CA BRIDGE

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Trauma-Informed Care for Opioid Use Disorder

Improving the Success of Medication for Opioid Use Disorder by Integrating Trauma-Informed Approaches

About

CA Bridge, a program of the Public Health Institute, works to ensure that all people with substance use disorder receive 24/7 access to high-quality care in every California health system. Addiction treatment should be part of standard medical practice in the emergency department and inpatient settings in order to increase treatment access and save lives.

Authors and Acknowledgments

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Introduction

The purpose of this document is to introduce the principles and practices of trauma-informed care (TIC) to substance use navigators (SUNs). TIC is a helpful way to understand and connect with patients with opioid use disorder (OUD) and can help improve the experiences and outcomes of care for both patients and the team members providing care to them.

Background

Childhood traumas, also known as Adverse Childhood Events (ACEs), are very common, especially among those with OUD.[1,2] The more childhood trauma someone has, the more likely it is that they will have unhealthy substance use as an adult. For example, the risk of having substance use disorder more than doubles for each additional ACE that a person experienced.[3] People who have experienced four or more ACEs have more than ten times the risk of having problematic substance use compared to people without any ACEs.[4] Understanding that individuals with OUD have probably experienced significant trauma is one of the first steps in providing trauma-informed care. This understanding can be very helpful for two main reasons:

1. **More successful treatment with medications for OUD (MOUD)**. Knowing that people with OUD likely have experienced trauma can help us understand why they may be reluctant, fearful, shameful, distant, or even angry. In many cases, individuals who have experienced trauma were betrayed by the very people who were supposed to be protecting and caring for them. For this reason, they may be more guarded and slower to trust. Understanding this allows us to be more patient and compassionate, and to engage with patients in a way that leads to safer and more trusting relationships. As a result, patients may be more successful accepting and following up on medications for OUD.

2. **More successful identification and treatment of other trauma-related conditions that can be just as life-threatening as OUD**. Most people with OUD also struggle with other conditions that are related to having experienced trauma and that are often just as dangerous as OUD. This can include unhealthy use of other substances (up to 80% of patients with OUD), serious mental illness (around 25%), intimate partner violence (IPV) and even chronic pain. Knowing about these other conditions can help you arrange treatment for them, help you be more successful in treating their OUD, and possibly help you save lives.

So, what exactly is trauma-informed care (TIC)? At its core, TIC is a patient-centered approach that helps providers understand that many physical and mental health problems, like OUD, come from having experienced trauma and from coping with the difficult and painful feelings that result from it. This understanding helps demystify why patients are struggling with addiction and allows providers to be more patient, compassionate, and non-judgmental with patients.

The guiding 6 principles of TIC are: safety, trustworthiness and transparency, collaboration, empowerment, cultural humility and responsiveness, and resilience and recovery.[5,6] **These principles can be condensed to 2 main ideas: safety and connection**. Safety means helping a patient *feel* safe emotionally with you and *be* safe from the things that might immediately put their life at risk such as overdose, other addictions and violence, or other safety concerns. Connection means building a trusting and dependable relationship. When patients feel safe and connected to you, they are more likely to trust you and share things that they may be ashamed about. They may share information that is crucial to the

success of their treatment including other addictions, mental illness, problems taking their medications as prescribed, fears about coming back to the next appointment, or that someone is hurting them.

It is often helpful to mention what trauma-informed care is <u>not</u>. Being trauma-informed does not require asking for a detailed history of all the trauma a patient has experienced. Rather, it is often better to assume that they have a history of trauma and work to establish a relationship based on safety and connection, especially when caring for someone with substance use disorder. Being trauma-informed also is not only about trauma. Understanding and talking about a patient's strengths – like their courage to seek treatment, their resourcefulness, or supportive people in their lives – helps patients believe that they have the inherent power to recover from traumatic experiences and addiction.

Exploring Trauma-Informed Care

Next, we describe a case. The purpose of this case is to provide an example of how to put trauma-informed values and practices to work with patients who are starting and/or being maintained on medications for OUD. This case example can be read on your own, or used for discussion in pairs or a group. If used for discussion, we suggest that someone read the *italicized* case presentation portion aloud, and then the group pauses to discuss: a) reflections and reactions; b) how they might handle the scenario; and c) compare and contrast what a trauma-informed vs. non-trauma-informed approach to the scenario would look like. Participants can then read through the discussion portion aloud or on their own before proceeding.

Part I. Recognize the impact of trauma

Case Presentation:

> ***Emergency Department (ED) Visit**: Laila is a 60-year old woman who presents to the ED with abdominal pain, vomiting, and muscle aches. She has presented to the same ED with similar symptoms several times and has heard staff refer to her as a "frequent flyer" or "drug-seeking" when she presents with symptoms of anxiety or pain. In the ED, Laila is uncomfortable and irritable and is given anti-nausea medications and ibuprofen. She does not want to leave the ED and her providers grow frustrated that her discharge is delayed. The provider sees that Laila had been prescribed oxycodone by her primary care provider for chronic pain in the past and assesses the patient for opioid withdrawal. Her chart describes several prior concerns for OUD.*
>
> *The ED provider, a White, cisgender male, sits and speaks with Laila for just a few minutes and learns a bit more about Laila's background. Laila is an African American, cisgender woman. She works as a childcare provider and lives with her older two children and her male partner.*
>
> *Although the provider is not aware, Laila grew up in a household where she witnessed repeated violence and had a parent with a substance use disorder. She was separated from her mother for periods of time and even experienced periods of homelessness as an adolescent. Her mother died of cancer recently, and Laila felt that her mother was treated poorly by the healthcare system. Her current home situation is unsafe, as she experiences verbal abuse and, at times, physical violence from her current partner. Her partner uses cocaine. For the last year, Laila has been buying and snorting 'pain pills.' She often visits the ED when she runs out, as she does not want her children or partner to see her unwell.*

Discussion:

Past and ongoing trauma is common among people with OUD. Traumatic experiences put people at higher risk for health conditions, including substance use disorders. More than 80% of people with OUD seeking treatment have experienced at least one adverse childhood experience (ACE) such as abuse, neglect, household dysfunction or witnessing of violence.[7] These traumatic experiences result in prolonged, damaging stress, known as "toxic stress." This toxic stress changes our brains and bodies, making people much more susceptible to addiction, mental illness, and many other trauma-related conditions. Understanding this impact of trauma helps us make sense of why many trauma-related conditions like addiction, depression, and chronic pain often co-occur in the same person. Trauma includes not only individual-level factors, such as those unique to Laila's life and childhood, but can also include intergenerational trauma, community violence, and structural violence, such as racism. For example, Black individuals experience opioid overdose, arrests, and incarcerations at much higher rates than White individuals, but are less likely to receive addiction treatment.[8,9]

One common form of trauma that people with substance use disorders face is widespread stigma, both in their communities and in the healthcare system. Patients have witnessed and experienced punitive responses, such as criminal sentences or family separation. Stigma, or even just the fear of stigma, commonly leads to people avoiding medical visits and attention. Many patients feel that they will be punished for disclosing what is happening in their lives. Using affirming language rather than stigmatizing language can reinforce to patients that they are worthy of care and that their substance use is not a personal or moral failing.[10] It is also important to create policies that do not unnecessarily punish patients for using substances, for arriving late, or for being reactive or defensive. Although hospitals must have boundaries around violence or threatening behavior, it is crucial that protecting staff does not inadvertently become overly authoritarian and defensive in ways that make patients feel like you are suspicious and fearful of them. They need the opposite of this: compassion, acceptance, and love.

Understanding Laila's trauma history and the context of her life experiences can help her clinicians understand her interactions with the healthcare system. But even without knowing the details of Laila's unique life experiences, it is safe to assume that people with OUD have likely experienced significant trauma. Trauma-informed approaches should be applied universally to all patients to help them feel safer revealing themselves, sharing their history, and engaging in a plan for healing. Some examples for the initial meeting in the ED could include:

- Reassure patients that they will be treated before being asked to do a lengthy intake.
- Ask permission first before asking about substance use or any sensitive history and give the patient permission not to answer any questions they don't want to answer. Respect the boundaries of what the patient does and does not want to share.
- Assume that patients likely have fears about Emergency Departments. Listen for and respond to fears with soothing tones and validation. Let patients know they will have more time and quiet space to share and be heard at their clinic follow-up visit.
- Thank patients for engaging, sharing, and seeking care. This shows respect, shares control, and starts building a relationship.
- Reinforce a non-punitive approach and assure the patient that they will not be punished for sharing and that opioid use is common and not a personal or moral failing.
- Recognize that many patients with OUD have had traumatic experiences with healthcare and may feel more comfortable engaging with a peer or a navigator who shares lived experience rather than a medical provider.

- Remember that members of the care team may also have experienced trauma, and this may explain why providers may feel frustrated or helpless.

Part II. Prioritize the immediate safety of patients

> ***During the ED Visit****: The ED provider next asks Laila if it would be okay to talk more about her use of opioid pills. She gives permission and with the information provided from the discussion, the provider diagnoses a moderate to severe OUD. Laila receives a dose of buprenorphine and feels more comfortable. Laila is interested in talking with the SUN in the ED. In addition to discussing a follow-up appointment the next day in the addiction clinic (BRIDGE), Laila expresses to the SUN that she is scared to go home tonight because her male partner is there.*

Discussion:

Initiating MOUD in the ED provides an opportunity to have a significant impact on the health of individual patients and reduce their risk of illness and death. However, other immediate dangers, such as risks of violence, harm from other substances, and suicide, may emerge if you ask or create the space for them to be revealed. There is an opportunity and responsibility to address these commonly co-occurring conditions because doing so can be lifesaving.

Providing a statement of empathy and validation that destigmatizes Laila's substance use may help her feel respected and safe and open the door to address any potential dangers she may be facing. "Laila, I can see that you are going through a lot. I can understand that using opiates might be a way to manage all the stressors and challenges happening in your life right now."

Any discussion of intimate partner violence (IPV) should be done in private. When patients like Laila raise immediate safety concerns, even during short encounters in the ED or hospital, the clinician/SUN should be prepared with a non-judgmental approach and knowledge of the local resources available. If a patient discloses that abuse is occurring in their relationship, it can be very helpful to contact a domestic violence (DV) advocate, with the patient's permission, through a local resource or, if not available, from the 24-hour National Domestic Violence Hotline. An advocate from the hotline can provide further education, a danger assessment, help in getting a restraining order, or can help the patient establish a safety plan that is right for them. This may include immediate referral to a domestic violence shelter if the patient's partner is an immediate threat and the patient needs somewhere safe to go. In California, medical providers have a duty to report any physical injury caused by domestic violence to the police. To foster a sense of safety and control for patients, it is important to inform patients of reporting requirements before inquiring about IPV.

Relationship Safety Card

Ideally, all patients should be educated about the ways in which relationships and violence impact health. Sharing and reviewing a Futures Without Violence relationship safety card with patients is an effective way to provide universal education on protecting oneself from unhealthy or abusive relationships.

store.futureswithoutviolence.org/index.php/product/did-you-know-safety-card

National Domestic Violence Hotline

The national hotline can connect you to local resources and provide support 24/7 via phone or online chat. 1-800-799-7233

thehotline.org

National Suicide Prevention Lifeline

The national lifeline provides free and confidential emotional support to people in suicidal crisis or distress, 24/7. 1-800-273-8255

suicidepreventionlifeline.org

If a patient expresses wishes to die or has thoughts of harming themselves, it is important to inform a medical or mental health provider immediately to ensure that a suicide assessment is conducted and a safety plan is created as needed. It is important to know your institution's protocols for suicide, IPV, or reporting ahead of time, so you are able to triage the situation calmly and get the patient the support they need.

Laila's relationship with her partner is unlikely to change during or right after one meeting in the ED, but providing information in a nonjudgmental way paves the way for future discussions about her safety and relationships.

Part III. Connect with patients by being transparent and trustworthy about your role and care environment

> ***Follow up at the BRIDGE Clinic****: Laila arrives for her visit at the BRIDGE clinic after discharge from the ED. She felt very ambivalent about coming but did so because, in the ED, she had connected with the SUN who was non-judgmental, seemed to really listen to her, and gave her detailed follow-up information. What really helped is that the clinic had open hours (didn't require an appointment) so she could come at her convenience.*
>
> *She felt physically better while taking buprenorphine for the last few days, but she was fearful that the clinic would perform a urine drug screen and stop treating her because the doctors would find out that she also had used cocaine. She hadn't told anyone, but she had previously tried methadone in an outpatient opioid treatment program and left when confronted about cocaine use. She wasn't sure whether she would feel comfortable with doctors in a "program" again. She had never liked doctor's offices; taking off her clothes, being asked personal questions, and being touched by male providers all made her feel uncomfortable. After her bad experience with her mother's recent illness and death, she has tried to avoid clinics altogether.*

Discussion:

The clinic environment itself can be traumatizing to patients – a phenomenon that is amplified for people with substance use disorders who have faced stigma in healthcare or carry other traumatic life experiences.[11] Common trauma triggers include the presence of security guards, loud noises, or positioning in an exam room where the patient's back is to the door. In addition, lack of privacy can be a trigger, for example, in shared hospital rooms or in a bathroom where urine drug testing may be observed. Healthcare settings can be re-traumatizing by being restrictive in their hours, where people can smoke or eat, and in the way decisions are often made without input from the patient.

Optimizing the care environment may help to prioritize the physical and emotional safety of patients. Laila may feel safer and more trusting in a BRIDGE clinic that has open access hours, food and coffee, greeters, and someone familiar to accompany her to the pharmacy or another clinic if needed. Clinics can promote trauma-informed care by making waiting rooms less chaotic, adjusting schedules and patient flow, and training all staff in strategies for de-escalating tense situations. They may also need to make physical changes, such as lowering the height of the front desk so patients can more equitably and comfortably interact with staff.[12] Simply saying something nice to each patient when they arrive can make a meaningful impact.

"There is a pride in knowing people's names and recognizing them… It's just such a different environment for someone who is experiencing homelessness and using heroin to be greeted 'Hello, How are you? Can I get you anything?' I don't think they get that in other healthcare settings."
- CA BRIDGE clinic provider

It can be helpful to anticipate and address patients' immediate fears, such as the urine drug screen. In Laila's case, this can happen by explaining why it is obtained and reassuring her about what will/will not be done with the results.[13] Laila can be reassured that use of substances like cocaine will not bar her from treatment.

Being transparent about your role will be noticed and appreciated by patients, especially those who have experienced trauma. Many patients are worried that they're going to be punished, for example, for being late to an appointment or for the presence of other illicit substances. It can be helpful to explain that this is not the case – we do urine drug screening because it is required by law or to help figure out how the treatment is going and to open dialog about how to use substances more safely.

Part IV. Collaborate with patients in decision-making

> ***Weeks later at the BRIDGE clinic****: Laila continued to work with the BRIDGE clinic and has stabilized on a daily dose of buprenorphine. She appreciated the open access hours and telephone visits as she is not sure she would have been able to make it to weekly scheduled appointments given her work and home responsibilities. She felt much more comfortable after talking with the navigator, who shared some similar life experiences with her. And Laila felt more trustful of the clinic and doctors after continuing to work with the same navigator who she first met in the ED. Laila has been accompanied by her son during a few telehealth visits recently. Now that she has been feeling well on the buprenorphine for a few weeks, Laila expresses to her doctor that she would like to stop buprenorphine. She does not want to be addicted to another opioid. And now that she is visiting the ED less frequently, she has time to take care of some personal finances and urgent business to secure housing. She suspects her partner continues to use cocaine. She also noticed that when she stopped using pain pills, she found herself using less cocaine as well. She has had more energy recently and has started attending church again on the weekends.*

Discussion:

Laila expresses common concerns that arise during the course of treatment with medications for OUD. Approaching these crossroads in treatment with a shared decision-making model has been shown to be associated with better outcomes and patient satisfaction. Exploring the patient's concerns and motivations, rather than prescribing a course of action is more patient-centered, non-hierarchical, and collaborative. In these conversations with patients, providers can use motivational interviewing, a communication strategy that elicits a patient's goals and helps them work through impediments to achieving their own goals. More resources can be found at SAMHSA's Decisions in Recovery: Treatment for OUD Handbook.[14]

In this case, the SUN and clinician can ask permission to share information about buprenorphine with Laila and, if she agrees, inform her that the longer people take medications for OUD, the less likely they are to return to the use of opioids.[15] Exploring the factors in her life outside of OUD, like housing or the relationship with her partner, will help in guiding her decisions about buprenorphine. For example, perhaps a monthly injection of long-acting buprenorphine would allow Laila to succeed in taking care of

other life priorities without the need to take a daily medication and come to frequent visits. Even if Laila decides to stop buprenorphine, the team should continue to support her and offer her an open door to follow up. Return to use, or "relapse," should be normalized so that the patient will feel comfortable returning to the care even if she feels like she has "failed."

Most importantly, using a strengths-based approach that centers on the patient's strengths, resources and expertise about their own life can help bring the patient into the decision-making process, together with their team. For example, Laila has shown great strength in following up regularly thus far and overcoming her initial fears of the urine drug screen. She is very organized and motivated to secure housing for herself and her family. She is a caretaker and continues to support her children and partner. She has clearly articulated what she needs to accomplish at the moment in order to stabilize her life and how feeling better on buprenorphine has helped her have more time to do so. She has started to invite her son into her visits, and to draw on her church as a source of community strength. Listening for these strengths, eliciting them, naming them, and building on them is how the care team can discuss the role of buprenorphine in Laila's journey.

Summary

Trauma-informed care approaches start with an understanding that a lot of illness and unhealthy behavior is related to experiences of significant trauma. The practice of trauma-informed care starts with compassion, listening, and being present with people. The case outlined here is not to exemplify exactly *what* to say but to shed light on *how to be* with patients. Trauma-informed care helps provide a foundation for safety and connection that opens the door for patients to be successful in their goals.

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Appendix

Additional resources about trauma-informed care

In addition to the resources cited in the text above, CA BRIDGE encourages all providers to seek more information about trauma-informed care and how it relates to the treatment of SUD.

- ACES Aware
- Laura van Dernoot Lipsky @ TEDxWashingtonCorrrectionsCenterforWomen: *Beyond the Cliff*
- Nadine Burke Harris @ TED MED: *How Childhood Trauma Affects Health Across a Lifetime*
- National Council for Behavioral Health: *Fostering Resilience and Recovery: A Change Package*
- The Trauma Stewardship Institute
- Trauma-Informed Care Implementation Resource Center

Other articles

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