RACGP's Lapse and Relapse Prevention webinar:

10 March 2021

Lapse – a momentary return to AOD use, able to control behaviour. ***Relapse*** – a full blown flare of the condition, no longer in control of their drinking. Ongoing use for usually a week or more. Both good learning opportunities.

- Patients may present feeling shame, sheepish, dispirited. Let emotions vent, to then start to re-engage executive thinking. Praise the person, particularly in lapse, this is a good demonstration on how they were able to control themselves.
- Review the key ingredients that made controlling their AOD use successful, exploration helps the patient become more aware of what happened. What worked or didn't work last time you stopped AOD use? What could be different? What measures would they put in place if they were in that situation again?
- Identify high risk situations (eg weddings/celebrations, gatherings, or stressful situations, being around certain individuals /groups of people), assist the patient to find ways to manage these. Going into these situations without being mindful of the potential impacts can make you vulnerable, where your actions may not align with your goals.
- Help your patient be mindful, have a plan for managing these situations. Make choices that align with their goals.

Motivational interviewing (MI), approaching patients who use AOD

- A collaborative conversation, relationship, understand their emotional state, validate and reflect emotions, comfortable conversation for patient, they come up with the solution to their problems
- Being the coach vs the problem solver. Resist the righting reflex – "RULE" (sit on hands, avoid telling people what to do. As Drs we have the impulse to 'fix')
- *Change talk* – discuss positive change they want in their life. What does it look like right now? Maybe in six-months time? The more the patient speaks their own truth on positive change, the more they connect with it
- Sustain talk – when patient keeps talking about status quo, talking on negative behavior, reinforces failure – discussing distressing memories, limbic system activation- emotions hijack logical brain. Respond by encouraging change talk "I hear that there's a lot that you are dealing with. But I'm curious because you're here today. Why did you book the appt?"
- Compare yourself to a personal trainer. If your trainer was negative about your ability/you achieving your fitness goals, you are not likely going to want to do what they're asking of you, let alone visit the trainer again.
- Patients presenting after relapse typically have low hope, self-esteem, self-efficacy, repeated episodes of failure. People around them remind and reinforce sense of failure
- Personal trainer gives hope that the patient can achieve their goals within the context of their lives, improve their function, social connections, relationships.
- OARS *(see table 3 in the hyperlink)* **O**pen ended questions, **A**ffirmations, **R**eflection, **S**ummarizing
- DARN CATS: **D**esire, **A**bility, **R**easons, **N**eed, **C**ommitment, **A**ctuation, **T**aking **S**teps

Ready willing and able *- helps to guide focus* for each consult. What does the patient need today?
Willingness- I recognise I could be fitter – discrepancy where I am and where I want to be
Able – Support structures in place? Do they have the skills to change? Self-belief? Other health issues impacting ability?
Readiness – may have the skills, maybe homeless, dealing with family issues, ceasing AOD use may be low priority right now.

Relapse prevention counselling

- Support the patient to avoid negative ways of thinking. ie black/white thinking (sober or nothing), generalising, 'I'm not good enough', 'I've controlled by SUD, so I can now "wing it" in more challenging settings like a wedding', emphasise importance of mindfulness so actions will help achieve goals.
- Consider the ABC model – CBT
- Long term behavior change needs to be fun. e.g. diets fail as they're unpleasant. Financial benefit, how to use the money previously spent on AOD to reward to self, help the patient to visualize something they want (focus on social connection)
- Identifying temptations, replacement behaviours, alternative activities, preparation for relapse- what would they do if they do relapse (crisis planning), strategies for coping

CHIME – *Frame your interventions*

- **Connectedness**- relationships, **Hope and optimism about the future**– hope that things can change. Share our ideas as GPs, e.g. 'some people respond better to outer accountability and some to inner accountability – Are you interested in finding out more about that?', **Identity** – Do they identify as 'an addict'. Work on what identity they want to have e.g. being a good mum or dad, teacher, friend. Helping the person to find a different path they're already on rather than defining themselves through their addiction, **Meaning in life, Empowerment**

Comparison to chronic disease, stigma and the importance of language

- Prevailing moral model of addiction, stereotyped views. The medical community don't use lapse and relapse in for example diabetes or asthma. SUD as a 'brain disease'. 'Power of words' – person centered. E.g. Drug seeker vs a patient with unmet needs.
- The patient found a solution that works for them, understand what is underlying, compassionate response. What people choose to do is up to them, the issue for us is - how to support them and give them the tools to improve the situation?
- Real stories of addiction- changing stigma: 1. Hearing real stories, humanizing. 2. Understanding the condition is treatable (e.g. HIV – a treatment that works). Get involved

GP Self care

- Patients come in with sense of failure, frustration, difficulties. This can be exhausting for GPs. GPs need to recognize their own humanity and triggers. Connection, networking and opportunities to draw on what's existing in the community

Relapse and goal setting in primary care

- 'What is it that you want and where do you see your alcohol and drug use in the future?' 'Where do you want to be?' (employment, education, reconnecting with family), 'In a years' time when everything is going well what does that look like? What does your AOD use look like?' 'What are the barriers that we need to work through to achieve your goal?'
- It is the clinician's responsibility to not take ongoing AOD use, 'lapse' or 'relapse' personally. Change is possible, addiction is treatable, GP needs to offer hope and belief
- Start where the patient is at – reflect emotion, validate them, "you've told me about all of your burdens, and I acknowledge that sounds very difficult, where would you like to start?"
- Stay curious and offer hope in the following ways: "in our next double appt we can explore further", "today what's the thing I could do to help you?", "I know you're saying you don't know, that's why you're here, two brains are better than one", "I know you say you don't know, but if you did know what would it be?" (If you were to tell a good friend?) "I'm just wondering between now and the next time we meet is there anything you could do that would help in that situation?"
- What are the different priorities, 'This is really tough, this has been going on for 20 yrs. What do we need to prioritise?' Make a list of the patient's top 5 priorities. Hold ourselves as GPs back and be realistic with ourselves in our expectations.
- Typically people say they want to develop relationships, they want to be heard.
- A lot has gone wrong, but there are lots that we can do, there needs to be a team around the patient and the GP, to the patient "You need a team around you and I need support of other people to help me help you"

Resources and links:

http://www.intrinsicchange.com/training-tools.html -
https://motivationalinterviewing.org/
https://www.youtube.com/watch?v=gm9CIJ74Oxw
https://www.ncbi.nlm.nih.gov/books/NBK64967/pdf/Bookshelf_NBK64967.pdf
https://www.racgp.org.au/afp/2012/september/motivational-interviewing-techniques/
https://www1.racgp.org.au/ajgp/2019/october/health-coaching-as-a-lifestyle-medicine
https://comorbidityguidelines.org.au/appendix-t-cognitive-behavioural-techniques/cognitive-restructuring
https://www.racgp.org.au/afp/2012/august/the-recovery-paradigm/
https://www.rethinkaddiction.org.au/realstories
https://cdn.adf.org.au/media/documents/The_Power_of_Words-Practical_Guide.pdf
https://insight.qld.edu.au/training/AODOrientation_relapse-prevention-and-management/detail
https://insight.qld.edu.au/training/motivational-interviewing-1-spirit-and-core-skills/detail
https://insight.qld.edu.au/training/motivational-interviewing-2-change-talk/detail
https://insight.qld.edu.au/training/motivational-interviewing-3-evoking-change-talk/detail
https://insight.qld.edu.au/training/motivational-interviewing-4-processes-and-planning/detail