Trauma Informed Practice & the Opioid Crisis

A Discussion Guide for Health Care and Social Service Providers

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INTRODUCTION

Canada is in the midst of a serious and growing opioid crisis. Nearly 30% of Canadians report using some form of opioids, such as oxycodone, morphine, codeine, and fentanyl in the past five years[1] and 1 in 8 Canadians (nearly 3.5 million) say they have a close friend or family member who has become dependent on opioids.[2] Not only do many health care and social service providers have a personal connection to the opioid crisis, many are increasingly aware of the impact of prescription and illicit opioids on the populations they work with and on our systems of care. For example:

- Opioid Poisoning and Overdose Deaths: In 2017, more than 1,400 people (almost 4 per day) in British Columbia died from illicit drug overdoses — a 43% increase from 2016. In 81% of those deaths, fentanyl was detected, and men accounted for 80% of the deaths.[3,4]
- Hospitalization: Opioid poisonings result in an average of 16 hospitalizations a day in Canada. Seniors account for nearly 25% of hospitalizations.[5]
- Neonatal Opioid Withdrawal/Neonatal Abstinence Syndrome: An increasing number of women are struggling with opioid use and misuse before and during pregnancy. Between April 2016 and March 31, 2017, 1,846 babies in Canada received treatment for opioid withdrawal following birth.[6]

This resource focuses on addressing one facet of the opioid crisis in Canada. Research has shown that the vast majority of individuals who struggle with opioid misuse and addiction have current or past experiences of trauma and violence.[7-13] Those experiences of trauma and violence are often gendered, in that women, men, trans and gender diverse people have different kinds of experiences. Trauma-informed practice is an approach to care that integrates an understanding of trauma into all levels of care, system engagement, workforce development, organizational policy and cross-sectoral collaborations. This resource builds upon the *Trauma-Informed Practice Guide* [14] developed by BC Mental Health and Substance Use Services in 2013,which have been adopted and implemented in many health authorities and other jurisdictions across the province.

Download the BC *Trauma Informed Practice Guide* → www.bccewh.bc.ca

Trauma-Informed Practice and the Opioid Crisis

Trauma-informed practice can contribute to addressing the opioid crisis by:

1. Improving access and engagement with health care and social services and creating opportunities for people to heal from trauma and related issues, including other problematic substance use, mental health concerns, and experiences of violence
2. Supporting the development of patient/client wellness skills and pain management skills to help prevent opioid misuse and prevent dependence
3. Improving the wellness and safety of service providers working with opioid-related issues, including supporting resilience and preventing vicarious trauma, compassion fatigue and burnout

This discussion guide is intended to stimulate further conversation on "becoming trauma-informed" and assist health care and social service providers in considering additional ways of addressing the opioid crisis in their particular context. These discussions can occur formally and/or informally as part of program planning or evaluation, at staff meetings over the course of a year, or as part of organized training and learning events. The discussion questions are practical and help to take small, concrete steps towards overall organizational change. You may find it useful to explore one topic at a time as a group or work to address specific areas in smaller groups.

The guide is in four sections. Each section provides a brief overview of one of the four principles of trauma-informed practice and their relevance to the use and misuse of prescription and illicit opioids. Many practice examples and skills for practice are included throughout the discussion guide, often highlighting sex and gender issues or questions. Each section concludes with discussion questions for small groups in a range of program and organizational contexts -- including primary health care providers, hospital emergency departments, first responders, shelter workers, clinicians in the mental health and substance use fields, pregnancy outreach workers -- so they can explore what they are already doing well and what else they might be doing to address opioid use and misuse.

WHAT IS TRAUMA-INFORMED PRACTICE?

Trauma can be defined as experiences that overwhelm an individual's capacity to cope. This can include trauma early in life, including child abuse, neglect, and witnessing violence as well as later traumatic experiences such as violence, accidents, natural disaster, sexual assault and rape, war, refugee experiences, sudden unexpected loss and other life events that are out of one's control. Trauma can also result from poverty, having a life-threatening illness, intergenerational events, and grief and loss. Trauma can involve a single event or multiple experiences. As well, a similar event or experience might be experienced as traumatic for one person but not for another.

People respond to trauma differently. Substance use, depression, and anxiety are very common responses to experiences of trauma and violence, and are differentially experienced by women and men, transgender and gender-diverse people. Post-Traumatic Stress Disorder (PTSD) is one specific type of response to trauma. It is a psychiatric diagnosis based on an individual experiencing symptoms from three "symptom clusters" including intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms.

Substance use, depression, and anxiety are very common responses to experiences of trauma and violence.

Research continues to demonstrate that past or current experiences of trauma and violence are common for people accessing a range of health care and social services. Trauma-informed practice is a way of working that recognizes the prevalence and impact of trauma on the lives of those accessing health care and social services. The goal of trauma-informed systems is to avoid re-traumatizing individuals and support safety, choice, and control in order to promote healing.

What Do Trauma-Informed Services Look Like?

Trauma-informed practice is about ensuring that organizations, programs and direct service providers develop approaches to care that avoid re-traumatizing people and place priority on their safety, choice, and control. Trauma-informed services look different depending on the service setting and organization, but they all:

- Provide welcoming spaces
- Offer choice, voice, and control to all patients/clients accessing services
- Work to create physical, emotional, and cultural safety for everyone, including staff
- Offer opportunities to learn wellness skills and coping skills for managing trauma responses
- Provide information about the effects of trauma and resources for learning more about trauma or how to access trauma treatment in the community
- Identify and work with people's strengths rather than focusing on deficits and "difficult behavior"

A trauma-informed approach can be implemented in any type of service setting or organization. Trauma-informed services are distinct from trauma-specific interventions, which are designed to address the need for healing from traumatic life experiences and facilitate trauma recovery though specialized counselling or other clinical interventions. Trauma-informed practice will look different in every organization based on the types of services offered and the resources available. Benefits of trauma-informed practice can include:

- Improved access to services, e.g., early help-seeking, higher rates of completing treatment, higher engagement in preventative services, increased satisfaction with services
- Improved staff retention and higher satisfaction with employment, e.g., less burnout or compassion fatigue, less vicarious trauma
- Promotion of health equity, i.e., supports the development of programs and services that reflect the needs, concerns, and preferences of diverse groups.

Although there are many different implementation routes, developing an awareness of the key principles of trauma-informed practice at both the individual and organizational levels is an important first step. These key principles include:

1. Trauma Awareness
2. Safety and Trustworthiness
3. Choice, Collaboration, and Connection
4. Strengths Based and Skill Building

Trauma-informed practice will look different in every organization.

This guide provides a brief overview of each of these principles. A more detailed description is available in the *Trauma-Informed Practice Guide* developed by BC Mental Health and Substance Use Services which can be downloaded from www.bccewh.bc.ca.

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Trauma-Informed Practice Principles

Trauma-Informed practice means integrating an understanding of past and current experiences of violence and trauma into all aspects of service delivery. The goal of trauma-informed systems is to avoid re-traumatizing individuals and support safety, choice, and control in order to promote healing. (Adapted from *Trauma-Informed Practice Guide*, BC Mental Health and Substance Use Services, 2013)

TRAUMA AWARENESS

Trauma awareness is the foundation for trauma-informed practice. Being 'trauma aware' means that individuals understand the high prevalence of trauma in society, the wide range of responses, effects and adaptations that people make to cope with trauma, and how this may influence service delivery (e.g., difficulty building relationships, missing appointments).

SAFETY & TRUSTWORTHINESS

Physical, emotional, spiritual, and cultural safety are important to trauma-informed practice. Safety is a necessary first step for building strong and trustworthy relationships and service engagement and healing. Developing safety within trauma- informed services requires an awareness of secondary traumatic stress, vicarious trauma, and self-care for all staff in an organization.

CHOICE, COLLABORATION & CONNECTION

Trauma-informed services encourage opportunities for working collaboratively with children, youth and families. They emphasize creating opportunities for choice and connection within the parameters of services provided. This experience of choice, collaboration, and connection often involves inviting involvement in evaluating the services, and forming service user advisory councils that provide advice on service design as well as service users' rights and grievances.

STRENGTHS BASED & SKILL BUILDING

Promoting resiliency and coping skills can help individuals manage triggers related to past experiences of trauma and support healing and self-advocacy. A strengths-based approach to service delivery recognizes the abilities and resilience of trauma survivors, fosters empowerment, and supports an organizational culture of 'emotional learning' and 'social learning.'

NOTES

TRAUMA AWARENESS

1. TRAUMA AWARENESS

The principle of trauma awareness means understanding the effects of trauma, the different types of trauma (e.g., single incident, developmental, intergenerational), and the impact on individuals, families and communities. Trauma can impact every aspect of an individual's life and may show up in different ways. Trauma can impact:

- Development
- How people cope and survive
- Potential substance use
- Physical health
- Mental health
- Social connections
- Social involvement

A person who has experienced trauma is at increased risk for re-traumatization. Re-traumatization is a situation, attitude, interaction, or environment that reminds an individual of a past trauma and that triggers the overwhelming feelings and reactions associated with that experience. Re-traumatization often replicates the dynamics of the original trauma, i.e., loss of power, control and safety.

Being "trauma aware" means asking "What has happened to this person?" rather than "What is wrong with this person?"

Being "trauma aware" means understanding that trauma is common, and every individual who accesses health care and social services may have an unknown trauma history. By taking "universal precautions," or assuming that all clients/patients may have a trauma history, services can be shaped to minimize the possibility that someone will be re-traumatized.

Trauma awareness also results in increased understanding of how individuals who have experience trauma may engage with services. When service providers are "trauma aware", it is possible to understand people's reactions and behaviours (e.g., rage, treatment refusal, mistrust, fear) as a result of previous injury, rather than as sickness or bad behavior. The question becomes "What has happened to this person?" rather than "What is wrong with this person?". Without trauma awareness, there is the possibility that service providers will misinterpret people's behavior and act in ways that increase feelings of fear and loss of control, which may cause them to disengage from services.

Past and current experiences of trauma and violence and opioid misuse and addiction are closely linked.[7-13,15-17] Rather than viewing opioid misuse and addiction as a problem in of itself, trauma awareness helps with understanding that opioid misuse and addiction is an attempt to cope with problems. Experiences of trauma are also closely linked with chronic pain. Outside of active cancer treatment, palliative care, and end-of-life care, chronic pain is one of the main reasons opioids are prescribed. Some people's chronic pain stems from a traumatic event, such as a physical or sexual assault, a motor vehicle accident, or some type of disaster. Under these circumstances the person may experience both chronic pain and trauma. Individuals who have experienced physical, psychological, or sexual abuse also tend to be more at risk for developing certain types of chronic pain later in their lives and be more vulnerable to opioid misuse.

Trauma Awareness and Opioid Prescribing Guidelines

The relationship between experiences of trauma and violence, mental health concerns, and problematic substance use are widely recognized and physicians and nurse practitioners are encouraged to consider these issues when discussing the possible benefits and harms of opioid use with their patients.

The 2017 *Canadian Guideline for Opioid Therapy and Chronic Non-Cancer Pain* reports that opioids are associated with a 5.5% risk of addiction and recommends avoiding opioid use for individuals with a history of substance use disorder or a diagnosis of mental illness and recommends against the use of opioids for individuals with current substance use concerns.[32]

While there are a number of screening tools available to help identify patients at risk of opioid misuse or addiction, none of them have been shown to predict who might be an unsuitable candidate for prescription opioids.[33] While screening tools can be a helpful guide, they do not replace an open and non-judgemental discussion of issues such as mental health, substance use, childhood abuse, gender-based violence and other experiences of trauma.

The 2017 *A Guideline for the Clinical Management of Opioid Use Disorder* developed by the BC Centre on Substance Use notes the high rates of trauma and post-traumatic disorder amongst individuals with substance use disorders and encourages clinicians to be familiar with principles of trauma-informed practice.[34]

Trauma, Gender, and Opioid Use

Most people with substance use problems report having experienced some form of trauma, and most have experienced multiple traumas.[18] People often report they use substances to help "cope" with the stress or "numb" negative emotions that result from trauma. Research is continuing to demonstrate that men, women, trans and gender diverse people often have different experiences of trauma and this affects their opioid use. For example:

- Compared to other types of substance use, women and men who are addicted to prescription opioids are more likely to report a traumatic event.[9] They also tend to have first experienced trauma at a younger age and are more likely to report a childhood trauma, including: childhood abuse or neglect, or having witnessed violence.[9] Depression, anxiety, self-harm and suicide are also common among women and men with opioid use disorder (including prescription opioid misuse and illegal opioid use).[7,8]

- Women and men who are addicted to opioids report different experiences. Among women, the greatest risk for opioid addiction is receiving a prescription for opioid medication.[19] Women tend to report experiencing more chronic physical pain, and are more likely to receive a prescription for an opioid painkiller.[20,21] The risk for chronic physical pain is even greater among women who have been victims of violence and abuse.[22] In contrast, men are more likely to use illegal sources of opioids, and engage in riskier drug-use including: using alone, increasing the amount used, and ingesting in a way other than intended.[23-26]

- Transgender populations experience very high rates of gender-based discrimination, harassment and physical and sexual violence. Almost all (98%) transgender people in a US study reported one or more traumatic event in their lifetime, compared with 56% of cisgender women and men from the general population.[27] While research on opioid misuse among transgender people is limited, the prevalence of non-medical prescription opioid use among transgender adults is high.[28] Higher rates of non-medical prescription pain medication use have also been reported among transgender youth, compared to cisgender youth.[29]

Men, women, trans and gender diverse people often have different experiences of trauma and this affects their opioid use.

Data from British Columbia also show trends related to gender and trauma:

- In BC, men are more likely to die from an opioid related overdose (fentanyl in particular).[30] Men who died due to opioid overdose were found more likely than women to have been using prescription opioids that were not prescribed to them (71% of men vs. 46% of women).[24]
- In a study with 692 female sex workers in Vancouver, 18.8% reported non-medical use of prescription opioids; both partner violence and police harassment were correlated with recent non-medical use.[10]
- In 2015-2016, 14% of all opioid overdose events in BC were experienced by First Nations people and First Nations people are five times more likely than non-First Nations people to experience an overdose event. Among First Nations people who overdosed, men were 2.5 times more likely to die than women. Although men were more likely to die from an overdose, among First Nations people the ratio of overdose events was almost even between men (52%) and women (48%). First Nations women experienced eight times more overdose events and five times more deaths from overdose than non-First Nations women. Intergenerational trauma is one reason that First Nations people in BC are more likely to experience an overdose event.[11]

Gender-informed approaches can improve access, safety, and satisfaction with health care and social services.

While research continues to demonstrate how trauma and gender influence substance use in diverse groups and populations, service providers should remember that many individuals they work with cross multiple sub-populations and may experience numerous and complex impacts from trauma. An increased awareness of these intersections can help service providers identify the unique strengths and perspectives of their clients/patients and develop tailored approaches to best meeting their concerns and needs.

Gender-informed approaches to services improve access and satisfaction with service provision. Gender specific services can also improve safety, especially for women and transgender people, and respond to the preferences and concerns of diverse gender groups. Further, evidence about sex specific effects of opioids, drugs, or various treatments can be incorporated into your practice.

For more information about integrating trauma, gender and sex informed approaches into your practice see *New Terrain: Tools to Integrate Trauma and Gender Informed Responses into Substance Use Practice and Policy* (available for download from www.bccewh.bc.ca).

Strategies for Service Providers

1. Recognize past and current experiences of trauma and violence as a potential risk factor for opioid misuse and that substance use can be a form of coping with the effects of trauma, sometimes differently for women, men, trans and gender-diverse people.

2. Be able to recognize the effects of trauma in patients/clients and also in staff, and how it may look for different people.

3. Assume "universal precautions". Most of the time, there is no need to ask patients/clients about the details of past or current experiences of trauma. Adapt procedures, practices, and services to reflect an understanding that trauma is common and assume that any or all patients/clients may have experiences of trauma.

4. Learn about local programs and services that provide trauma specific treatment for women, men, trans and gender-diverse people who may be interested in a referral. Also consider integrated, interdisciplinary, multimodal, or holistic programs that address multiple concerns related to trauma, addiction, and chronic pain.

5. There are many reasons why people may use opioids. For individuals who use opioids or other substances as a way of coping with the effects of trauma, it may be helpful to normalize their responses. Ask if they are interested in more information about the effects of trauma and offer hope for healing.

6. Offer information about the relationship between pain, trauma, and opioid use to patients/clients. This increased understanding of how past experiences of trauma affects their physical well-being can create understanding and self-compassion. If people are interested, service providers can promote mind-body interventions that they might find helpful such as mindfulness meditation, yoga, trauma-focused cognitive therapy; self-management resources such as smartphone apps. Recognize and reinforce that these interventions may not have immediate benefits and that developing new skills related to coping with trauma and physical pain take time to develop.

Strategies for Organizations

1. Provide all staff, at all levels, with basic foundational training on trauma, its effects, and how trauma affects service engagement.

2. Develop policies or procedures to minimize the possibility of re-traumatization, e.g. de-escalation strategies, "trauma-informed" best practices for delivery of procedures such as urine tests or administering medicine.

Gender-Informed Overdose Prevention Sites

SisterSpace is the first women's only overdose prevention program in Canada. The program is run by Atira Women's Resource Society, in partnership with Vancouver Coastal Health (VCH), the City of Vancouver, B.C. Housing, B.C. Women's Hospital, and the Provincial Health Services Authority.[31] SisterSpace provides women a safe and secure indoor environment where they can inject their own drugs, be connected with other supports such as health and community services, additional harm reduction, and access housing, if they choose.

The program was designed to be gender responsive and its development was guided by trauma-informed principles. Many women have difficulties accessing mixed-gender programs because of their experiences of violence and their need to avoid men who have or may hurt them. In addition to preventing overdose death and increasing women's connection to other services, women benefit by receiving social and emotional support and by finding physical and emotional safety.[31]

ACES and Preventing Opioid Misuse

The Adverse Childhood Experiences (ACE) study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. The study found that adverse childhood experiences were much more common than recognized and were often coexisting and directly linked to later-life substance use and mental health problems as well as a range of chronic diseases such as diabetes and heart disease.

There have been a number of studies showing a strong correlation between adverse childhood experiences (there are 10 types of childhood trauma measured in the ACE study) and opioid misuse and addiction.[12, 15, 17, 35-37] The research suggests that people who have experienced multiple ACEs are the most likely to experience problems with opioid misuse. For example, a large population-based study in the US found a dose-response relationship between the number of traumatic experiences and increased risk of prescription drug misuse in adults. Individuals with five or more ACEs were three times more likely to misuse prescription pain medication and five times more likely to engage in injection drug use.[12]

Programs and initiatives that reduce exposure to adverse childhood experiences and that promote resilience for those who have been exposed to adversity can have a critical role in reducing later-life risk for opioid misuse and addiction. These include programs such as home visiting programs, early childhood education, infant development, parenting programs, prenatal and postpartum care and support, and community health promotion. As well, service providers who work with adults who have experienced childhood adversity can promote resilience-building practices; community development approaches to building connection and social support are also important.

Signs of a Trauma Response

Trauma can affect how people engage with services. As many people will experience a trauma response while accessing services, it is important to be able to recognize and respond to these trauma responses. Being "trauma aware" does not mean that service providers need to be an expert on treating trauma. However, service providers should know enough to be able to recognize possible trauma responses, and if appropriate, explain to their patients/clients what trauma is and its effects.

How service providers choose to respond will depend on their role in their program or organization, their relationship with the individual, and their experience and knowledge of addressing trauma. Some considerations in deciding how to respond:

- *What would be helpful for the client/patient in this moment?* E.g., Moving to a quieter location, having a friend or family member come sit with them, working with them to use a grounding or coping skill that they have previously told you helps them in these particular situations.
- *When the client/patient is ready, debrief what happened with them. Are they aware of what triggered the response? If so, are there ways to adapt care and treatment for this person in the future?* For example, if they were overwhelmed by a busy waiting area, perhaps they can wait in a quieter office in the future. If locked doors and other security measures made them uncomfortable, perhaps it is possible to meet with them off-site or to show them how the locks work so they can open and close them when they choose.
- *How does the patient/client view what happened to them?* Service providers can play an important role in helping to re-frame and validate trauma responses as attempts to cope with overwhelming experiences, i.e., they are normal response to an abnormal event. This type of re-framing can be empowering and help people understand they are not "going crazy" or "out of control."

Possible Signs of a "In-the-Moment" Trauma Response

- Sweating
- Change in breathing (breathing quickly or holding breath)
- Muscle stiffness, difficulty relaxing
- Flood of strong emotions (e.g., anger, sadness, etc.)
- Rapid heart rate
- Startle response, flinching
- Shaking
- Staring into the distance
- Becoming disconnected from present conversation, losing focus
- Inability to concentrate or respond to instructions
- Inability to speak

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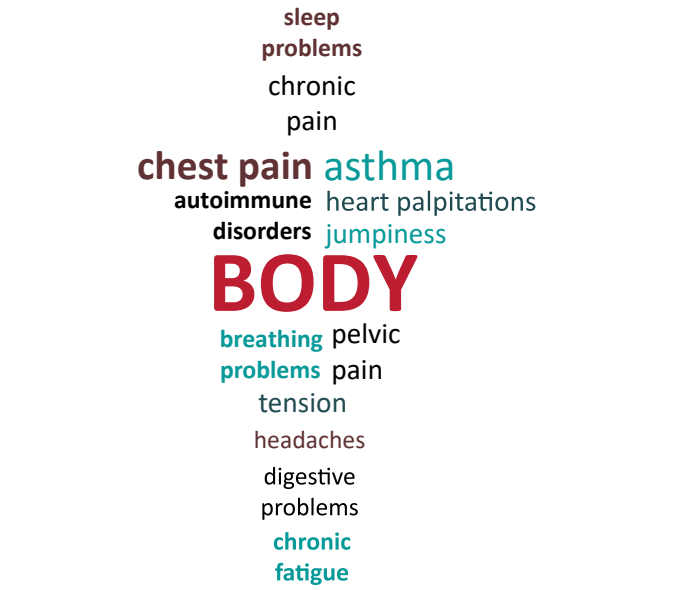

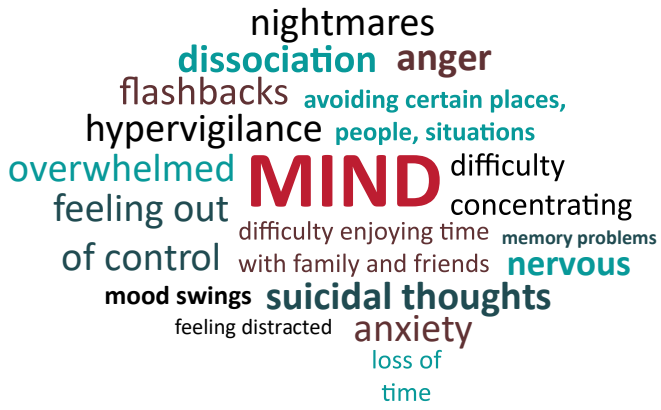

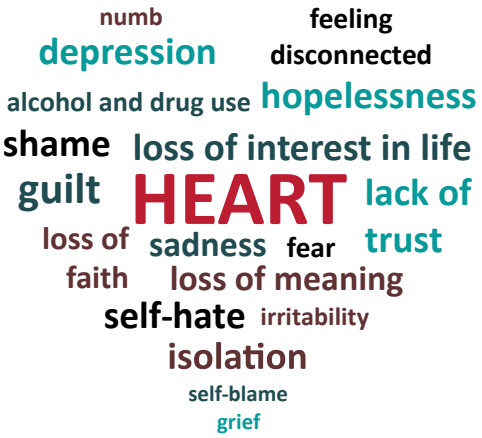

Trauma affects everyone differently.
People can and do heal from trauma.

Discussion Questions

The following discussion questions are intended for small groups to consider and reflect on their work and to ask "What are we doing well? What else can we be doing?"

1. Overall, how prevalent is trauma in the population(s) you work with? In what ways is your organization already 'trauma-informed' and addressing trauma (directly or indirectly) with your clients?

2. In what ways has increasing opioid use and misuse affected your work? Which populations are affected and in what ways (e.g., women using prescription opioids, accidental overdoses by seniors)? In your opinion, what are the factors contributing to these trends? Are there additional ways your organization can address these trends, e.g., changing prescribing practices, prevention by addressing adverse childhood experiences, family support?

3. Trauma-informed practice is sometimes described as a "universal precaution." Given the prevalence of trauma, all staff in an organization are highly likely to encounter individuals with histories of trauma. What are some of the shifts that can be made universal in your program delivery and that do not require knowledge of an individual's trauma history, but address the needs for safety, choice, and control for this person? Are there possible benefits for individuals who do not have a history of trauma?

4. What kind of information about trauma and substance use is available to your clients? Is it accessible, up-to-date, and tailored to the population you work with?

5. Do all staff in your organization have a basic understanding of the causes of trauma and possible effects? Do they know how to respond to clients/patients who might be experiencing a trauma response? What resources are available for learning more?

NOTES

SAFETY AND TRUSTWORTHINESS

2. SAFETY AND TRUSTWORTHINESS

Physical, emotional, spiritual and cultural safety and trustworthiness is key to trauma-informed practice because people who have experienced trauma may feel unsafe on an ongoing basis, are likely to have experienced abuse of power in important relationships, and may currently be in unsafe relationships or living situations. The safety and needs of health care and social service providers are also a critically important component of trauma-informed practice, especially support related to managing job stress that may result in vicarious trauma, burnout, and compassion fatigue.

In order to successfully engage with services, people need to feel they are out of immediate danger. Safety and trustworthiness for patients and clients can be established or enhanced through such practices as:

- Welcoming intake procedures
- Adapting the physical space to be less threatening
- Providing clear information about the programming (i.e., who does what and how)
- Ensuring informed consent
- Demonstrating predictable expectations
- Scheduling appointments consistently
- Non-judgemental interactions

People need to feel they are out of immediate danger before they can engage with services.

Culture plays an important role in how people who have experienced trauma understand and express what has happened to them. It can also influence what supports and interventions they might find helpful in healing from trauma. Cultural safety is an influential perspective in developing better health care and social services for Indigenous people and cultural safety initiatives to improve the health and well-being of Indigenous peoples align with trauma-informed practice. Training in cultural safety can be a helpful tool for improving relationships between service providers and Indigenous peoples, for analyzing organizational practices, and for developing policies that support healing and self-determination.

Burnout, vicarious trauma, secondary trauma, traumatic response, and compassion fatigue are some of the words used to describe the impact of job stress. Many service providers have themselves experienced or witnessed varying degrees of trauma and many more have witnessed or heard stories of trauma and violence from the populations they work with. For many service providers, the opioid crisis has intensified the trauma they are exposed to. First responders as well as staff and volunteers in community agencies, social housing programs, neighborhood health centres, and municipal social services have all been directly affected by the overdose events and deaths. Many service providers are becoming more vigilant (e.g., checking on clients who are sleeping, worrying about contact overdoses involving accidental exposure to synthetic opioids) and many are grieving or supporting those who are grieving the loss of loved ones to overdose deaths.[38, 39] In other contexts, service providers are working with clients and patients experiencing increasingly complex health concerns, including chronic pain, unmet pain needs, and side effects and long-term effects of opioid use. This is resulting in increased primary care and emergency room visits, increased hospital admissions, and longer hospital stays.

For many service providers, the opioid crisis has intensified the trauma they are exposed to on a daily basis.

Community organizations and institutions policies and procedures can have an enormous impact on reducing the stress and trauma experienced by their staff and how well their staff are able to respond to and manage these increasing pressures. Debriefing practices, opportunities for self-care, resilience training, paid leave, supervision, peer support, staffing models, and access to counselling and other supportive services can greatly affect the emotional and mental well-being of staff and ensure that individuals do not have to deal with the impacts of work on their own.

Strategies for Service Providers

1. In your work, be as transparent, consistent and as predictable as possible, i.e., explain why before doing something.

2. Become aware of possible triggers in routine aspects of the care you provide, e.g., locks and lighting, security glass, intake questions, lack of privacy during procedures, chaotic environments. If possible, develop strategies, no matter how small, to minimize the possible impact of these activities.

3. Help build trusting and open relationships by being clear about confidentiality of information shared, reporting requirements, and informed consent procedures. Substance use remains a highly stigmatized issue and people may be concerned about losing their job or possible police or child welfare involvement if they disclose problems with substance use.

4. Be open to learning and asking questions about a client's culture. If possible, offer or respond to requests to engage in cultural rituals, speak in a first language, etc. and make referrals to culturally-relevant healing services.

5. Learn about the signs of burnout, vicarious trauma, and compassion fatigue and be able to recognize them in yourself and other co-workers. Learn about how and where to access support and care.

Strategies for Organizations

1. Create opportunities for clients/patients and staff to provide feedback on how the program environment affects physical and emotional safety, e.g., locks and lights, layout of furniture, safety glass.

2. Develop policies and procedures for working with clients who may be suicidal, intoxicated, psychotic, or engaging in challenging behaviors, e.g., de-escalation plans, training in non-violent crisis intervention, guidelines for calling 911.

3. Provide staff with training in cultural competency, cultural safety, and cultural humility, including understanding of different cultural responses to trauma and practices for self-awareness and self-assessment.

4. Provide staff with information and support related to burnout, vicarious trauma, and burnout, including how it manifests and ways of minimizing its effects.

5. Ensure supports and resources are in place to support staff who may be experiencing burnout, vicarious trauma, and burnout.

Overdose Prevention Sites

Overdose prevention sites are one of the main strategies to address the opioid overdose crisis. Their primary purpose is to provide a space where people can use substances in the presence of others who are trained in overdose intervention. As of May 2017, there were 23 overdose prevention sites across BC with 85,000 visits, over 600 overdoses managed and 0 deaths.[40]

The structure and function of each of the sites varies depending on local needs and resources, but most sites have a less medicalized environment than supervised injection sites and other health clinics, which increases their accessibility for many of the groups affected by the overdose crisis. [41-43] Some of the ways the sites are creating welcoming and safe spaces include:

- Staffing primarily by community members or peers with lived experience in illicit drug consumption and dependence and who have either been at risk of overdose themselves or have lost friends and family to overdose and death (Peer staffing models encourage the formation of trusting, respectful, and non-judgemental relationships)
- Furniture arranged in a "living room" style
- Mobile furniture so that people can re-arrange it according to their needs
- Single chairs and screens for people who prefer privacy and couches or larger tables for people who want to connect with staff and others
- Murals and art reflective of the community
- As "low barrier" as possible. Sites have few guidelines and are flexible and accommodating to a wide range of needs and behaviours.

Indigenous Cultural Safety Training

Although substance use is common across BC, the opioid public health emergency has disproportionately affected First Nations peoples and communities in BC due to the ongoing legacy of colonization. Data from 2015-2016 show that 14% of all overdose events and 10% of all overdose deaths in BC were experienced by First Nations people (First Nations in BC comprise 3.4% of the population). Racism, intergenerational trauma, and reduced access to mental health and addictions treatment, such as methadone maintenance therapy and suboxone, are some of the possible reasons as to why Indigenous communities are more affected by the crisis.[11]

Culturally safe health care and social services reduce barriers to accessing care for Indigenous people. Training in cultural safety helps service providers understand how Indigenous health today is a result of a history of colonization, residential schools, and other practices and policies of cultural and social assimilation. This can help service providers address power imbalances that affect care and treatment; create safer environments where individuals and their families experience respect; support services that are relevant and appropriate to the wellness beliefs, goals, and needs of Indigenous people; and works towards developing practices and policies that avoid re-traumatization.

The San'yas Indigenous Cultural Safety Training Program (www.sanyas.ca) is one example of cultural safety training offered in BC. Developed by the Provincial Health Services Authority, it provides online training for service providers in a range of contexts, including health, justice, child welfare, education, and business. The program is designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Indigenous people.

Creating Welcoming and Safe Spaces

Creating a welcoming environment for individuals with current or past experiences of trauma and violence can be a simple but important strategy in 'becoming trauma-informed.' Making changes to the physical space in which programs and services operate can reduce possible triggers for patients and clients, increase feelings of emotional and physical safety, and encourage the development of new and trusting relationships. Many organizations experience factors that limit their ability to achieve these changes; however, even small changes can make a difference. Below is a list of suggestions for getting started.

1. Who greets clients/patients? What are some of the things they might say? Does someone provide an orientation to the physical space? E.g.,

- Showing people where they can sit or wait;
- Offering or showing them where they might be able to get something to drink or eat;
- Mentioning any activities happening in the building that might be contributing to noise;
- Providing directions to the bathroom;
- Giving people an opportunity to ask questions?

2. Is the program space organized in such a way that recognizes that people might require different things to be comfortable, and that staff might need to accommodate a wide range of behaviours? Providing choices about where people can wait and providing information about how long the wait might be can help people feel more in control. E.g.,

- Is there a quieter place where someone can wait for an appointment if they are unsettled by noise or clutter?
- Some clients might prefer to wait outside or need to move around more. Is it possible for a staff member to meet them outside the building or in a hallway or text them when they are ready?

3. There are many aspects of the physical environment that can be triggering and/or potentially re-traumatizing for people. While it's impossible to address all possible triggers, there are some changes that might be easy to make or important to consider when working with specific populations. E.g.,

- Is it possible to make certain physical spaces feel less "institutional", perhaps with plants, a box of toys, art or posters that are reflective of the community or population the program serves, warm colours?
- Policies about lights and locks – considering both clients/patients and staff, what feels restrictive and what contributes to feelings of safety?

Discussion Questions

The following discussion questions are intended for small groups to consider and reflect on their work and to ask "What are we doing well? What else can we be doing?"

1. What are the barriers to developing physical, emotional, spiritual, and cultural safety in your particular service and community context? What are some of the strategies you have used to increase feelings of safety? Have they improved engagement and retention? What else could you be doing?

2. What are some of your strengths in working with people, e.g., friendly or easy-going staff, creative ways of working? How are you already using these strengths to build trustworthy and safe relationships with others?

3. What are possible triggers for re-traumatization in your particular area of work, e.g., urine testing, searching belongings, administration of medications, locks and lighting? What are some of the ways these could be minimized, e.g., explaining the reasons for these procedures, providing clients/patients with some control over how a procedure is implemented?

4. Has the opioid crisis directly or indirectly affected the ability of your organization to provide physical, emotional and cultural safety? How is this being handled by individual service providers and at an organizational level?

5. What supports and initiatives exist to support the safety and well-being of staff? Are there areas where further support might be helpful, e.g., opportunities for self-care, resiliency training, personal/professional boundaries, access to counselling for vicarious trauma?

6. What are some of the strengths of your organization in supporting staff? Is there recognition of good work, regular supervision, opportunities for evaluation and feedback from staff, adequate compensation, manageable caseloads? Are mistakes seen as opportunities to learn? Are safety concerns responded to by management? Given resource limitations, what else could be helpful?

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CHOICE, COLLABORATION, AND CONNECTION

3. CHOICE, COLLABORATION, AND CONNECTION

The principle of choice, collaboration, and connection reflects the importance of creating services that do not further traumatize or re-traumatize people and that support healing and recovery. Experiences of trauma often leave individuals feeling powerless, with little choice or control over what has happened to them (e.g., interpersonal violence, natural disaster) and, possibly, what they have done (e.g., war, political violence, motor vehicle accident).

Offering choice, whenever possible, gives control and responsibility back to individuals. Choice can relate to all aspects of service, for example:

- How they are addressed (e.g., first name, nick name, title and family name, pronoun reflecting their gender identity)
- How they will be contacted
- Who will be involved in their care
- What the priorities and goals of treatment will be
- Pacing of treatment or level of participation in programming.

Health care and social service providers often represent power and control to individuals who have experienced trauma and this can be frightening and overwhelming or prompt anger and mistrust. Having a sense of personal control in interactions with service providers can be crucial to successfully engaging with services.

Experiences of trauma often leave individuals feeling powerless, with little choice or control over what has happened to them.

Collaboration involves sharing expertise and power. Rather than service providers making decisions on behalf of clients and patients, individuals should be involved in developing a plan for their own care. Service providers are able to share their knowledge, experience, and access to resources and patients/clients can share their own ideas on what might work and draw upon their personal resources and strengths. Collaboration can also extend to the organizational levels where individuals are involved in evaluating services and are invited to form service user advisory councils that provide advice on service design as well as service users' rights and grievances.

For individuals who have current or past experiences of trauma, being able to establish positive and safe connections – with service providers, peers, and the wider community – can promote healing and encourage further engagement with care and support.

Harm Reduction and the Opioid Crisis

Harm reduction is a pragmatic approach to addressing substance use. It recognizes that abstinence from substance use may not be possible or desirable for everyone and that there are many ways of providing care and support that can help people improve their health and promote healing. Trauma-informed practice and harm reduction approaches both focus on providing choices and "meeting people where they are at."

Harm reduction allows for flexible, respectful and non-judgemental ways of working that increase feelings of safety and encourage engagement with services. Harm reduction approaches to reduce the harm of opioid use include:

- Needle distribution programs – provision of clean needles and other supplies
- Overdose prevention and response training, e.g., access to naloxone, training in the workplace and schools, take-home programs
- Supervised consumption and overdose prevention sites
- Peer support programs
- Outreach and education
- Medications such as methadone or prescription heroin
- *Good Samaritan Drug Overdose Act* (2017)

Strategies for Service Providers

1. When meeting a client/patient for the first time, ask how they would like to be addressed. Check whether they would like to be called by their first name or last name or by their title (e.g., Ms. Smith, Freddy, Dr. Medley). Use pronouns that reflect a person's gender identity (e.g., he, she, they); if unsure, respectfully ask.

2. Use statements that make collaboration and choice explicit, e.g., "I'd like to understand your perspective." "Let's look at this together." "Let's figure out the plan that will work best for you." "What is most important for you that we should start with?" "It is important to have your feedback every step of the way." "This may or may not work for you. You know yourself best."

Strategies for Organizations

1. Language reflects the culture of an organization and is reflected in policies and procedures Review language used in policies, forms, reports, and other documentation. Identify where it is possible to move towards more supportive, recovery-oriented, strengths-based language that emphasizes choice, collaboration and control, e.g. "Client chooses to opt out of treatment" instead of "Client is non-compliant."

2. Women, men, trans and gender-diverse people have unique and gendered pain care and addiction treatment needs, and may benefit from choosing gender specific spaces and programming. Transgender and gender-diverse people should be able to choose to access services and be referred in a way that is consistent with their gender expression or stated preference. Use inclusive language (including a range of gender identities on intake forms), have gender neutral washrooms and display transgender positive resources in waiting areas as a way of demonstrating respect and increasing feelings of trust. All clients may be interested in discussing their gender roles and expectations.

3. Involve clients and patients in evaluating services and as part of service user advisory councils.

The Good Samaritan Drug Overdose Act (2017)

The *Good Samaritan Drug Overdose Act* became Canadian law on May 4, 2017. Many opioid overdose deaths are preventable if medical attention is received quickly. However, evidence shows that witnesses to an overdose do not call 911 for fear of police involvement.

The *Good Samaritan Drug Overdose Act* provides some legal protection for individuals who seek emergency help during an overdose. The Act provides an exemption from charges of simple possession of a controlled substance as well as from charges concerning a pre-trial release, probation order, conditional sentence or parole violations related to simple possession for people who call 911 for themselves or another person suffering an overdose, as well as anyone who is at the scene when emergency help arrives.

The *Act* is an example of a harm reduction approach to addressing opioid use and helps to reduce barriers to asking for help. It also helps increase awareness of opioid overdose events as medical emergencies and not a police matter. (Currently, law enforcement agencies in British Columbia have a policy of "non-attendance" at overdose events and will not attend an overdose call unless requested, e.g., in the case of safety concerns for first responders).[39, 44]

Conversations About Opioid Tapering

Evidence-based clinical guidelines on how to taper opioids safely and effectively are still being developed.[45] However, emerging research suggests that a collaborative approach to weighing the benefits and harms of reducing or discontinuing opioids and developing a care plan are promising.[46-49] The opioid crisis has made these conversations more challenging for service providers as patients can often feel like they did something wrong or that their pain is being ignored or that they are being viewed as a "criminal or addict." Providing choices to patients can help with creating more successful outcomes.

Some strategies to consider:

- Explain to patients the reasons for tapering in their particular situation. Go beyond a general discussion of concerns about addiction potential and focus on reducing pain and improving functioning and quality of life.
- Prepare patients for the possibility of tapering. Help them to understand the circumstances in which opioids can be helpful and when it might be better to consider other alternatives.
- Address fears that some patients might have about being abandoned throughout the tapering process or of going too fast.
- Allow patients to have input, even it is simply related to the rate of tapering.
- Empathize with their experience. Help them to understand what is causing their pain and what is being done to address the underlying condition.
- Work collaboratively to develop a multi-modal pain care plan. Help advocate for other non-pharmacological treatments that might be helpful (e.g., physiotherapy, chiropractic, counselling).
- Acknowledge that there may be sex and gender differences that impact tapering (e.g., men can experience reduced testosterone levels during withdrawal and during methadone maintenance therapy,[50, 51] women may report greater dependence and craving of opioids than men[52]).
- Recognize that alternate approaches to pain management need to be in place before people will be receptive to reducing their opioid use, especially if opioids are helping them to cope and manage a daily basis.

Language to Reduce Stigma and Promote Healing

Language reflects the culture of an organization. Language can play an important role in whether people choose to access services and whether they will connect with and continue to engage with service providers.[14, 53, 54]

- Use language that conveys optimism, supports recovery, and provides hope for healing. What clients and patients hear or read can positively impact their health and well-being.
- For individuals who have experienced trauma and violence, language can normalize and re-frame their responses to the trauma. Rather than talking about "disorders" and "problem behaviors," you can discuss "coping", "adaptations," "survival skills" and "resilience."
- Substance use remains highly stigmatized and prevents people from accessing care. Use "person-first" language that refers to the person before their condition or behaviour, e.g., person with an opioid use disorder. This recognizes that a person's condition, illness, or behaviour is only one aspect of who they are and not a defining characteristic.
- Be careful with labelling certain behaviors and conditions as these labels can be highly stigmatizing and can "follow" people around in their lives. This is particularly true when working with pregnant women and new mothers who use substances. Avoid using terms like "addicted babies" or "born addicted to heroin." Try "exposed to substances in utero" or "experiencing withdrawal."
- Use language that respects an individual's autonomy and reflects collaboration between patients/clients and service providers.

From	To
Unmotivated, non-compliant, resistant	*Opted not to, choosing not to, prefers not to, seems unsure about*
Manipulative	*Resourceful, seeking support, trying to get help*
Refused	*Declined, repeatedly said no*
Borderline	*Doing the best they can given their early experiences*
Suffering from, victim of	*Has a history of, working to recover from, living with, experiences*
Dirty or clean test results	*Positive or negative test results*
Born addicted, addicted babies	*Experiencing withdrawal symptoms, exposed to substances in utero*
Drug abuser, substance abuser, addict, junkie	*Person who uses opioids, person experiencing problems with substance use*

Discussion Questions

The following discussion questions are intended for small groups to consider and reflect on their work and to ask "What are we doing well? What else can we be doing?"

1. How much choice do your clients have in the services they receive, and when, where, and by whom the service is provided, e.g., time of day or week, office vs. home vs. other locale, gender of provider? Are you able to work in more flexible ways? What groups might benefit from these types of strategies?

2. What are you already doing to encourage collaboration with patients/clients, with other programs and organizations, and with other systems of care? How can collaboration with other services reduce barriers to care and/or support engagement with care and treatment, e.g., child care may facilitate women's ability to access substance use services?

3. Can clients choose to access gender specific programming? Gender specific programs can contribute to feelings of safety for certain groups of men, women, trans or gender diverse people, e.g., individuals who have experienced gender-based violence.

4. In what ways do you already involve service users in the design and implementation of services? How can this type of feedback support the development of increased choices for clients/patients and strategies for creating safety?

5. What is your program's philosophy towards substance use? What is the value of both harm reduction and abstinence-based services? How can each contribute to addressing the opioid crisis?

6. The language that service providers use and the language used in forms and documentation can affect whether and how individuals engage with services. In what ways does the language currently used at your organization support hope for healing from trauma and reduce stigma related to substance use? What else might be helpful?

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STRENGTHS BASED AND SKILL BUILDING

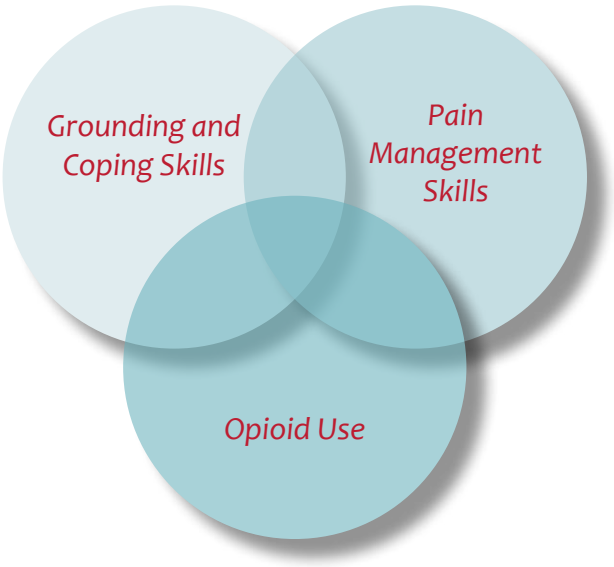
4. STRENGTHS BASED AND SKILL BUILDING

A strengths-based perspective focuses on "what works" for a person and how to do more of "what works."

The principle of strengths based and skill building promotes healing, recovery, and growth for individuals who have experienced trauma and violence. Often, the behaviours and responses of individuals who have experienced trauma are misunderstood and labelled in stigmatizing and deficit-based ways (e.g., something is missing or wrong with the person). A strength-based perspective examines "what works" and "how to do more of what works" rather than focusing primarily on identifying and eliminating problems. By focusing on strengths, rather than deficits, service providers:

- Acknowledge the ability of all people to survive and even grow from adversity
- Recognize the resilience that it takes for people to thrive despite numerous challenges in their lives
- Emphasize that people can and do heal from experiences of trauma.

Opportunities for helping clients/patients build skills, especially coping skills, self-regulation skills, and other skills for recognizing triggers and managing trauma responses, are important for promoting healing and can be done by service providers in a range of contexts. Skills such as mindfulness and other self-care practices are also important for service providers as they promote wellness and reduce burnout and vicarious trauma.



Many of the skills that support resilience, promote healing from trauma, and assist with pain management and reduction of opioid use overlap or build upon each other. This provides service providers with flexibility in developing tailored approaches to working with clients/patients and for best utilizing available resources. Skill-building in a number of areas can be helpful, including:

- Social emotional and resiliency skills
- Grounding skills and coping skills for managing trauma responses, i.e., recognizing triggers, calming, centering, and staying present
- Pain management skills– relaxation training, mindfulness, yoga, physical exercises, breathing techniques
- Attachment and relational skills
- Creating safety plans, goal-setting, skills for post-traumatic growth

Grounding skills are simple and practical activities that can help individuals re-connect following an "in-the-moment" trauma response.

Trauma-informed practice focuses on resilience and healing not just at the individual level, but also at the community level. The opioid crisis has increased attention to how issues such as lack of affordable housing, poverty, racism, and the impacts of colonialism are related to experiences of trauma and violence and addiction. Communities are developing unique approaches to fostering resilience and healing, reducing stigma and trauma, and addressing problematic substance use and mental health challenges through social networks, education, new models of housing, and economic opportunities. Many of these approaches embed values like hope, safety, dignity and trust, which all contribute to resilience at a community level.

Naloxone Training

Naloxone is a medication that quickly reverses the effects of an overdose from opioids such as heroin, methadone, fentanyl and morphine. It is available in BC without a prescription and often given as an injection into a muscle.

BC Center for Disease Control (www.towardtheheart.com) started the *Take Home Naloxone* program in 2012 to provide life-saving training and kits to people at risk of an opioid overdose. There are now over 1500 distribution locations across British Columbia. In 2017, 56,698 naloxone kits were distributed. Approximately 20,000 kits have been reported as having been used to reverse an overdose.[55] Free and online training and free kits are part of the BC public health emergency response.

Strategies for Service Providers

1. Help patients/clients identify their strengths. Ask about people's interests, survival strategies, practical skills, spirituality, and community connections.

2. Teach and model skills for recognizing triggers, calming, centering and staying present.

3. Support patients/clients in developing new skills for managing pain and/or make referrals to other organizations or services or provide information about online or self-management resources.

4. Develop a range of practices for your own self-care. Identify your own strengths and build self-awareness of your own triggers and signs of burnout.

Strategies for Organizations

1. Encourage strengths based policies and procedures throughout the organization from how staff answer the phone, to making referrals, to report writing, to program planning and evaluation.

2. Provide training on secondary trauma and stress management for all staff, promote self-care and well-being through policies and communications and encourage ongoing discussion among staff and administration.

First Responders and Vicarious Trauma

In 2015, Vancouver Fire and Rescue Services responded to 2,600 overdose calls in Vancouver. In 2016, the number of calls almost doubled to 4,712[39] and to over 6,000 in 2017.[56] In 2015, BC Ambulance Service attended 12,263 suspected overdose and poisoning events in B.C. (3,055 were in Vancouver). In 2016, this number rose to 19,275 (5,944 occurred in Vancouver).[39] The volume of overdose calls has significantly impacted response times for first responders and has reduced service levels for others in need. As well, it has had an enormous impact on the mental health and well-being of first responders.

Signs of burnout and vicarious trauma include [14] (and are not limited to):

Job Performance	Morale	Behavioural	Interpersonal
Obsession about detail	Loss of interest	Frequent job changes	Poor communication
Decreased productivity	Apathy	Overwork	Staff conflicts
Avoidance of certain tasks	Dissatisfaction	Tardiness	Withdrawal from others
Low motivation	Decreased confidence	Exhaustion	Impatience

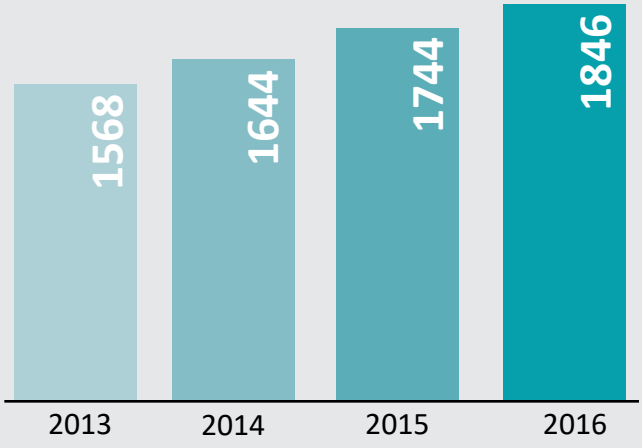
Both individual service providers and agencies/organizations have a role to play in supporting resilience in staff to prevention burnout and vicarious trauma. The opioid crisis is leading to the development of new ways to support service providers. For example, in 2017, Health Emergency Management BC formed a Mobile Response team that provides support and education to help build resiliency and capacity to cope with the trauma of responding to overdoses, deaths and loss. Support includes one-on-one meetings, educational events, or providing debriefs following a death or critical incident.[57] BC Emergency Services also began piloting a new online "Opioid Crisis Resilience" course for paramedics and dispatchers. The training is designed to help first-responders both prepare and respond to stressful incidents by teaching them how to identify stress, mentally rehearse, and use breathing techniques.[58]

Neonatal Opiate Withdrawal and Rooming-In

Neonatal Opiate Withdrawal or Neonatal Abstinence Syndrome (NAS) affects infants who were exposed to opioids (and other substances) in utero, causing physical dependence on opioids and often leads to withdrawal symptoms after birth. In Canada, between April 2016 and March 2017, 1,846 infants received treatment in hospital for opioid withdrawal following birth. Hospitalization rates have been increasing each year from 1,568 in 2013-2014, to 1,644 in 2014-2015, to 1,744 in 2015-2016.[6]

In the past, the standard of care was to separate newborns who may be at risk for Neonatal Opiate Withdrawal from their mothers. A study at FIR Square, a unit at BC Women's Hospital that provides care for women who use opioids and other substances during pregnancy, looked at the impact of rooming-in (where infants are kept with their mothers after birth) on symptoms of withdrawal and other outcomes. The researchers found that infants who remained with their mothers had fewer admissions to the neonatal intensive care unit, a shorter hospital stay, were more likely to be breastfed while in hospital, were less likely to require pharmacological management and were more likely to go home with their mothers.[59]

Research is continuing to demonstrate the importance of non-pharmacological interventions such as skin-to-skin contact, and breastfeeding on reducing symptoms of withdrawal in substance-exposed newborns.[60-63] This has led to shifts in practice that support the mother-infant dyad model of care with an emphasis on skill-building in mothers. Immediately following birth, mothers and infants are cared for together in the same room. Service providers encourage and teach mothers how to hold their babies, with the aim of settling infants and minimizing withdrawal symptoms.[64] Skin-to-skin contact, breastfeeding, and cuddling are all safe and effective ways to support maternal-infant bonding, and reduce symptoms of opiate withdrawal in infants.



Hospitalization rates for Neonatal Opiate Withdrawal have been increasing since 2013. (Source: Canadian Institute for Health Information)

Box Breathing

Box breathing (also called square, tactical, or four-part breathing) is a technique that can be used to interrupt a "fight-or-flight" response or to promote calm and relaxation. It can be adapted and used in range of contexts and with different populations. Box breathing can be taught or used as:

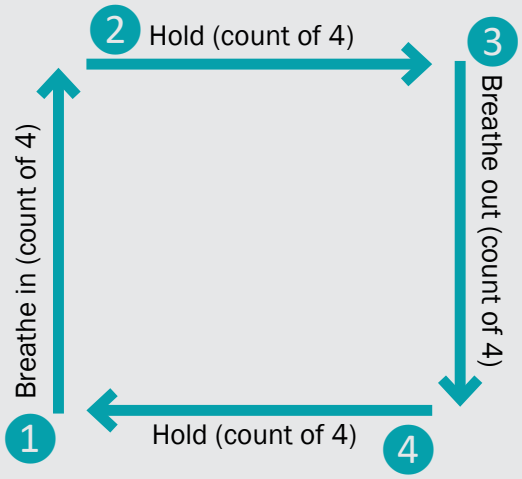
- A calming or grounding tool for individuals who experience trauma responses such as shortness of breath, shallow breathing, agitation or muscle tension;
- A relaxation or meditative tool for individuals with symptoms of mild anxiety or depression;
- A pain management tool for individuals who are experiencing chronic pain;
- A calming and focusing tool for first responders during an emergency or traumatic event;
- A tool for individuals experiencing insomnia;
- A part of self-care and wellness for service providers.

How to do box breathing:

1. Breathe in to a count of four.
2. Pause/hold your breath for a count of four.
3. Breathe out to a count of four.
4. Pause/hold your breath for a count of four.
5. Repeat for a few minutes or as long as you like.

Some individuals may find it helpful to use the image of a square to help them focus. Drawing a "square in the air" or "table top square" can be particularly useful for certain populations, e.g., young children or individuals with cognitive challenges. Instructions for three variations:

- "Visualize a square. As you count to four, move your attention from corner to corner."
- "You can also draw a square in the air with your finger or in the palm of your hand. Begin by placing your finger in the lower left corner. As you breathe in, move your finger towards to the top left corner. As you hold your breath for a count of four, move your finger to the top right corner. As you breathe out for a count of four, move your finger to the bottom right corner. And we'll repeat that again."
- "You can also draw a square on a piece of paper and trace your finger along the lines as you breathe. Let's begin together in the lower left corner…." (Creating an "artsy" table top square can be a fun activity to incorporate into individual or group therapy sessions.)



Discussion Questions

The following discussion questions are intended for small groups to consider and reflect on their work and to ask "What are we doing well? What else can we be doing?"

1. How do you contribute to a sense of hope when working with your clients? How can using strengths-based language and approaches help foster change and growth?

2. What policies and practices within your organization support a focus on strengths? What about those that seem more focused on deficits? Some areas to consider include program entry requirements, intake procedures and organizational values. What are some first steps for helping to shift your organization towards being more strengths-based?

3. Consider the population(s) you work with. What skills might be the most helpful in promoting healing from trauma, e.g. negotiation, conflict resolution and self-assertion are key to a trauma-informed practice when working with girls,[65] skill building to support men to identify emotions and deal more effectively with anger, guilt and shame may improve men's resilience to the effects of trauma[66]? What are some of your strengths as an organization in terms of providing practical skills training? What additional training for staff might be helpful? What other organizations could you work with in the community?

4. How is education and support related to vicarious or secondary trauma provided within your organization? What's working well? What else might be needed to support staff?

5. What is the role of your organization in the community? In what ways are you connected to initiatives to support resilience at a community level? Are there other things you can be doing with regards to addressing some of the underlying conditions contributing to the opioid crisis?

NOTES

Making Connections
Gender, Trauma, and Opioid Use

Opioid Poisonings and Overdose Deaths

In BC, men are more likely to die from an opioid related overdose. In 2017, men accounted for 80% of deaths and women for 20%.[4]

Adverse Childhood Experiences

Early experiences of neglect, abuse and violence are linked with later-life substance use problems, including opioid misuse and addiction.[12, 15, 17, 35-37] Boys are more likely to experience physical abuse while girls are more likely to experience sexual abuse.

Prescription Pain Medications

While 13% of all Canadians use opioid pain relievers,[67] men and women have different patterns of health care. Women tend to visit health care providers more often, are more likely to use prescription drugs, and are more likely to be prescribed opioids and anti-anxiety medications.[68-71]

Intergenerational & Historic Trauma

In BC, First Nations men and women are five times more likely to experience an opioid overdose than non-First Nations people. Although First Nations men are 2.5 times more likely to die than women, the rates of overdose events are similar for First Nations men (52%) and women (48%). Intergenerational trauma is one reason that First Nations people are more likely to experience problems with opioid use.[11]

Chronic Pain

Anatomy, physiology, genes, hormones, and other sex factors intersect with social and cultural (gender) influences to affect how men and women experience pain, when they seek help as well as treatment preferences and effectiveness.[72]

Pregnancy

Many women are prescribed opioids before they become pregnant and pregnant women are increasingly prescribed opioid medications. Opioid use can increase the chance that the baby will be born prematurely or experience symptoms of withdrawal.[67]

Centre of Excellence for Women's Health

What Helps
Prevention to Treatment

Safe Spaces

Services recognizing that men and women might have unique and gendered pain care and addiction treatment needs, including men-only, women-only, and trans-only spaces and programming.

Community Resilience

Social networks, education and economic opportunities, new models of housing, and other initiatives that address early life experiences, poverty, mental health, and safety.

Integrated Pain Treatment

Improved access to treatment including physiotherapy, counselling, trauma treatment, massage, chiropractic, yoga and acupuncture.

Cultural Safety

Training for all health care providers to improve quality of care for Indigenous peoples, including recognizing the value of Indigenous wellness and healing practices for addressing problematic substance use.

Continuum of Addiction Services

Range of treatment options from withdrawal management to outreach and peer support to aftercare. Integration with primary care and mental health services. Specialized programs such as family residential programs that offer child care, community-based detox, gender-specific programming, and cultural interventions.

Care for Mother and Child

Services to improve the health of pregnant women and newborns, including access to opioid agonist treatment during pregnancy and practices such as rooming-in, breastfeeding, and skin-to-skin contact after birth to reduce possible symptoms of withdrawal.

Online Resources

Resources related to trauma-informed practice and opioids with a focus on British Columbia.

Trauma-Informed Practice

Trauma-Informed Practice Guidelines, BC Mental Health and Substance Use Services
www.bccewh.bc.ca

Opioid Crisis and Response

Overdose Prevention and Response in BC
www2.gov.bc.ca/gov/content/overdose

Overdose Prevention Information for First Nations
www.fnha.ca/overdose

BC Centre for Disease Control
www.bccdc.ca

Government of Canada
http://canada.ca/opioids

Harm Reduction and Reducing Stigma

Take Home Naloxone Program
http://towardtheheart.com/naloxone

Indigenous Harm Reduction Principles and Practices
www.fnha.ca/overdose

Language Matters and Compassionate Engagement Training (BC Centre for Disease Control)
http://towardtheheart.com

Stop Stigma, Save Lives Project
https://www.northernhealth.ca/YourHealth/Stigma.aspx

Women and Opioids

Women and Opioids Fact Sheets
www.bccewh.bc.ca

SisterSpace Women-Only Overdose Prevention Site (infographic)
www.atira.bc.ca

Opioids and Neonatal Abstinence Syndrome infographics
http://www.nationalperinatal.org/Infographics

Cultural Safety

San'yas Indigenous Cultural Safety Training
www.sanyas.ca

Cultural Humility webinars and resources
http://www.fnha.ca/wellness/cultural-humility

Cultural Safety: Respect and Dignity in Relationships (booklet)
https://indigenoushealthnh.ca/initiatives/cultural-safety

Clinical Guidelines

A Guideline for the Clinical Management of Opioid Use Disorder
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Clinical Management of Opioid Use Disorder in Pregnant Women
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Glossary

Cisgender: People whose gender conforms to social norms related to their biological sex.

Coping: Coping skills or coping strategies are the ways that an individual manages stress and responses to traumatic experiences. Substance use is one strategy that individuals might use to manage the effects of trauma. Other coping skills include relaxation exercises, talking to friends and family, physical activities like yoga and running, listening to music, or spending time in nature.

Cultural safety: Cultural safety considers how social and historical contexts, as well as structural and interpersonal power imbalances, shape health and health care experiences. The goal of cultural safety is for all people to feel respected and safe when they interact with the health care system.

De-stigmatizing language: Language can reduce stigma associated with substance use and addiction. De-stigmatizing language includes using words and phrases that reflect the medical nature of substance use disorders and treatment and demonstrating respect for people's autonomy and strengths.

Equity: Ensuring (by different treatment if necessary) fair or even opportunities, rights and benefits for all.

Fentanyl: Fentanyl is a potent synthetic (man-made) opioid that can be prescribed by a physician to help control severe pain. Fentanyl is also produced in illegal labs and sold on the streets, often mixed with other drugs. Increasingly, fentanyl is being detected in overdose deaths in BC.

Gender: The socially constructed roles, behaviours, expressions, and identities typically ascribed to binary notions of biological sex. Gender influences how people perceive themselves and each other, how they act and interact, and the distribution of power and resources in society.

Gender identity: A person's felt, inherent sense of gender. Since gender identity is internal, it is not necessarily visible to others.

Gender-informed: Refers to strategies that take all aspects of gender related factors (roles, norms relations, expression) into account.

Gender-transformative: Approaches that actively strive to examine, question, and change rigid gender norms and imbalances of power as a means of reaching health as well as gender equity objectives. Gender transformation seeks to shift gender roles and relations closer to gender equity in any given context.

Grounding skills: Grounding skills are simple and practical activities that can help individuals relax, stay present, and re-connect with what is happening around them following an "in-the-moment" trauma response. Grounding skills are often categorized as "mental," "physical," and "self-soothing." They can include strategies such as counting backwards slowly from 10, saying the words to a comforting song, visualizing a safe or relaxing place, or a focused breathing activity.

Harm reduction: Harm reduction is a public health approach that works to save lives and provide choices to people struggling with addiction. Harm reduction programs focus on "meeting people where they are at" and do not require abstinence to engage in services.

Naloxone: A medication that reverses the effects of an overdose of opioids such as heroin, methadone, fentanyl, or morphine. When administered along with rescue breaths, naloxone can restore breathing within a few minutes.

Neonatal Opiate Withdrawal: Also called Neonatal Abstinence Syndrome (NAS), Neonatal Opiate Withdrawal affects infants who were exposed to opioids (and other substances) in utero, causing physical dependence on opioids and often leads to to withdrawal symptoms after birth. Most babies who experience symptoms of withdrawal will have no long-term effects on their health and development.

Opioid: Opioids are drugs with pain relieving properties that are used primarily to treat pain. They can also cause euphoria or make people feel "high." Examples of common opioid medications include morphine, codeine, oxycodone (e.g., Oxycontin®, Percodan® or Percocet®), hydrocodone (e.g., Hycodan®, Tussionex®), hydromorphone (e.g., Dilaudid ®), fentanyl, methadone, tramadol, and buprenorphine. Opioids such as heroin and fentanyl can also be produced or obtained illegally.

Opioid agonist: Methadone and buprenorphine (Suboxone) are opioid agonists. These medications are long-acting opioid medications that help prevent withdrawal and reduce cravings for opioid drugs. These medications can help people to stabilize their lives and reduce the harms of their substance use.

Opioid misuse: Opioid misuse includes using opioids together with alcohol, other drugs or medications, using more of a prescribed medication than is recommended or taking it at the wrong time, using an opioid medication that was prescribed for someone else, or changing how the opioid is intended to be ingested (e.g., snorting or injecting).

Overdose: An overdose can happen when an individual takes too much of a drug. Opioids affect the part of the brain that controls breathing. When an individual takes more opioids than the body can handle, breathing slows which can lead to unconsciousness and death.

Re-traumatization: Re-traumatization is a situation, attitude, interaction, or environment that reminds an individual of a past trauma and that triggers the overwhelming feelings and reactions associated with that experience. Re-traumatization often replicates the dynamics of the original trauma, i.e., loss of power, control and safety.

Resilience: Resilience refers to a person's ability to "bounce back" or adapt to difficult situations and stressful experiences. Individuals can learn skills and strategies to support their own resilience. Organizational practices and policies can also promote resilience in service providers.

Self-care: Self-care refers to any activity a person does to take care of their physical, emotional, spiritual, and mental health. Examples include getting enough sleep, exercise, meditation and prayer, and spending time with supportive friends and family.

Sex: A multidimensional construct that encompasses anatomy, physiology, genes, and hormones that together create a human "package" that affects how we are labelled. Common conceptualizations of sex usually employ the female/male binary; however, in reality, individuals' sex characteristics exist on a continuum that reflects variations in anatomy, physiology, genes and hormones.

Sexual orientation: A person's sexual and/or emotional attraction to another person – heterosexual, gay, lesbian, bisexual, asexual, pansexual.

Stigma: Stigma refers to negative attitudes (prejudice) and negative behaviour (discrimination) toward people with who use opioids and other substances. For individuals struggling with substance use problems, stigma has been identified as a significant barrier to accessing health care and social services. Stigma also decreases public support for evidence-based health interventions and harm reduction approaches for addressing substance use and addiction.

Transgender and gender-diverse: A broad category used to describe individuals whose gender identity is different than the sex they were assigned at birth. Transgender people may identify as male or female, or masculine or feminine, or they may identify as neither. Gender fluid and non-binary people may identify as both male and female, neither male nor female, not identify themselves as having a fixed gender, or as another traditional gender recognized by Indigenous or other cultural group.

Trauma: Trauma describes the effects of experiences that overwhelm a person's capacity to cope. These experiences may be early life events of abuse, neglect, and witnessing violence, or later live events such as assault, partner violence, natural disaster, war, accidents, sudden unexpected loss, forced disconnection from home or culture, etc. The experiences may be one time or cumulative, and may be experienced as an individual or as a group.

Trauma-informed services: Integrate an understanding of trauma and prioritize the individual's safety, choice, and control in service delivery. Such services create a treatment culture of nonviolence, learning, and collaboration. Utilizing a trauma-informed approach does not necessarily require disclosure of trauma. Rather, services are provided in ways that recognize the need forphysical and emotional safety, as well as choice and control in decisions affecting one's treatment. A key aspect of trauma-informed services is to create an environment where service users do not experience re-traumatization and where they can learn coping or self-regulation skills and make decisions about their treatment needs at a pace that feels safe to them.

Trigger: A situation, attitude, interaction, or environment that reminds an individual of a past trauma. A person who is "triggered" may experience emotions such as fear, sadness or panic, may lose focus or the ability to respond to instructions and may have physical responses such as shaking, heart palpitations, and light-headedness.

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