this population (Health Canada, 2006).

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Appendix J: Alcohol Screening, Brief Intervention & Referral: A Clinical Guide

The *Alcohol Screening, Brief Intervention and Referral: A Clinical Guide* is a resource for Canadian family physicians, nurse practitioners, and other health-care providers to use when working with clients who are at risk for or experiencing a substance use disorder. This guide sets out a simple 3-step screening, brief intervention, and referral protocol.

The Alcohol Screening, Brief Intervention and Referral: A Clinical Guide can be downloaded from: http://www.sbir-diba.ca/docs/default-document-library/2012-screening-brief-intervention-and-referral-clinical-guide-enB0E406423349865474B15064.pdf?sfvrsn=4

NEW!

ALCOHOL SCREENING, BRIEF INTERVENTION & REFERRAL: A CLINICAL GUIDE

This resource provides an overview of a simple 3-step **alcohol screening, brief intervention and referral** process.

1 SCREENING AND ASSESSMENT

2 BRIEF INTERVENTION AND REFERRAL

3 FOLLOW-UP AND SUPPORT

It incorporates **Canada's Low-Risk Alcohol Drinking Guidelines** into your routine alcohol screening.

More details and related resources can be found at

WWW.SBIR-DIBA.CA

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

CCSA · CCLAT Canadian Centre on Substance Abuse

SCREENING FOR AT-RISK DRINKING

ASK ABOUT ALCOHOL USE — STEP 1A

QUESTION 1

DO YOU DRINK BEER, WINE, COOLERS OR OTHER ALCOHOLIC BEVERAGES?

NO

ASK WHY NOT?

- Religious / Cultural
- Family History
  - Explore possible history of trauma
  - Refer to health care or community resources
- Medications or other issues
- In Recovery

ASK HOW ARE YOU DOING?

WELL
- Reinforce and support continued abstinence
- Review current steps to maintain abstinence

NOT WELL
- Acknowledge that change is difficult
- Support efforts to change and address barriers
- Renegotiate goal and plans to achieve abstinence
- Consider engaging additional or different supports
- Reassess diagnosis: is there a concurrent mental illness?
- Offer support: detox, rehab, community addiction services, medication, etc.
- Refer to health care or community resources as indicated

GO TO STEP 3-AD

YES — PROCEED TO QUESTION 2 & QUESTION 3

QUESTION 2

ON AVERAGE, HOW MANY DAYS PER WEEK DO YOU HAVE AN ALCOHOLIC DRINK?

_____ days per week

QUESTION 3

ON A TYPICAL DRINKING DAY, HOW MANY DRINKS DO YOU CONSUME?

_____ drinks per day

CALCULATE DRINKS PER WEEK

_____ (days/week X drinks/day)

ARE THE DAILY AND/OR WEEKLY AMOUNTS ABOVE THE LIMITS IN CANADA'S LOW-RISK ALCOHOL DRINKING GUIDELINES?

2 drinks/day
10 drinks/week

3 drinks/day
15 drinks/week

NO
- Reinforce positive behaviour
- Individualize your advice especially if patient is part of a subpopulation for which lower level use is recommended?
- Rescreen annually
- Provide patient with Canada's Low-Risk Alcohol Drinking Guidelines

YES

GO TO STEP 1B

ASSESSING LEVEL OF AT-RISK DRINKING

DETERMINE LEVEL OF RISK — STEP 1B

ELEVATED RISK

Patient drinks at levels above alcohol limits set in Canada's Low-Risk Alcohol Drinking Guidelines and does not meet the criteria for either Alcohol Abuse or Alcohol Dependence.

ALCOHOL ABUSE*

In the past 12 months, patient's drinking has caused or contributed to:

- Role failure (i.e., failed work or home obligations)
- Injuries or risk of injuries
- Drinking while driving or operating machinery
- Legal issues (e.g., arrested, charged)
- Relationship issues (e.g., spouse or friends complained about patient's drinking)
- Does not meet criteria for Alcohol Dependence

ALCOHOL DEPENDENCE*

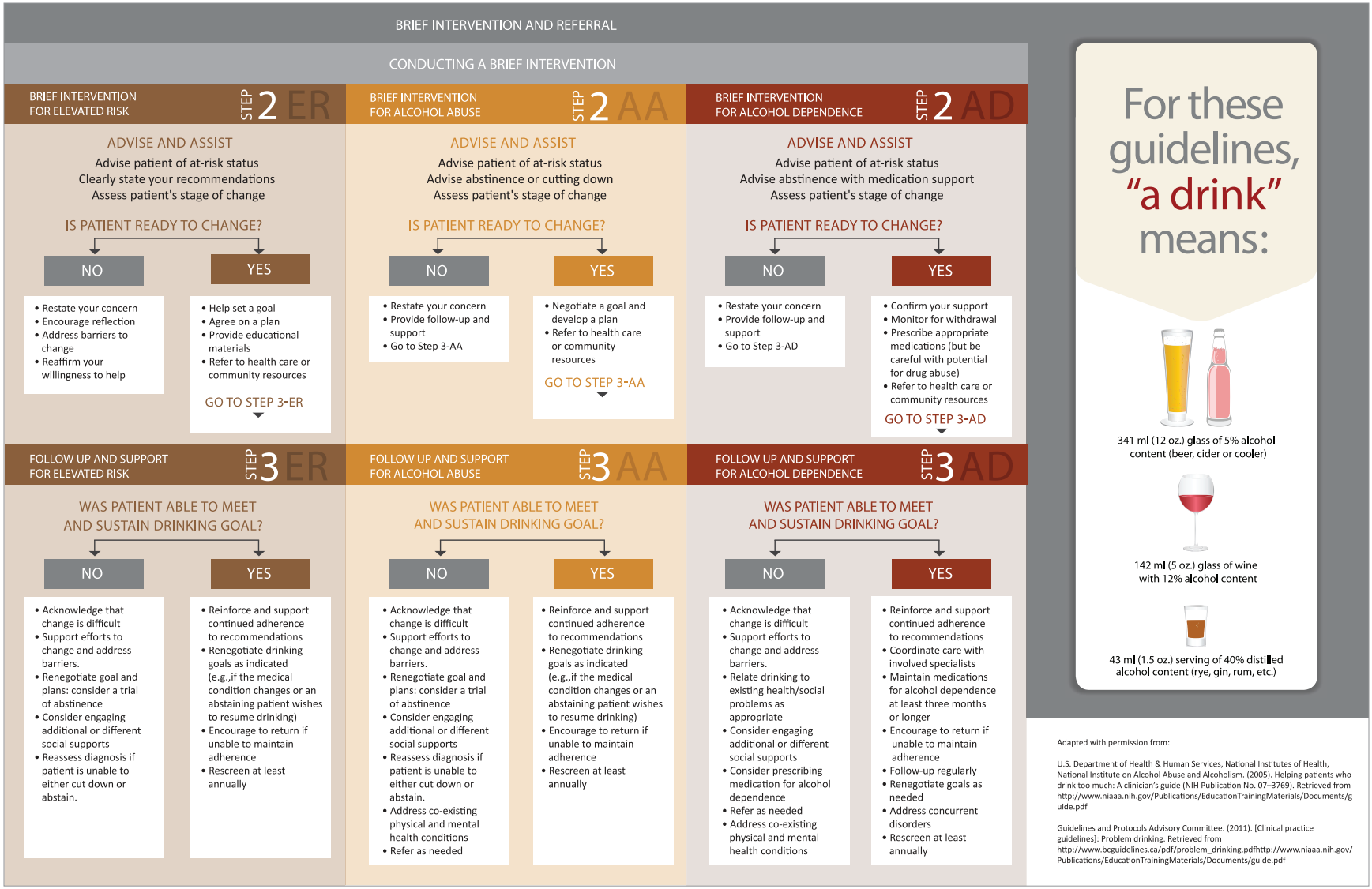
In the past 12 months, patient's drinking has caused or contributed to:

- Increased tolerance (i.e., need to drink more to achieve the same effect)
- Withdrawal (e.g., tremors, sweating, nausea or insomnia when trying to quit or cut down)
- Failed attempts to stick to limits
- Failed attempts to cut down or quit
- More time spent anticipating or recovering from drinking
- Less time spent on other activities that had been important or pleasurable
- Continuation of drinking despite problems (e.g., personal, work, social, physical, psychological, and/or legal)

*American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC.

WHAT IS THE PATIENT'S AT-RISK STATUS?

ELEVATED	ALCOHOL ABUSE	ALCOHOL DEPENDENCE
GO TO STEPS 2-ER & 3-ER	GO TO STEPS 2-AA & 3-AA	GO TO STEPS 2-AD & 3-AD
ER	AA	AD



Reprinted from Alcohol Screening, Brief Intervention & Referral: Helping patients reduce alcohol-related risks, by Canadian Centre on Substance Abuse and College of Family Physicians of Canada, 2012. Copyright 2012 by College of Family Physicians of Canada, 2012. Reprinted with permission.

Appendix K: Types of Psychosocial Interventions

This appendix includes a summary table of ten different types of psychosocial interventions used in the management of substance use disorders. The list was informed by the literature and by expert panel consensus; it is not exhaustive. The interventions are further specified as a formal intervention[G], informal intervention[G] or a type of service delivery.

NAME	SUMMARY	BENEFITS	TYPE OF INTERVENTION OR SERVICE DELIVERY
12-Step and Self-Help Groups[1, 2]	12-step and self-help groups are generally peer-led, non-professional community-based groups for people with a substance use disorder. Examples of 12-step groups include Alcoholics Anonymous (AA) Narcotics Anonymous (NA). The Al-Anon, Alateen, and Nar-Anon Family Groups provide support for family and friends of individuals with substance use issues.	These groups generally encourage abstinence and are focused on long-term recovery. Groups for families and friends of those with a substance use disorder provide support and education regarding substance use, and help individuals gain insight into how their own behaviour may facilitate their loved ones' substance use.	Informal Intervention

NAME	SUMMARY	BENEFITS	TYPE OF INTERVENTION OR SERVICE DELIVERY
Alternative Therapies	Alternative therapies (e.g., mindfulness meditation, acupuncture) can be a beneficial intervention for clients with a substance use disorder when combined with standard therapies. The expert panel recommends that alternative therapies be used as an adjunct or complementary form of therapy to traditional therapy, and should never be the sole type of therapy for clients with a substance use disorder. For additional information on alternative therapies, visit the National Center for Complementary and Alternative Medicine (NCCAM) website: http://nccam.nih.gov/	Acupuncture therapy may complement existing intervention modalities for those with a substance use disorder; further research is required to demonstrate its effectiveness (Lu et al., 2009). Mindfulness meditation can help clients with a substance use disorder manage their unwanted thoughts, craving sensations, and negative emotions, and help maintain healthy lifestyle behaviors.	Formal Intervention
Case Management[3, 4, 5]	Case management is a client-centered strategy for assessing, planning, and providing access to adequate community services. The goal of case management is to provide continuity of care and coordination of service delivery for clients with a substance use disorder. Case management models include: (i) Intensive Case Management, (ii) Assertive Community Treatment, (iii) Strengths-Based Case Management, and (iv) Intensive and Generalist Case Management.	Case management has demonstrated positive effects for general client outcomes, including: (i) access and retention in care, (ii) quality of life, (iii) client satisfaction, and (iv) reduced hospitalizations.	Service Delivery

NAME	SUMMARY	BENEFITS	TYPE OF INTERVENTION OR SERVICE DELIVERY
Cognitive Behavioural Therapy (CBT)[3, 6]	CBT aims to modify negative or self-defeating thoughts and behaviour. Clinicians using CBT focus on changing the client's automatic thoughts, core beliefs, and problem behaviours.	CBT helps to: (i) identify intrapersonal and interpersonal triggers for relapse, (ii) develop positive coping skills, (iii) develop drug refusal skills, and (iv) increase non-use-related activities.	Formal Intervention
Community Reinforcement Approach (CRA)[7, 8]	CRA aims to provide individuals with alternative environmental reinforcements (e.g., substance-free social recreation) to mitigate negative substance use behaviours. CRA is based on the theory that environmental conditions reinforce substance use. Clinicians who work in residential or partial hospital programs will find this approach helpful.	A systematic review (Rosen et al, 2012) found that CRA has a limited to moderate effectiveness in persons with a substance use disorder resulting from alcohol, heroin, cocaine, and opioid use.	Formal Intervention
Contingency Management (CM)[1, 9, 10, 11, 12]	CM aims to reinforce positive behaviours through the use of planned, positive rewards. CM emphasizes that neurobiological and environmental factors influence substance use behaviours, and that the application of reinforcing environmental consequences can assist in changing negative behaviours. Evidence suggests that CM is an effective approach for promoting abstinence during and after management of a substance use disorder.	Benefits of CM include: (i) decreased illicit drug use, (ii) positive engagement in management services that promote recovery, (iii) increased compliance in completing screening for transmittable diseases (e.g., TB tests), and (iv) increased compliance with medication regimens (e.g., compliance with HIV medications).	Formal Intervention

NAME	SUMMARY	BENEFITS	TYPE OF INTERVENTION OR SERVICE DELIVERY
Couples and Family Therapy[13]	Family and couples therapy actively involves the family in care as an adjunctive therapeutic strategy to care. Family therapy focuses on learning self-control, developing coping skills, and improving functional relationships in the family, which can help reduce substance use. It has been shown to have positive results when compared to non-family therapy modalities for both the adult and adolescent populations.	Benefits of family and couples therapy include: (i) higher rates of engagement and retention in care, (ii) improved outcomes in care, (iii) sustained recovery, and (iv) positive impact upon future family generations.	Formal Intervention
Group Therapy[3, 7]	Group therapy utilizes a variety of modalities of psychosocial interventions for substance use disorders, and may include: (i) psychoeducational groups, (ii) skills development groups, (iii) CBT groups, (iv) support groups, and (v) interpersonal groups.	Group therapy can provide: (i) basic training to engage and motivate new clients with basic relapse prevention strategies, (ii) skills training utilizing role play, and (iii) practice sessions that apply learned concepts and skills to real-life situations.	Formal Intervention
Multi-Family Dimensional Therapy (MDFT) **(Adolescent/ Youth-Based Intervention)**[14, 15]	MDFT is a phased approach that engages both the youth and family to formulate therapeutic alliances within the family to develop individualized intervention options for each family member involved. MDFT focuses on establishing positive social behaviours, networks and anti-drug behaviours, and encourages family members to acquire the problem-solving and decision-making skills required to create and maintain positive change.	Benefits of MDFT include: (i) significant reduction in substance use among youth; (ii) improved family functioning post-intervention, and (iii) effectiveness with ethnically diverse groups.	Formal Intervention

NAME	SUMMARY	BENEFITS	TYPE OF INTERVENTION OR SERVICE DELIVERY
Telemedicine[7, 16, 17]	Telemedicine is the use of computer, mobile, or Internet-based devices to provide prevention strategies, assessment, management, and evaluation to clients with a substance use disorder. Telemedicine is delivered via: (i) telephone, (ii) interactive voice response systems, (iii) Internet (e.g., websites, email, chat, and web conferencing), (iv) computer-based programs, (v) videoconferencing, and (vi) text messaging. Evidence suggests that telemedicine can be used as a valid substitute for, or supplement to, traditional care.	Telemedicine overcomes financial, geographical, and psychological barriers to care, as it provides clients with flexible, portable, and easy access to care.	Service Delivery

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Appendix L: Ongoing Evaluation of the Plan of Care

This appendix outlines several evaluative components for determining the effectiveness of the plan of care with clients who use substances. The ongoing evaluation of the plan of care should include assessment of the following factors, in collaboration with the client:

A) Client Goals
- a) What are the client's goals?
- b) What has been working for the client in reaching their goals?
- c) Where are the gaps in reaching their goals?
- d) What are the next steps in achieving treatment goals and/or in setting new goals?

B) Ensuring Client Safety
- a) Does the client have any impulses to engage in violent or self-injurious behaviour?
- b) Is the client in immediate danger from others?
- c) Is the client at risk for falls?
- d) Does the client have the capacity to drive safely (assess risk for motor vehicle accidents)?

C) Physical Health
- a) Is there improvement in the physical health of the client?

D) Psychological Health
- a) Is there improvement in the psychological health of the client?
- b) Are co-occurring psychiatric and medical conditions being treated?

E) Treatment
- a) Is the client engaged in treatment?
- b) Does the client have retention in treatment?
- c) Is the client adhering to the established treatment plan?
- d) Is the client satisfied with the treatment plan interventions?
- e) What has the client progress been in treatment?

F) Substance Use
- a) Is there a reduction in the severity and frequency of substance use episodes?
- b) Are harms caused by substances being reduced with treatment?
- c) Have there been any relapse episodes? Are there any prevention strategies in place to reduce future relapse episodes?
- d) Is there a reduction in hospitalization rates (if treatment is being provided in an outpatient setting)?

G) Criminal Activity
- a) Has the client been engaged in any recent criminal activity?
- b) Is there a reduction in the client's interface with the law or criminal justice system?

H) Quality of Life
- a) Is there an improvement in the client's social functioning and overall quality of life (e.g., interpersonal and family relationships, meaningful occupation, safe and secure housing, food security)?

Compiled by the RNAO expert panel, 2015.

References: American Psychiatric Association (APA, 2006), Kunyk & Els (2010), and SAMHSA (2005).

Appendix M: Additional Resources

The expert panel, with input from external reviewers and other key stakeholders, has compiled a list of websites and other resources that may be helpful when working with clients who use substances. This list is not exhaustive.

Links to websites that are external to the RNAO are provided for information purposes only. The RNAO is not responsible for the quality, accuracy, reliability, or currency of the information provided through these sources. Further, the RNAO has not determined the extent to which these resources have been evaluated. Questions related to these resources should be directed to the source.

RESOURCE	WEB-LINK/REFERENCE
STRATEGIC REPORTS	
Changing Directions, Changing Lives: The Mental Health Strategy for Canada (Mental Health Commission of Canada, 2012)	http://strategy.mentalhealthcommission.ca/pdf/strategy-text-en.pdf
Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy (Ministry of Health and Long Term Care, 2011)	http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth.aspx
SUBSTANCE USE OVERVIEW	
RNAO Mental Health and Addictions webpage	www.rnao.ca/mentalhealth
RNAO Engaging Clients Who Use Substances eLearn Module (Adults)	http://rnao.ca/bpg/courses/engaging-clients-substance-use-disorders
RNAO Engaging Youth Who Use Substances	http://rnao.ca/bpg/courses/engaging-youth-who-use-substances
RNAO Addictions eLearning Series	http://rnao.ca/bpg/courses/addictions-elearning-series
Opioid Dependence Treatment Certificate Program	Certificate program from the Centre for Addiction and Mental Health (CAMH) and the University of Toronto www.camh.net

SUBSTANCE USE OVERVIEW	
Substance Abuse and Mental Health Services Administration	http://www.samhsa.gov/
Canadian Centre on Substance Abuse	www.ccsa.ca
ConnexxOntario: Health Services Information	http://www.connexontario.ca/
Opioids: Best Advice For People On, Or About To Start Taking Opioid Medications, Related To Chronic Non-Cancer Pain	http://www.evanshealthlab.com//opioids/
Primary Care Addictions Toolkit	http://knowledgex.camh.net/primary_care/toolkits/addiction_toolkit/Pages/default.aspx
Parent Action on Drugs (PAD): Youth and Substance Use	http://parentactionondrugs.org/

SUBSTANCES AND PHARMACOLOGY	
Drugs and Alcohol Treatment Information System (DATIS)	http://www.datis.ca/
Sunshine Coast Health Center: Drug Information	http://www.sunshinecoasthealthcentre.ca/drug-information/
Mouse Party: Interactive Teaching Tool on Substances	http://learn.genetics.utah.edu/content/addiction/mouse/
Health Canada: Substance Abuse	http://healthycanadians.gc.ca/healthy-living-vie-saine/substance-abuse-toxicomanie/index-eng.php?_ga=1.149822454.1578135294.1418843079
CAMH's Mental Health and Addiction Information A-Z	http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/Pages/default.aspx
SAMHSA: Alcohol, Tobacco and Other Drugs	http://www.samhsa.gov/atod

HARM REDUCTION	
Canadian Harm Reduction Network	http://www.canadianharmreduction.com
CATIE: Best Practice Recommendations For Canadian Harm Reduction Programs That Provide Services To People Who Use Drugs And Are At Risk For HIV, HCV And Other Harms	Webinar Link: http://www.catie.ca/en/programming/best-practices-harm-reduction Best Practice Recommendations Document Link: http://www.catie.ca/sites/default/files/bestpractice-harmreduction.pdf
Canada's Low Risk Drinking Guidelines	http://www.ccsa.ca/Eng/topics/alcohol/drinking-guidelines/Pages/default.aspx

HUMAN RIGHTS: DISCRIMINATION	
Minds That Matter: Report on the Consultation on Human Rights, Mental Health and Addictions (Ontario Human Rights Commission, 2012)	Ontario Human Rights Commission (OHRC). (2012). *Minds that matter: Report on the consultation on human rights, mental health and addictions*. Retrieved from http://www.ohrc.on.ca/en/minds-matter-report-consultation-human-rights-mental-health-and-addictions
Policy on Preventing Discrimination Based on Mental Health Disabilities and Addictions (Ontario Human Rights Commission, 2014)	http://www.ohrc.on.ca/en/policy-preventing-discrimination-based-mental-health-disabilities-and-addictions
Ontario Human Rights Commission: Grounds of Discrimination	http://www.ohrc.on.ca/en/learning/basic-rights-and-responsibilities/grounds-discrimination
Community Legal Education Ontario	http://www.cleo.on.ca/en

TRAUMA-INFORMED APPROACHES TO CARE	
Trauma-Informed Care in Behavioral Health Services: Part 3: A Review of the Literature	Substance Abuse and Mental Health Services Administration. (2014). *Trauma-informed care in behavioral health services. Part 3: A review of the literature*. Treatment Improvement Protocol (TIP) Series 57. Rockville, MD: Author. http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816
Trauma-Informed Practice Guide	British Columbia Provincial Mental Health and Substance Use Planning Council. (2013). *Trauma-informed practice guide*. Vancouver, BC: Author. http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

SOCIAL DETERMINANTS OF HEALTH	
RNAO Social Determinants of Health webpage	www.rnao.ca/sdh
Health Providers Against Poverty	http://www.healthprovidersagainstpoverty.ca
Poverty: A Clinical Tool for Primary Care	http://www.healthprovidersagainstpoverty.ca/Primary%20Care%20Toolkits
Ontario Disability Support Programs (ODSP) Application: Information for Health Professionals	http://www.cleo.on.ca/sites/default/files/book_pdfs/ods-prof.pdf
Campaign 2000	http://www.campaign2000.ca
Health Equity Impact Assessment (HEIA)	http://www.health.gov.on.ca/en/pro/programs/heia/

STAGES OF CHANGE	
Changing for Good: The Revolutionary Program That Explains the Six Stages of Change and Teaches You How to Free Yourself from Bad Habits	Prochaska, J. O., Norcross, J. C., & DiClemente, C. C. (1994). *Changing for good: The revolutionary program that explains the six stages of change and teaches you how to free yourself from bad habits*. New York, NY; William Morrow & Co.

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT	
SBIRT Primary Care	http://sbirtoregon.org/index.php
SAMHSA: Screening, Brief Intervention and Referral to Treatment	http://www.samhsa.gov/sbirt
Brief Intervention: The ASSIST-Linked Brief Intervention for Hazardous and Harmful Substance Use	http://www.integration.samhsa.gov/clinical-practice/sbirt/Brief_Intervention-ASSIST.pdf

MOTIVATIONAL INTERVIEWING	
MINT: Excellence in Motivational Interviewing	http://www.motivationalinterviewing.org
Motivational Intervention in Nursing Practice: Empowering the Patient	Dart, M. (2010). *Motivational intervention in nursing practice: Empowering the patient*. Toronto, ON: Jones and Bartlett publishers.
Motivational enhancement therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence	http://pubs.niaaa.nih.gov/publications/ProjectMatch/match02.pdf

FAMILY-BASED RESOURCES	
A Family Guide to Concurrent Disorders	O'Grady, C. P., & Skinner, W. J. W. (2007). A family guide to concurrent disorders. Toronto, ON: Centre for Addiction and Mental Health http://www.camh.ca/en/education/about/camh_publications/Pages/family_guide_concurrent_disorders.aspx
Family Pathways to Care, Treatment and Recovery	Skinner,W., Kourgianitakis, T., and O'Grady, C. (2014). Family pathways to care, treatment and recovery. In M. Herie & W. Skinner (Eds.), *Fundamentals of addiction: A practical guide for counsellors*, (Chapter 13, pp. 293-320). Toronto, ON: Centre for Addiction and Mental Health.

REFLECTIVE PRACTICE	
Professional Standards (College of Nurses of Ontario, 2002)	http://www.cno.org/Global/docs/prac/41006_ProfStds.pdf
Quality Assurance Program (College of Nurses of Ontario, 2015)	http://www.cno.org/myqa/
Guidance for Critical Reflections on Practice Development	Foundation of Nursing Studies. (2013). *Guidance for Critical Reflections on Practice Development*. London: FoNS. Retrieved from: http://www.fons.org/resources/documents/Journal/IPDJCriticalReflectionResources-Jan-2013.pdf

Appendix N: Description of the Toolkit

Best practice guidelines can only be successfully implemented if planning, resources, organizational, and administrative supports are adequate and there is appropriate facilitation. To encourage successful implementation, an RNAO expert panel of nurses, researchers, and administrators, has developed the *Toolkit: Implementation of Best Practice Guidelines* (2nd ed.) (2012a). The Toolkit is based on available evidence, theoretical perspectives, and consensus. We recommend the Toolkit for guiding the implementation of any clinical practice guideline in a health-care organization.

The *Toolkit* provides step-by-step directions for the individuals and groups involved in planning, coordinating, and facilitating the guideline implementation. These steps reflect a process that is dynamic and iterative rather than linear. Therefore, at each phase, preparation for the next phases and reflection on the previous phase is essential. Specifically, the *Toolkit* addresses the following key steps, as illustrated in the "Knowledge-to-Action" framework (Straus et al., 2009):

1. Identify problem: identify, review, select knowledge (Best Practice Guideline);
2. Adapt knowledge to local context:
   - Assess barriers and facilitators to knowledge use, and
   - Identify resources;
3. Select, tailor and implement interventions;
4. Monitor knowledge use;
5. Evaluate outcomes; and
6. Sustain knowledge use.

Implementing guidelines to effect successful practice changes and positive clinical impact is a complex undertaking. The *Toolkit* is one key resource for managing this process. The *Toolkit* can be downloaded at http://RNAO.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition.

Endorsements

Canadian Centre
on Substance Abuse
Centre canadien **de lutte**
contre les toxicomanies

Partnership. Knowledge. Change.
Collaboration. Connaissance. Changement.

March 4, 2015

Dr. Doris Grinspun
Chief Executive Officer
Registered Nurses' Association of Ontario
158 Pearl Street
Toronto, ON M5H 1L3

Dear Dr. Grinspun:

On behalf of the Canadian Centre on Substance Abuse (CCSA), I am pleased to provide endorsement of the Registered Nurses' Association of Ontario's (RNAO's) evidence-informed clinical best practice guideline, *Engaging Clients Who Use Substances*.

Informed by evidence from research and other sources and developed in partnership with a multi-disciplinary focus, *Engaging Clients Who Use Substances* will serve as a valuable resource for many of our partners and networks across the country. It will be useful for nurses as well as their healthcare colleagues who are invested in providing effective, evidence-informed services to Canadians who are at risk for or experiencing substance use disorders.

By way of background, CCSA is a national, not-for-profit organization created by a federal Act of Parliament in 1988. For more than 25 years, we have provided national leadership and advanced knowledge and solutions to address alcohol and other drug-related harm by working collaboratively with all orders of government, the not-for-profit and private sectors.

CCSA has developed a number of evidence-informed resources that may be of interest to RNAO members. As an example, the *Alcohol Screening, Brief Intervention & Referral: Helping patients reduce alcohol-related risks* (http://www.sbir-diba.ca) was developed for primary healthcare practitioners to assist them in helping patients better manage their alcohol consumption. We welcome an opportunity to discuss this tool and its potential to assist RNAO members.

Congratulations and many thanks for developing *Engaging Clients Who Use Substances*, an important contribution to reducing the harm associated with alcohol and other drugs among Canadians.

Sincerely,

[redacted]

Rita Notarandrea
Chief Executive Officer (interim)
Canadian Centre on Substance Abuse

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February 27, 2015

Doris Grinspun, RN, MSN, PhD, LLD (Hon), O.Ont.
Chief Executive Officer
Registered Nurses' Association of Ontario
158 Pearl Street
Toronto, ON M5H 1L3

RE: *Engaging Clients Who Use Substances Guidelines*

Dear Dr. Grinspun

On behalf of the Canadian Federation of Mental Health Nurses (CFMHN), I would like to provide CFMHN's endorsement of RNAO's Best Practice Guideline: Engaging Clients Who Use Substances.

CFMHN's primary objectives are to assure national leadership in the development and application of nursing standards that inform and affect psychiatric and mental health nursing practice; examine and influence government policy, and address national issues related to mental health and mental illness; communicate and collaborate with national and international groups that share professional interests; and, facilitate excellence in psychiatric and mental health nursing by providing members with educational and networking resources and opportunities.

The intent of this guideline meets with our mandate and objectives for CFMHN. The guideline acknowledges the complexity of issues that can be attributed to substance use such as societal costs, stigma and discrimination, as well as early onset. The guideline is also clear as to what it does not address, such as concurrent disorders. It is appreciated that this guideline addresses the interprofessional nature of this work with a focus on practice, education, organizations and policy.

Sincerely

Lorelei Faulkner-Gibson, RN, MN, CPMHN(C)
President, Canadian Federation of Mental Health Nurses

Canadian Federation of Mental Health Nurses www.cfmhn.ca

camh

Centre for Addiction and Mental Health
100 Stokes Street
Toronto, ON M6J 1H4
www.camh.ca

Centre de toxicomanie et de santé mentale
100, rue Stoke
Toronto, ON M6J 1H4
www.camh.ca/fr

Peter Selby, MBBS, CCFP, FCFP, dip ABAM
Chief, Addictions and Head,
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February 12, 2015

Doris Grinspun, RN, MSN, PhD, LLD (Hon), O.Ont.
Chief Executive Officer
Registered Nurses' Association of Ontario
158 Pearl Street
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Dear Dr. Grinspun,

As Chief of the Addictions Division at the Centre for Addiction and Mental Health, it is my pleasure to write this letter of endorsement of the RNAO's evidence-based clinical best practice guideline, *Engaging Clients Who Use Substances*.

The RNAO's new best practice guideline has followed a rigorous approach to guideline development with practical advice on implementation into a client's plan of care. *Engaging Clients Who Use Substances* provides enormously valuable direction for the practicing clinician, especially nurses, as well as education, system and policy recommendations. The involvement of over 20 experts from various areas of the health care sector in the development of these guidelines is particularly noteworthy since considerations for the interprofessional team were acknowledged and, as a result, these guidelines could have a far-reaching influence in the Canadian health care field filling a major gap for the non-expert in addictions who encounters substance use behaviours in their clients/patients.

This new evidence-based clinical best practice guideline is an excellent resource for nurses, physicians, and health care administrators and any other health care professional across Canada.

Congratulations and thank you for this important work!

Sincerely,

[redacted]

Peter Selby, MBBS, CCFP, FCFP, dip ABAM

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