Alcohol and drug clinician perspectives on the blame/rescue trap: A qualitative study

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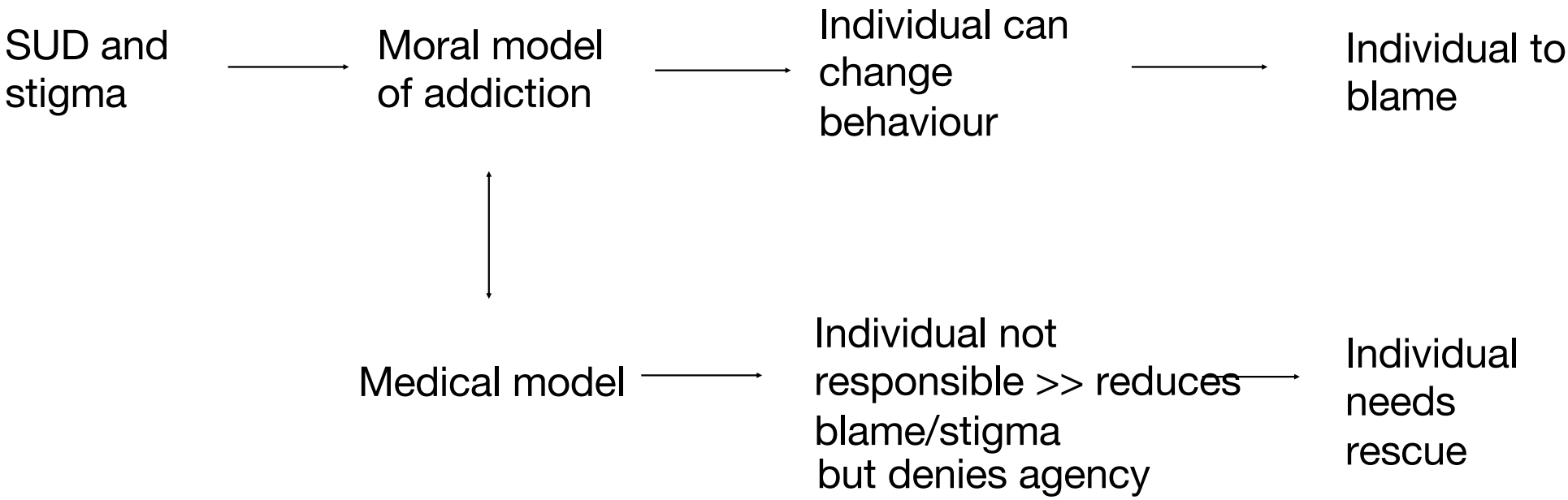
The ‘blame/rescue’ trap



Pickard: Responsibility without blame

blame → Hold accountable

Respect agency

rescue → Remove blame

Remove agency

Pickard: Responsibility without blame

"Responsibility without blame" framework

blame → Hold accountable → Respect agency

Respect agency

rescue → **Remove blame** → Suspend the moral emotions (affective blame)

Remove agency

A solution justified by therapeutic aims and/or recognition of disadvantage among people with SUD

The framework in practice

"Responsibility
without blame"
framework

A solution justified by therapeutic aims
and/or recognition of disadvantage
among people with SUD

- How do AOD clinicians discuss the tension identified as the blame/rescue trap/navigate it in practice?
- How workable is the 'responsibility without blame' framework likely to be?

Method

- Qualitative interviews with 12 AOD clinicians in Victoria, Australia
- Guided by reflective thematic analysis (Braun and Clarke 2022)
- Recruitment via professional networks, VAADA newsletter, AOD professionals' mailing list
- Interview guide aimed to avoid prompting clinicians to use our framing, invited exploration with 8 open-ended questions
- Qualitative coding using NVivo, organisation into themes via research team discussion
- Mix of professional backgrounds (nursing, AOD practitioner, counselling, addiction medicine…) and settings (community health, inpatient, mental health services, NGO services)

1. The clinical encounter

Non-judgmental approach	“if people feel forced into it or coerced into it, you know our ability to sustain that change over a longer period of time is often going to be quite compromised
Client-set goals	“I accept any goal... if they are like, ‘I’m using a gram of heroin a day, but I’d prefer to be using 9 points’, I wouldn’t be saying, 9 points is too much. I’d be saying, alright, let’s go ahead with this.”
Empathy and trust	“there is this tension. Because if you read some of the policy documents, you're meant to be doing urine drug screens, you're meant to have a patient who's abstinent before you do certain things. I never do urine drug screens ever because if I put a urine drug screen in front of my my client, I'm saying to them, I don't trust you.”

1. The clinical encounter

Honest recognition of problems	“There is no point telling your client things are gonna be okay when they're not… …. it's really tough to be able to turn around and say, if you continue to do what you're doing, you're gonna die. But it's helping them to make an informed consent about their choices.”
Holding accountable	“My role is not to supply the client with drugs which the client can sell, but it's about having an open and honest relationship.”
Enabling respect	“So much of it is about looking at a particular person in spite of their behaviour and their addiction… not [to] overlook those things, but but still recognise that underneath that is a person who has probably had a really rough life, a really impoverished life … We want to create an environment within our work where we can change the way that they look at other people and where we can develop that sense of respect for them when they might not have experienced that before.”

2. Interprofessional and structural stigma

Interprofessional stigma

[Some have the attitude that] “’we don’t actually want those people in our practice’ … they're ‘bad patients’ because they make the doctor feel bad because the doctor doesn't know what to do with them…”

2. Interprofessional and structural stigma

Structural stigma

“The health system itself is a barrier.”

“Treatment is ‘person centred’, but you're only going to be funded to deliver … this kind of intervention that looks like this, and if the clients don't attend, you need to close them and move them on because you've got a waiting list. It's going to be one 50-minute session a week, sitting in a small room that's not particularly soundproof, and you've got either 4 sessions, if we assess you as this, [or] 12 sessions if we assess you like this. ... obviously from a funding and system perspective you need to have models of care, but these are very, they're very tight boxes.”

2. Interprofessional and structural stigma

Structural stigma

“We work with the mental health in the same building. But... I can't just walk up to another staff member and say, ‘I've got this client who needs this service.’ We've got to get them to self refer, and go through another process of paperwork”

“The person can be lost in that [referral] process”

“the systems and the funding... never support the ambitions of documents like this… you see just this over and over in AOD policy. Nice idea, zero commitment to it.”

Discussion

- Participants' statements support Pickard's analysis of a 'blame/rescue trap'
- Their responses may align with the 'responsibility without blame' framework — though terminology differs
- Individual clinicians' attempts to navigate this trap are limited by features of the broader context (structural and interprofessional stigma). What is outside the treatment room affects what occurs within the treatment room
- Showing respect for clients as a form of agential education?