Thoughts on Trauma Informed Prescribing in Addiction Services

(I am currently expanding this so please feel free to give feedback so I can improve it)

'The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Physicians' failure to understand the nature of suffering can result in a medical intervention that (though technically adequate) not only fails to relive suffering but becomes a source of suffering itself.' Dr Eric Cassell

Alcohol and drug addiction has been traditionally viewed as difficult to treat with positive outcomes of under 10% for opiates, which left people believing that people were either hard to engage or hard to treat. As new information and evidence about addictions is discovered we can see that we were providing the wrong treatment to a lot of people; obviously the traditional way did work for some people, so we need to keep that but as we learn better we adapt to provide the treatment that suits each person best, & we all want to do our best for people.

The majority of people with alcohol & drug issues successfully recover without accessing treatment, and those that do end up at services are the ones whose addiction is rooted in unresolved childhood trauma. I know that after 20 years of working in services every single client I worked with had childhood trauma. The Adverse Childhood Experience (ACE) Study showed that those with a score of 4+ were 10x more likely to end up with an alcohol problem & 7x more likely to inject illegal drugs, but we know there are other types of traumas too. This is not a case of people using alcohol/ drugs to cope with bad events – trauma changes the way the brain and body develop, and one outcome is the physical inability to manage emotions and a constant state of fear (that they hide). This is where alcohol and drugs come in to artificially fulfil that function and manage emotions. The damage can be deep rooted & not just a case of try a new way to change how you feel – the brain literally needs rewiring and traditional treatment doesn't help with that so whenever someone stops using drugs or alcohol they can be left feeling the pain of the trauma as if it were fresh. Some people will be able to process this, but a lot will need help – not therapy help but a safe space to process is enough for most people. When a brain feels safe it can start repairing, without it the amygdala is in control and survival behaviours take over – none of which are future planning. These behaviours can include all forms of fight, flight, freeze or fawn (compliance). These are not choice; to take away their way of managing emotions without a safe space to process can set them up to fail by providing the wrong treatment & then blaming them. Now we know that we need to change our approach so everyone feels safe & included.

To be clear **using is not a behaviour choice, it is a trauma response.** Reward & punishment do not work long term. The structure of Opiate Substitution Therapy (OST) treatment can leave some clients feeling like they are doing something wrong & retraumatise them – hindering their recovery. I know it can be justified as 'managing risk' but after COVID we know we were too overly cautious and can be more flexible with prescribing. And **we need to assess**

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the risk of retraumatising as equally as the physical/ OD risk by understanding how we can unintentionally retraumatise & avoid doing so. If trauma is why they use, retraumatising will never be a safe, or effective, treatment & will lead to people disengaging or using more – which increases the risk we are trying to avoid!

Some prescribers will already be working this way, for some it will be new, and we can all improve. To become fully trauma informed will take time & adapting to new learning, but it will also make your job easier & help clients more. Please do not think it will be more stuff for you to do – most of it is just about how you do what you already do, & I promise will make it easier! It is also about having clear boundaries still, but just not retraumatising ones.

The first and only priority needs to be creating a safe place before we even think about interventions, and we need to keep learning and improving at that. What we think of as safe is probably not from their point of view - nice people are not necessarily safe people (abusers are nice at times too). I cover the how & more on creating safe relationships in other places but I want to talk specifically with regard to prescribing here. Please note trust can be an immediate feeling so do not discount because you only have 15mins with someone.

In essence:

Addiction is a response to trauma, not a choice

Considering the risk of retraumatising is responsible prescribing

Understand that the way you treat someone has a bigger impact on outcome than what you prescribe - but together is the magic

Consciously level out the power imbalance by understanding trauma behaviours

Make all decisions together (choice & collaboration)

Never assume you know what is best for them, or that you are a safe person to them. Keep learning.

Fuller examples of the TI approach

I have had the privilege of working in a trauma informed way with a prescriber and learnt the following:

(Disclaimer - I will not be commenting on whether prescribing guidelines are correct, but just how we work within them)

- Always be mindful of the power imbalance - you have the power to help or hinder a client's life by deciding whether they can have a script, and how often they have to go to the chemist. Being controlled in that way can feel similar to how abusers control people so it is your job to level out that power so they can feel safe to be themselves rather than fearing you will harm them (stopping a script, increasing pickups, deciding

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if they can go on holiday etc are seen as harm to them no matter how nicely you think you explain it is in their best interest).

- Same prescriber every time, with key worker sat in every time, so it becomes a team with the client working together. This is possible so no reason not to other than for our convenience over their need.
- This also means the prescriber gets to know the client, builds trust & can accurately assess risk. Unfortunately, we sometimes have clients who will be prescribed differently depending on how the prescriber assesses risk rather than on the actual risk, ie one may feel safe taking off supervised consumption then the next puts it back. This will hinder the clients being able to feel safe & being able to plan.
- If we build trust the client will feel safe enough to be honest too, rather than a trauma response of not knowing what the right thing to say is. Sadly, some people assume the client lies rather than looking at why they feel the need to lie; if they felt safe they wouldn't. It's our job to create safety so they can be honest. Also be aware of where we reward lies, ie increasing pickups if they admit to lapsing so they don't tell you, or them bringing in someone else's Urine Test (UT) so they can get their holiday script etc
- Trauma can be retriggered if someone feels they have no choice or control over what happens to them so again a teamwork approach works. Of course, there are limits within prescribing but as far as possible within that give the person choice, ask what they feel would help them achieve abstinence and then creatively see what can be done. Examples – people who have anxiety & struggle to leave the house without a substance – let them try unsupervised so can take it before they go to chemist. They can still be on daily pickup if concerned, and agree an outcome, ie how will we know this has helped? Do we review in 2 weeks & see if can do a clear test? To insist on a clear test before we take them off supervision is unfair in most cases.
- Framing things as rewarding good behaviour or penalising for lapsing should be avoided. Just because someone has a positive UT does not mean they cannot be trusted to take home their script. Or not allowed to go on holiday. Discuss with them concerns and assess risk in totality with their worker, give people the benefit of the doubt. (& also understand that to a client giving them 2/3 days to take home over BH or w/ends, then saying it's safer to stay on daily supervised consumption (DSC) in the week doesn't make sense)
- If someone is going through a difficult time be flexible, ie I had a lady who had mobility issues and her child was having lots of hospital admissions so we gave her unsupervised so she had one less thing to worry about getting to the chemist at a set time. Again, knowing the lady and risks helped this and built trust with her that we would do what we can to help.
- If you are reducing pickups – give them choice about what days.

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- Do not treat someone who uses 1x pw the same as a poly drug user using every day just because they both give a positive drug test.
- Treat what the client asks help for – if they test positive for cannabis do not force them to stop in order to change their OST plan (unless there is a genuine high risk & not just our opinion). They can still successfully detox from their chosen drug & be using another. (& it is their life, so they get to choose without judgement from us)
- Assume the client knows themselves and what works for them – do not tell them they are on too low a dose if they feel it is right, and certainly never force someone to increase their dose (& be aware that they may agree even if they don't want to, compliance is a survival skill).
- Let them teach you – often they know more about drugs that you can possibly do! You could say 'this is what I was taught – is that your experience?' 'this has worked before, how does it sound to you?' Assuming you know best will break trust and cause you more problems but being open to learn will gain trust. You are there to serve them.
- It is better to trust & be wrong than not trust & be wrong, if you are not certain someone is selling their medication do not challenge them – use your intuition and evidence. Ask their key worker, who should know them better and approach cautiously. (I had a client that another told me was selling but when we checked with the chemist they were on methadone DSC and complying)
- Work out, with them, what works for that person, ie do incentives work? As a key worker I will book a test in when the client feels they can achieve a clear test best, ie just before benefit day, and that gives them some control over when. That may seem like cheating but once they get one it will help them do a 2nd etc
- When someone has strong views about what will work for them, even if it is around prescribing, listen and be open to their view, ask questions to understand. That doesn't mean to say you will do what they ask but do not dismiss it, and you can use what you learn to tailor their treatment. Listen to the underlying message. I have told people I will look into their request even if I know it is a very slim chance of a yes, then they appreciate I am doing all I can even when I tell them a no. (eg a client wanted methadone tablets at home, still checked although was sure couldn't)
- Be honest – I have sometimes had to say 'you maybe right & I wish we could do that, but we really do not want to risk our jobs by doing so. Sorry. Maybe you can get involved in service user forums to discuss changing things but right now this is what we got?' (they wanted detoxing using dihydrocodeine)
- It is our job to do everything we can to keep them on script while they heal what drives their use, NEVER use stopping a script to motivate. Forcing people to change never works long term, work with the key worker and client to find out what is really going on.

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- Sometimes you do need to nudge people, I have had clients who want to stay on OST for life as it helps them avoid dealing with the underlying issues. Some may end up on OST for life but always give them hope rather than give up on them – you really never know for certain if they will heal or not. You can have an end goal of off it – even if the goal is years ahead, but also accept that some people may never want to deal with the underlying issues, and respect that. This is their life & emotional pain will always be more feared than physical pain, and alternative medication to support that can sometimes be enough to free them from OST.

- Detox – again give choice and know your client. Be flexible about what works best for them – a structure regime or more flexible approach? I had a client finish his detox on holiday in Spain, and it worked well & none of the horror risks some of you will be fearing. Trust them to know what is best for themselves, you can share advise but let them decide. Trying what they want & it fails is a much better approach then forcing them to do it your way (after a failed attempt you reflect & create a better plan together)

- And yes, some people are chaotic and do not 'behave' how you think they should – that is what trauma does, and the antidote is psychological safety not punishment. I've worked with people on final warnings & by using this approach had no issues at all. It works by connecting with them behind the behaviour & trusting that part of them; you are capable of assessing risk and doing that.

- As far as possible do not run late – you are saying they are not important. Stuff happens so apologise & let them know but it is very retraumatising if we refuse to see them if they are late but make them wait 30+mins for us. (then blame a highly anxious person cos they leave)

- Realise that going to the chemist can cause shame so of course sometimes it will be easier for them to send a text and get drugs delivered. Acknowledge that obstacle we have, even if we cannot beat it! But also do all we can to ease it for them.

- Always believe people can change, even if you have seen them in treatment for years and no shift. You never know…be aware and release any judgements you have as they are about you & not the client anyway. (& be certain clients can sense them even if you think you hide your emotions)

- Choose what is best for the client over what is easiest for us; some will challenge us and trigger our own issues – it helps us grow and be better at our work.

- Look after yourself & learn how to shift gears between clients so you do not carry stuff forward. Dealing with suffering is hard – caring too much is damaging for us & too little is damaging for them. Learn balance and be kind to you.

- Progress not perfection.

(I have not discussed alcohol or other drug prescribing as that tends to be shorter term & have less hoops for people to jump through. Principles of trust are the same though)

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Resources & Research links

List of research into the prescribing relationship

Drug Treatment Matrix cell B3: Practitioners; Medical treatment (findings.org.uk)

Including:

"Predictors of non-prescribed opioid use after one year of methadone treatment: An attributable-risk approach (ANRS-Methaville trial)": https://www.sciencedirect.com/science/article/pii/S0376871613004432

Substance use, childhood traumatic experience, and Posttraumatic Stress Disorder in an urban civilian population (nih.gov)

Example of One safe adult research

https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-017-1260-z

TED Talks

https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=fi

How 40 Seconds of Compassion Could Save a Life | Dr Stephen Trzeciak | TEDxPenn - YouTube

Original ACE Study results:

https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html

Review of original Study:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6326558/

ACE Aware Scotland report

http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces

Books:

In the Realm of Hungry Ghosts by Dr Gabor Mate, & training A Masterclass For Healers – Wholehearted.org

(also books by Bessel van de Kolk, Dr Nadine Burke-Harris & Dr Bruce Perry)

Finally – I have more resources via my website so please feel free to look around & ask me any questions, or give me feedback on this……

Thanks *Kathryn*

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