Domain 1: Workplace Practice

Enhance the understanding, skills, and inclusive mindset of all staff to provide thoughtful and expert care to individuals with an opioid use disorder (OUD), using a person-centered approach.

This toolkit was made possible by funding from the Connecticut Department of Mental Health and Addiction Services. We would also like to thank representatives from Connecticut Department of Mental Health and Addiction Services, Connecticut Department of Public Health, and the Connecticut Women's Consortium for their contributions in the development and review of this toolkit and the adjunctive training and implementation of this initiative.

The toolkit outlines six domains to help LTCFs care for residents with Opioid Use Disorder (OUD). Administrators, directors of nursing (DON), medical directors, social workers, nurses, and certified nursing assistants (CNA) can all use these resources. Each domain can be used on its own when implementing. Below is Domain 1: Workplace Practice.

Throughout the domains there are links to educational resources, including links to brief learning management modules to aid in understanding of key topic areas. In the appendices you will find sample template forms and tools to help guide development of LTCFs policies and procedures.

Toolkit Domains:

Contents

Domain 1: Workplace Practice

Goal:

Enhance the understanding, skills, and inclusive mindset of all staff to provide thoughtful and expert care to individuals with an opioid use disorder (OUD), using a person-centered approach.

Objectives:

1. Employ specific strategies for recruiting and onboarding new staff and ongoing training about OUD.
2. Define key skills related to OUD for professional and frontline staff.
3. Assess the need for new and expanded competencies to support long-term care facility (LTCF) residents with OUD.

Description:

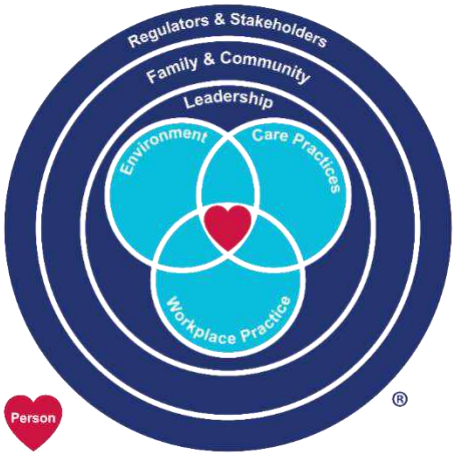
The workforce domain refers to the high engagement and performance of all those whose labor and efforts impact residents. It calls on leaders of LTCFs to create a culture of continuous learning. Within this domain are ways to enhance person-centered care and develop competencies to provide more effective support for individuals with OUD. It addresses best practices in hiring, strategies for onboarding new staff members, and ongoing training around key skills and competencies (e.g. such as a trauma- informed care, reducing or eliminating stigma and bias, de-escalation techniques, and motivational interviewing). Also, for consideration, there are ways to expand/enhance staff roles to create a resilient, competent workforce.

Changing Demographics

As the opioid crises in America grows, the healthcare system is responding to increasing encounters with those with an OUD. Many individuals living with OUD experience a wide array of comorbidities and frequently need compassionate care to bring them back to baseline. A significant number of individuals recover from injuries, drug events, and complications from comorbidities in local LTCFs following hospital stays. Consequently, LTCFs frequently find themselves caring for notably younger residents. This trend is compelling LTCFs to reevaluate and reimagine certain aspects of their operations and care delivery. They are transitioning from an elder care model to one that embraces and supports younger residents with vastly different needs and healthcare goals. Providers are learning to adjust to the changing demographics by reinventing their services to include more social service support, behavioral health counselors, support groups that address substance use disorder (SUD), and a much more fluid activity calendar.

Additional roles could include an aftercare specialist. Aftercare specialists are responsible for providing support to individuals with OUD, and/or mental health needs. Aftercare specialists are being employed to assist with discharge placement ensuring that individuals have a safe setting from which they can continue their path to recovery. Recognizing that some newly admitted residents with active SUD may have been using substances as part of their daily routine prior to admission requires new levels of competency, care, system knowledge of behavioral health and OUD, and support on the part of staff.

Person-Centered Approach



Person-centered care, an approach that puts the resident at the heart or center of care with services encompassing their needs, is especially relevant to residents with OUD, as the concepts embedded in that care are also key drivers of recovery.[1] The Centers for Medicare & Medicaid Services (CMS) defines person-centered care as "integrated health care services delivered in a setting and manner that is responsive to individuals and their goals, values and preferences, in a system that supports good provider–patient communication and empowers individuals receiving care and providers to make effective care plans together."[2]

Continuous growth and education focused on person-centered care, provides all staff with an opportunity to become increasingly competent. Leaders and managers who "model the way" and inspire a shared vision are likely to accelerate the staff's understanding of person - centered care. Watching leaders handle situations that offer dignity, respect, kindness and empathy with residents will ensure that staff emulate these skills. Involvement of staff members in "just in time" discussions based on behaviors they have witnessed, escalations they have encountered, or other uncomfortable episodes is powerful, providing them with key opportunities to review how person-centered care helps support any resident but also those with OUD. Bolstering staff engagement in these types of discussions and experiences helps them to gain confidence and competence and even goes a long way in helping to reduce staff turnover, thus providing consistency and continuity for residents and many other positive effects.[3] This is an opportunity to build the knowledge, skills, and attitudes of staff to help create and sustain a person-centered culture.

Some ideas:

- Encourage staff in the early days of a resident's admission to learn more about the resident, explore their likes and dislikes, daily routine, and goals the resident might have and share them with other team members during huddles or reports, so that staff can support the resident.
- Consider applying the 'it takes a village' approach.
- Educate staff in such a consistent and ongoing way that the organization experiences a notable positive shift in the culture and care for residents.
- Identify champions who can work on specific goals and performance improvement projects that will assist in creating a high performing, uniquely caring environment for people with OUD.[4]

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[1] Substance Abuse and Mental Health Services Administration. (2012). SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery. Retrieved from https://store.samhsa.gov/system/files/pep12-recdef.pdf
[2] Centers for Medicare & Medicaid Services. (2024). CMS Innovation Center Key Concepts. Retrieved from https://www.cms.gov/priorities/innovation/key-concepts/person-centered-care
[3] Baldoni, J. (2013, July 4). Employee Engagement Does More than Boost Productivity. Retrieved from Harvard Business Review: https://hbr.org/2013/07/employee-engagement-does-more
[4] Baldoni, J. (2013, July 4). Employee Engagement Does More than Boost Productivity. Retrieved from Harvard Business Review: https://hbr.org/2013/07/employee-engagement-does-more

Here is an example of person-centered care:

Tyler is a 42-year-old male who has experienced unsheltered homelessness for the last four years. After experiencing a concussion, and a fracture to his occipital lobe with lacerations caused by a recent drug overdose, he was discharged to a local nursing home after spending two days in the hospital. It is the first time he has ever been to a nursing home. The home makes a special effort to support Tyler's need to construct his own daily schedule. Staff identify that Tyler doesn't usually sleep "in a bed" and frequently wanders around at night downtown until he gets tired. He has a few safe places that he frequents to sleep and sometimes stays on the couch at his cousin's house. He eats late and as a result, he tends to sleep a bit longer in the morning (or until it gets light out or he hears the traffic moving around him). The team discusses with Tyler the best ways they can make him comfortable. They offer him a room close to the patio so he can walk at night. There, he can relax. They buy snacks that he particularly enjoys which are left in his drawer and have made accommodations so that a meal will be available to him late at night. Tyler was delighted when the team offered him a recliner (a donated item from a former resident) that was put in his room. He thought this would be better than the bed and it would give him a place to take a nap. The team got a "Do not disturb" sign for the door so when he wanted to nap, no one would enter. They gave him a calendar so he could see the day's activities, but he said he just likes to listen to music. The team connected him with a radio as part of the Music & Memory program and downloaded a playlist of his favorite songs.

Staff Recruitment

LTCFs are starting to recognize a growing need to offer screening questions addressing candidate's biases, level of empathy, safety needs and de-escalation competencies. This is important and reflects a shift in competencies. When recruiting and interviewing staff, introducing person-centered care questions into the process will set expectations that reflect the values and culture of the organization. It will also strategically bring individuals on board who already possess the required person-centered orientation.

Recruitment efforts may prioritize building a diverse workforce that is reflective of the community, especially regarding culturally linguistically appropriate services (CLAS) considerations around language and culture (**See Domain 4: Leadership for more information on CLAS).**

When interviewing potential staff describe the culture of the organization as an empathetic, bias and stigma-free environment where we assist all people to reach their highest practicable potential. After helping them understand what makes the culture unique, begin to ask questions that help the candidate share their values.

Here are some potential questions to add to existing interview guides:

- What does a person-centered approach mean to you? Provide a concrete example of how this shows in your work, or how you act on your values.
- Our culture relies on empathy. Can you give an example of a time you showed empathy to another person.

- How would you approach a resident who is behaving aggressively?
- Are you familiar with person-first language? If no, would you be willing to adopt it?
- Are you aware of the psychological signs that someone might be experiencing addiction?
- Describe your experience with a resident who required a lot of your time. How did you manage this resident's care while ensuring your other residents were adequately cared for?

What motivates you most in your role? What brought you into the field, and what sustains your interest and energy in this work?

Staff Training

A staff training plan should incorporate an interdisciplinary, person-centered approach. Training should enhance staff competencies in the following areas (*click on each competency below to be directed to the section of the toolkit that covers them in more detail*):

1. Understanding of LTCFs mission and vision statements to develop a culture of person-centered care.
2. Clear knowledge and understanding of OUD as a chronic disease.
3. Overdose prevention and naloxone use.
4. Recognizing signs of withdrawal, utilizing the Clinical Opiate Withdrawal Scale (COWs).
5. Stigma and bias training and use of person first language.
6. Understanding of what Harm Reduction is (see Domain 3: Care Practices).
7. How to engage residents to establish a positive relationship including de-escalation and empathy techniques.
8. Understanding of the six stages of behavioral change.
9. Trauma-informed care and addressing underlying trauma.
10. Use of motivational interviewing
11. Training in recreation therapy to meet the needs of younger residents and programs to support recovery.

Education on OUD and Medication for Opioid Use Disorder (MOUD)

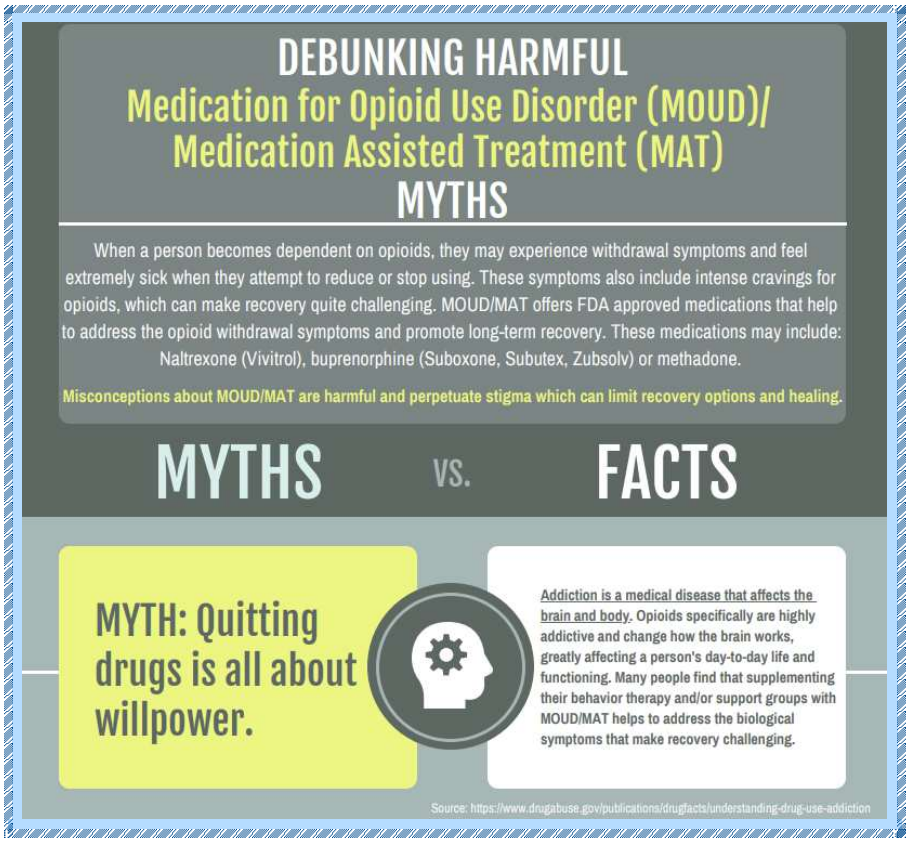
Training should include education on OUD and MOUD, and the skills, attitudes and awareness required to best support residents. Training should also include education around co-occurring substance use disorder (SUD). Furthermore, the organization should prioritize implementing ongoing case reviews, overdose drills, or peer-sharing sessions for staff members to address potential stress, feelings of isolation, or negative emotions. Review **Domain 3: Care Practices for a full understanding of OUD and MOUD.**

Review the learning management module on the Opioid Epidemic here: https://learningforquality.org/courses/strategies-for-supporting-residents-with-opioid-use-disorder-in-long-term-care/

There are many false assumptions that exist about MOUD that put residents with OUD at risk. Persistent myths include "methadone or other opioid agonists are a crutch, or MOUD trades one addiction for another and medications should be discontinued as soon as possible". The messages that staff need to hear are as follows: MOUD bridges the biological, and behavioral

components of addiction and research has shown that individuals on MOUD, for at least one to two years, have the highest rates of long-term success.[5] It is important to recognize that "addiction is a chronic disease similar to other chronic diseases, such as type II diabetes, cancer, and cardiovascular disease."[6]

Review with LTCF staff the myths that are associated with MOUD that can be harmful. Download and share the infographic from the Department of Mental Health and Addiction Services (DMHAS) debunking harmful MOUD myths. See Domain 3: Care Practices for additional information on the types of MOUD, buprenorphine and methadone and regulatory requirements.



Signs of Overdose and Use of Naloxone

Educating LTCF staff on recognizing signs of overdose and appropriate actions to take if a resident has overdosed is a best practice.

Review the information on the Connecticut Department of Public Health (CT DPH) website on opioids and drug overdose prevention for more information, and include in staff training the following naloxone training video and the Naloxone + Overdose Response App (NORA):

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[5] Aaron M. Williams, M., Jordan Hansen, M. L., & Ashel Kruetzkamp, M. R. (2017, June). Identifying and Lifting Barriers to Integrating MAT with 12 Step Modalities. *Retrieved from The National Council for Behavioral Health*: https://www.thenationalcouncil.org/wp-content/uploads/2017/06/MAT-with-12-Steps-slide-deck.pdf

[6] National Institute on Drug Abuse. (2005, June). Drug Abuse and Addiction: One of America's Most Challenging Public Health Problems. Retrieved from https://archives.drugabuse.gov/publications/drug-abuse-addiction-one-americas-most-challenging-public-health-problems/addiction-chronic-disease

- Review the DMHAS Opioid Services website for the most up-to-date information on Naloxone (Narcan) use: https://portal.ct.gov/dmhas/programs-and-services/opioid-treatment/naloxone
- NORA App[7]

Additionally, the CT Department of Mental Health and Addiction services has many resources on how to obtain Naloxone: https://portal.ct.gov/dmhas/programs-and-services/opioid-treatment/naloxone

Signs of Overdose:

- Unconscious/not responsive
- Pinpoint/very small pupils
- Gurgling/uneven snoring
- Shallow/slowed abnormal/irregular breathing
- Not breathing
- Foaming from the mouth and nose
- Blue lips, nails, or blue/grayish skin color
- Signs of drug use (needles, pills, etc.)

Here are the steps to follow if overdose is suspected:

1. Call 911 right away.
2. Check for a response. If the person can respond, hold off on giving naloxone.
3. Check the person's mouth and throat to ensure that there is nothing blocking the airways.
4. If you need to leave the area, roll them onto their side.
5. Check for a pulse. If you cannot feel a pulse, start cardiopulmonary resuscitation (CPR).
6. If the person is still breathing but not responding, administer naloxone.

[7] CT State Department of Public Health (2019). Naloxone + Overdoes Response App. Retrieved from https://egov.ct.gov/norasaves/#/HomePage

DO	DON'T
Attend to the person's breathing and cardiovascular support needs by administering oxygen or performing rescue breathing and/or chest compressions. This is the most critical step and should be continued until Emergency Medical Services (EMS) arrives.	Slap or forcefully try to stimulate the person; it will only cause further injury. If you cannot wake the person by shouting, rubbing your knuckles on the sternum (center of the chest or rib cage), or light pinching, the person may be unconscious.
Administer Naloxone and use a second dose if no response to the first dose.	Put the person into a cold bath or shower. This increases the risk of falling, drowning, or going into shock.
Put the person in the "recovery position" on the side, if you must leave the person unattended for any reason.	Inject the person with any substance (e.g., saltwater, milk, stimulants). The only safe and appropriate treatment is Naloxone.
Stay with the person and keep the person warm.	Try to make the person vomit drugs that may have been swallowed. Choking or inhaling vomit into the lungs can cause a fatal injury.

Consider running a suspected overdose response drill:
(pulled from the IPRO QIN-QIO Naloxone Toolkit)[8]

Procedure

1. Plan a time and location for the drill. Inform staff, residents and visitors in the area about the plan.
2. Conduct drill.
3. Complete a post drill review to capture successes and develop an action plan that incorporates lessons learned.

Before the Drill

1. Develop the overdose drill scenario.
   - When will the drill occur (choose a location where an overdose may occur)?
   - How will the alarm be called and what will it sound like?
   - Designate a staff member to play the role of the person who has overdosed and explain their role (unresponsive to intervention attempts).
   - Plan how to proactively communicate the date, time, location, and purpose of the drill (e.g., to staff, residents around the drill location, and visitors). Include how you will proactively reassure observers during the drill.
2. Review drill with the LTCF's Medical Director to ensure that they are involved in the planning and implementation.
3. Prepare staff for the drill.

[8] IPRO Quality Innovation Organization- Quality Improvement Organization. (2023). Nursing Home Naloxone Policy & Procedure Toolkit. Retrieved from https://qi-library.ipro.org/2023/07/31/nursing-home-naloxone-policy-and-procedure-toolkit/

- Notify all staff, including administration and security, of the date, time and location of the drill, and review the overdose response plan.
- Assign specific staff to roles and orient them to their task(s). Each task can be assigned to a different person.
  Roles to be assigned:
  - Discoverer of an individual with a suspected overdose.
  - Individual experiencing the overdose.
  - Obtain naloxone training device/verbalize location and how to obtain actual naloxone and how to identify expiration date of naloxone.
  - Obtain crash cart/emergency supplies (e.g., CPR board, oxygen).
  - Individual who would Call 911.
  - Meet fire/EMS at the door.
  - Use Ambu bag to support respiration, as needed.
  - Administer naloxone.
  - Provide crowd control.
  - Observer- to review and observe any gaps of care seen during the drill.
  - Person to facilitate and complete the Suspected Overdose Response Drill Debrief Form
- Review "***Tips for Overdose Reversal Using Naloxone"*** *(see Appendix 4)*

4. Gather equipment.
   - Naloxone training kit.
   - CPR doll and board to be used to simulate administration of naloxone.

Conduct the Drill

Conduct the drill as planned and in accordance with the Naloxone Use for Opioid-Induced Respiratory Depression Policy and Procedures.

After the Drill (Fill out the: ***Suspected Overdose Response Drill Form***) (see Appendix 3)

- Debrief with the team and the person playing the overdose role together.
  - What went well?
  - What would you do differently?
  - What needs improvement?
  - Who will be responsible for follow-up actions, and by when?
- Develop/modify your Suspected Overdose Response plan.
- Provide additional education as needed.

Recognize Symptoms of Withdrawal

Opioids can lead to physical dependence within a short time and the body will become dependent on opioids so that it has difficulty functioning without opioids. With chronic use, abruptly stopping use of opioids leads to withdrawal symptoms, including generalized pain, chills, cramps, diarrhea, dilated pupils, restlessness, anxiety, nausea, vomiting, insomnia, and very intense cravings.[9] The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician (see Appendix 7). The summed score for the complete scale can be used to help clinicians determine the stage or severity of opiate withdrawal and assess the level of physical dependence on opioids.[10] The COWS score will

[9] American Psychiatric Association (2024). Opioid Use Disorder. Retrieved from https://www.psychiatry.org/patients-families/opioid-use-disorder

[10] Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs, 35(2), 253–9. Retrieved from: https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf

help determine the next steps in caring for the resident. Review the LTCF's policy based on mild, moderate, moderately severe, or severe withdrawal and communicate with the resident's physician or LTC medical director, Opioid Treatment Program (OTP) and interdisciplinary care team regarding suspected withdrawal symptoms and COWS score to determine the next steps and/or if the resident should go to a higher level of care. See Domain 3 Care Practice for additional information on withdrawal symptoms and the COWs scale.

Addressing Stigma and Bias

Johns Hopkins University conducted a research study that suggests people are more likely to have a negative attitude towards those with OUD than those with a mental illness.[11] Stigma and biases can influence how residents are cared for within LTCFs. Training staff on how to recognize personal stigma/bias and dispel misconceptions is an important step in creating a healthy healing environment. The National Institute on Drug Abuse defines stigma as "a discrimination against an identifiable group of people, a place, or a nation. Stigma about people with OUD might include inaccurate or unfounded thoughts like they are dangerous, incapable of managing treatment, or at fault for their condition."[12]

Launch a campaign to raise awareness of the damaging effects of stigmatizing language and suggest alternative language as part of ongoing culture change and staff training efforts to reduce stigma. Start with having facility leaders and staff "Take the Pledge" to empower person-first language. Shatterproof's National Movement to End Addiction Stigma states that "Person-first language places emphasis on people rather than their diagnosis or condition (e.g. "person with schizophrenia" vs. "schizophrenic", "person with a substance use disorder" vs. "addict"). This type of language can shift the way people with substance use disorders are viewed."[13] The table below provides examples of appropriate language to reduce stigma.

[11] Morrow, S. D. (2014). Drug addiction viewed more negatively than mental illness, Johns Hopkins study shows. Johns Hopkins Magazine.
[12] National Institute on Drug Abuse. (2024). Opioid-Overdose Reduction Continuum of Care Approach. (2023). Retrieved from https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education.
[13] Shatter Proof (2023) https://www.shatterproof.org/our-work/ending-addiction-stigma/pledge-to-reduce-stigma

Avoid Stigmatizing Language		
Non-Stigmatizing Language	Stigmatizing Language	Rationale
• Person with an opioid use disorder • Person with a substance use disorder	• Substance abuser or drug abuser • Alcoholic • Addict • User • Abuser • Drunk • Junkie	Neutral, non-judgmental language. Several studies compare "abuser/ abuse" to "person with substance use disorder" and confirm that person-first language is less stigmatizing.
• Substance use disorder or addiction • Use, misuse • Risky, unhealthy, or heavy use	• Drug habit • Abuse • Problem	Neutral, non-judgmental language
• Person in recovery or person in long-term recovery • Abstinent • Not drinking or taking drugs	• Ex-addict, former/ reformed addict • Clean	Neutral, non-judgmental language. Several studies compare "abuser/ abuse" to "person with substance use disorder" and confirm that person-first language is less stigmatizing.
• Treatment or medication for addiction • Medication for Opioid Use Disorder/Medication for Alcohol Use Disorder • Positive, negative (toxicology screen results)	• Substitution or replacement therapy • Clean, dirty	Treatments for other diseases are not labelled "medication assisted treatment," so substance use disorder should not be treated differently. "Replacement" suggests that patients are trading one substance use disorder for another.
• Adherent • Non-adherent	• Compliant • Non-compliant	Neutral, non-judgmental language.
Adapted from: Boston Medical Center Grayken Center for Addiction, Reducing Stigma and Shatter Proof Addiction Language Guide		

Resources to help assist training staff, residents, families, and resident representatives include:

- Shatter Proof- Addiction Language Guide[14]
- Harm Reduction Coalition- Respect to Connect Undoing Stigma Resource[15]
- Videos to show during training on Stigma:
  - Review the Stigma and Bias learning management module
- DMHAS/Shatterproof Stigma Reduction Webinar: Addressing Addiction Stigma in Connecticut: The Impact Public Stigma has on Social Isolation, Seeking Help and Employment (60mins)

[14] Shatterproof (2021). Shatterproof Addiction Language Guide. Retrieved from: (https://www.shatterproof.org/sites/default/files/2023-02/Stigma-AddictionLanguageGuide-v3.pdf

[15] Harm Reduction Coalition (2020). Respect to Connect: Undoing Stigma. Retrieved from: https://portal.ct.gov/-/media/DMHAS/Opioid-Resources/Resource-HarmReductionBasics-UndoingStigma.pdf

Trauma Informed Approach

The requirements of participation and final rule in the fall of 2016 established the need for LTCFs to provide regular Trauma Informed Care (TIC) training to staff to better support their care needs. Establishing and promoting TIC as part of organizational culture aligns with a person-centered approach. Taking steps to ensure the adoption of TIC practices throughout the LTCF is vital, especially for residents with an OUD. People who have experienced four or more adverse childhood events (ACEs) have more than ten times the risk of having problematic substance use compared to people without any ACEs. Research shows a link between OUD and other risky health behaviors and traumatic experiences.[16] The experience of childhood trauma has a detrimental effect on how individuals see the world and their place in it. Traumas that result from acts such as abuse, and neglect create a negative self-image. People who have suffered childhood trauma may struggle with self-esteem.[17] They may also see the world around them as a hostile place. Childhood traumas can teach us that the places and situations we should associate as safe, and comforting could be seen as hostile environments. Survivors of trauma may seek relief from their emotional pain and stress. With this information in mind, training that develops or enhances staff empathy is essential for providing TIC.

Domain 3: Care Practices discusses the importance of an organization-wide approach to workplace training and development in TIC. This domain examines the importance of TIC, providing therapeutic approaches, and utilizing resident and family advisory councils.

Begin with emphasizing the six foundational principles of TIC: safety, trustworthiness and transparency, collaboration, empowerment, cultural humility and responsiveness, and resilience and recovery.[18] All staff, volunteers, board members, and administrative staff should receive foundational training about trauma and its impact. The primary goal of this training is to sensitize them to trauma-related dynamics and avoid re-traumatization. Education about trauma and TIC for all staff should be included in orientation and ongoing training.

The following short videos are helpful resources to incorporate in staff training:

- What is Trauma-Informed Care?[19] (3 minutes)
- What is Trauma?[20] (2 minutes)
- Relationships between trauma and addiction[21] (11 minutes)

Additional resources to help build LTCF staff training:

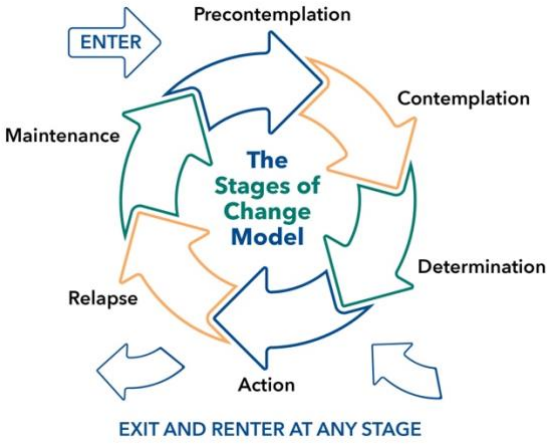
[16] SAMHSA. (2019). Trauma and Violence. https://www.samhsa.gov/trauma-violence
[17] Safe & Sound Treatment- Drug & Alcohol Treatment Center (2024). Childhood Trauma and Addiction: The Connection Explained. Retrieved from: https://safesoundtreatment.com/childhood-trauma-and-addiction/
[18] CA Bridge. (2021). Trauma-Informed Care for Opioid Use Disorder: Improving the Success of Medication for Opioid Use Disorder by Integrating Trauma-Informed Approaches. https://bridgetotreatment.org/wp-content/uploads/CA-BRIDGE-TOOL-Trauma-Informed-Care-for-Opioid-Use-Disorder-April-2021.pdf
[19] Center for Healthcare Strategies. (2019). Retrieved from What is Trauma-Informed Care? https://www.youtube.com/watch?v=fWken5DsJcw
[20] National Council for Behavioral Health. (2018). https://www.youtube.com/watch?v=uraDbhfFvsk
[21] Trauma and Addiction: Crash Course Psychology #31(2014). Retrieved from: https://www.youtube.com/watch?v=343ORgL3kIc.

- Adverse Childhood Experience Questionnaire for Adults[22]
- Implementing Trauma Informed Care: A Guidebook by Leading Age[23]
- Toolkit by CA Bridge: Trauma-Informed Care for Opioid Use Disorder: Improving the Success of Medication for Opioid Use Disorder by Integrating Trauma-Informed Approaches.[24]

Six Stages of Behavioral Change

The Transtheoretical Model (also called the Stages of Change Model) was developed by Prochaska and DiClemente in the late 1970s. For each stage of change, different intervention strategies are needed to effectively move the resident to the next stage of change and subsequently through the model. The model is a process by which residents make an intentional change, but also the support from themselves and others that can help. The focus is on enhancing intrinsic motivation, which comes from within (rather than on providing the resident with extrinsic motivation, like rewards). By training LTC staff on the stages, they can assist residents in developing and understanding their intrinsic motivations and help them see "where they are" versus "where they want to be." Meeting the resident where they are encourages autonomy so that they can make the choices that meet their goals about changing their behaviors. The stages of change provide a guide for how to help residents depending on where they are in the model.

Six stages of readiness experienced by a resident attempting to change[25]:



- **Precontemplation** – Residents in the precontemplation stage typically do not consider their behavior to be unhealthy. This may be because they have not yet

[22] ACES Aware (2020). Adverse Childhood Experience Questionnaire for Adults. Retrieved from: https://www.acesaware.org/wp-content/uploads/2022/07/ACE-Questionnaire-for-Adults-Identified-English-rev.7.26.22.pdf
[23] LeadingAge Maryland. (2019). Implementing Trauma-Informed Care: A Guidebook. https://leadingage.org/wp-content/uploads/drupal/RFA%20Guidebook.pdf
[24] CA Bridge (2021). Trauma-Informed Care for Opioid Use Disorder: Improving the Success of Medication for Opioid Use Disorder by Integrating Trauma-Informed Approaches. Retrieved https://bridgetotreatment.org/wp-content/uploads/CA-BRIDGE-TOOL-Trauma-Informed-Care-for-Opioid-Use-Disorder-April-2021.pdf
[25] Boston University School of Public Health (2022). Behavioral Change Models. Retrieved from: https://sphweb.bumc.bu.edu/otlt/mph-modules/sb/behavioralchangetheories/index.html#headingtaglink_1

experienced any negative consequences of their behavior, or it may be a result of denial about the negativity or severity of the consequences they have experienced.

- **Contemplation** – A resident at the contemplation stage is generally more open to receiving information about the possible consequences of their behavior. They may be open to learning about different harm reduction strategies or what recovery could look like for them, without committing to a specific approach or even promising to make a change.
- **Preparation** – During the preparation stage, a resident might plan the kind of change to be made, determine how to make the change, obtain necessary resources, remove triggers, and put the needed supports in place.
- **Action** – The action stage is the stage at which behavior change starts happening. The action stage may be stressful, but with adequate preparation, it can also be an exciting time that gives way to new options.
- **Maintenance** – The maintenance stage is concerned with continuing to achieve the progress that began in the action stage. For residents with substance use disorders, this means upholding the intentions made during the preparation stage and the behaviors introduced in the action stage. Maintenance can be difficult when faced with the stress of life. This is why it is important to learn new ways of coping with stress during the action stage so that alternative strategies are available during the maintenance stage.
- **Termination/Relapse**- In any behavior change, relapses are a common occurrence and can happen at any time. When a resident goes through a relapse, they might experience feelings of failure, disappointment, and frustration. The key to success is to not let these setbacks undermine their self-confidence. If a resident relapses back to an old behavior, support them through the process of understanding why it happened. What triggered the relapse? What can be done to avoid or manage these triggers in the future? Relapses can be difficult, but they are an expected part of the recovery process and can be managed.

It is important to note that resident's behavior through earlier stages may not be linear. Instead, it occurs in cycles; they may revisit or relapse to prior stages before moving on to the next. Being in certain situations can trigger previous trauma, which may lead to substance use. High-risk situations vary across residents. There are also a range of other factors that fluctuate over time that can influence behavior. For example, being around individuals who are consuming substances could be triggering.

There are several factors which impact change, such as one's ability to focus on personal strengths and their understanding of where different behaviors will lead (e.g. closer or further away from their goals).

Helpful resources to enhance training on the six stages of change:

- Boston University School of Public Health: The Transtheoretical Model (Stages of Change)[26]

[26] Boston University School of Public Health (2022). Behavioral Change Models. Retrieved from: https://sphweb.bumc.bu.edu/otlt/mph-modules/sb/behavioralchangetheories/index.html#headingtaglink_1

- The 6 Stages of Change: Worksheets For Helping Your Clients[27]
- SAMHSA TIP 35: Enhancing Motivation for Change in Substance Use Disorder Treatment[28]

Motivational Interviewing

The relationship built between residents and staff can be a powerful tool for change and recovery. One effective technique to aid relationship-building is motivational interviewing (MI).MI is collaborative and goal-oriented technique that activates the resident's inherent capacity for positive change in an accepting, compassionate manner.[29] MI can be used by clinical and non-clinical providers (e.g., peers) with little or no training in counseling or therapy. It is effective in various settings and can be provided in one or multiple sessions.

MI resources that could be utilized in LTCF staff training:

- CT Department of Mental Health and Addiction Services (DMHAS) Motivational Interviewing[30] (includes self-paced training, webinars, a podcast, and toolkits)
- MI: Talking with Somone Struggling with OUD from Providers Clinical Support System[31]
- MI Quick Reference Sheet[32] from University of Virginia
- Motivational Interviewing Network of Trainers (MINT)[33]

How to Engage a Resident (or Residents)

It is important to establish secure, consistent and genuine relationships with residents to build trust. Discovering residents' habits, beliefs, passions, preferences, and health goals will also help foster rapport.

Here are some tips to include in trainings on how to engage:

- Think about their room, their first day, their first encounters with others. Ask- How they have adjusted to the new room and meeting others.
- What can you do to positively impact their time with you?
- What are their favorite snacks? Do they prefer coffee or tea?
- Who are their supportive people?
- What do they need at their bed stand that brings them comfort?

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[27] Sutton PhD, Jermey (2020). The 6 Stages of Change: Worksheets for Helping your Clients. Retrieved from: https://positivepsychology.com/stages-of-change-worksheets/

[28] SAMHSA (2019). TIP 35: Enhancing Motivation for Change in Substance Use Disorder Treatment. Retrieved from: https://store.samhsa.gov/sites/default/files/tip-35-pep19-02-01-003.pdf

[29] Substance Abuse and Mental Health Services Administration. (2013). Enhancing Motivation for Change in Substance Abuse Treatment. Rockville, MD: US Department of Health and Human Services.

[30] CT Department of Mental Health and Addiction Services. (2024) Motivational Interviewing: https://portal.ct.gov/DMHAS/Initiatives/Evidence-Based/Motivational-Interviewing

[31] Provider Clinical Support System (2021). Retrieved from Motivational Interviewing: Talking with Someone Struggling with Opioid Use Disorder: https://pcssnow.org/courses/motivational-interviewing-talking-with-someone-struggling-with-oud/

[32] University of Virginia. (2012). Retrieved from MI Quick Reference Sheet: https://www.med-iq.com/files/noncme/material/pdfs/XX183_ToolKit_%20QuickReferenceSheet.pdf

[33] Motivational Interviewing Network of Trainers. (2020) Welcome to the Motivational Interviewing Network of Trainer (MINT): https://motivationalinterviewing.org/

De-escalation

De-escalation is a technique that can be used in any situation where there is potential for conflict or aggressive behaviors, with the goal of diffusing tension, promoting understanding, and preventing further escalation.

Review the Center of Excellence for Behavioral Health in Nursing Facilities De-escalation toolkit which is organized in three parts:

1. How to conduct a self-check to determine one's feelings, triggers, and biases.
2. Tips to de-escalate challenging behaviors.
3. Debriefing tips to allow the team to review what happened, identify areas for improvement, and devise a plan to manage situations more effectively in the future.[34]

Another resource to consider using in training is from the Crisis Prevention Institute, Inc., CPI's Top 10 De-Escalation TIPS. Included in this resource are tips to help respond to different behaviors.[35]

- Tip 1: Be empathic and nonjudgemental.
- Tip 2: Respect personal space.
- Tip 3: Use nonthreatening nonverbals.
- Tip 4: Avoid overreacting.
- Tip 5: Focus on Feelings
- Tip 6: Ignore challenging questions.
- Tip 7: Set limits.
- Tip 8: Choose wisely what you insist upon.
- Tip 9: Allow silence for reflection.
- Tip 10: Allow time for decisions.

Empathy Techniques

Empathy is the capacity to understand and relate to someone's experience and emotions. It colors most of our relationships, in every setting, and can be very important for residents who are working towards recovery or are in recovery. For more detailed information on Empathy as a Care Practice see **Domain 3: Care Practices**.

Review these two videos:

- Empathy: The Human Connection to Patient Care (4 mins) from the Cleveland Clinic.[36]
- RSA Short: Empathy (3 mins) from Brene' Brown[37]

[34] Center of Excellence for Behavioral Health in Nursing Facilities De-escalation toolkit. (2024). Retrieved from https://nursinghomebehavioralhealth.org/wp-content/uploads/2024/01/COE-De-escalation-Toolkit-12-27-23_508.pdf

[35] Crisis Prevention Institute. Top 10 De-escalation tips. Available at https://institute.crisisprevention.com/De-Escalation-Tips.html/?ref=branded. Accessed February 16, 2024.

[36] Cleveland Clinic (2020): Empathy: The Human Connection to Patient Care.https://www.youtube.com/watch?v=dYhpxn81xus

[37] Brene' Brown (2013). Empathy. Retrieved from: https://brenebrown.com/videos/rsa-short-empathy/

Here are some examples staff can use to express empathy towards residents.[38]

Technique	Examples (may overlap)
Naming	"It seems like you are feeling…" "I wonder if you are feeling…" "Some people would feel… in this situation." "I can see that this makes you feel…"
Understanding	"I can understand how that might upset you." "I can understand why you would be… given what you are going through." "I can imagine what that would feel like." "I can't imagine what that would feel like." "I know someone who had a similar experience. It is not easy." "This has been a hard time for you." "That makes sense to me."
Respecting	"It must be a lot of stress to deal with…" "I respect your courage to keep a positive attitude in spite of your difficulties." "You are a brave person." "I am impressed by how well you handled this." "It sounds like a lot to deal with." "You have been through a lot."
Supporting	"I want to help in any way I can." "Please let me know if there is anything I can do to help." "I am here to help you in any way I can." "I will be with you in this difficult time." "I will be with you all the way."
Exploring	"Tell me more about what you were feeling when you were sick." "How are you coping with this?" "What has happened since we last met?"

Enhancing Staff Roles

To enhance retention and person-centered care, LTCFs may want to look at enhancing or adding staff positions to help support residents. Below are some examples of how some LTCFs have enhanced and/or developed new roles.

Aftercare Specialists

The Aftercare Specialist is responsible for providing support to individuals with substance use disorder, and/or mental health needs (or mental illness). This role provides care for those with OUD in a safe and therapeutic environment. Potential responsibilities could include coordination with community organizations to identify and address the needs of residents, provide interventions, and support services, and assist residents in a successful discharge to the community. The ideal staff person has a solid

[38] Juergens, J. (2016, July 14). How Empathy in Addiction Treatment Helps You Heal. Retrieved from Addiction Center: https://www.addictioncenter.com/community/empathy-in-addiction-treatment/

understanding of the recovery process and has excellent connections with community organizations, and strong communication and interpersonal skills.

Specialist responsibilities and qualifications could include:

- Develop and implement individualized discharge plans for residents, including goals and objectives, in collaboration with interdisciplinary team.
- Connect clients to appropriate community resources and services prior to discharge.
- Provide education and resources to residents and families.
- Facilitate weekly support groups.
- Maintain accurate records and documentation.
- Coordinate with other staff to ensure continuity of care.
- Recovery Specialist credentials.
- Bachelor's degree in a related field.
- Minimum 2 years of experience working in a recovery setting.
- Knowledge of substance use disorders, mental health, and physical health recovery services.
- Excellent communication and interpersonal skills.
- Able to work independently and as part of a team.
- Able to multitask and prioritize efficiently.

Recreation Therapy

In some cases, residents in need of care due to an OUD might be considerably younger than the typical nursing home resident. Many homes are dedicated to reimagining their programs to provide recreational therapy to a younger population.

Recreation therapy includes participation in healthy leisure activities, team problem solving and trust exercises. Those who have been living with a substance use disorder for some time may feel unwelcome and awkward in certain social settings due to fear of stigma and being misunderstood or disrespected, for example. Recreation therapy can offer a non-judgmental approach with failure-free leisure activities to help promote overall wellness and build self-esteem and self-confidence. Some of these activities might take place in the community, such as at a local gym.

Some recreation therapy activities include:

- Social activities such as 'Pop Ups!' These are unique, spontaneous events (often to get people outside). One example may be a baseball opening day event with hot dogs and hamburgers grilled outside.
- Leisure education and lectures
- Spiritual programs
- Team sports
- Team-building activities
- Trust activities that might be available in the local area such as ropes courses, climbing walls giant's ladder, zip line and multi-vine features.
- Fitness center activities with cardiovascular machines, universal circuit machines, free weights, and space to follow aerobic and yoga videos.
- Nine-hole disc golf course
- Music therapy

- Nature activities
- Relaxation and stress management
- Arts and crafts

Resident Ambassador program

The Resident Ambassador program is focused on providing high-level customer service through companionship and engagement in meaningful and individualized leisure pursuits. The Ambassadors partner with a resident to become a vital support, friend and/or sounding board. They serve as an advocate for residents and ensure any needs that are brought to their attention are passed along to the appropriate department.

The program is an integral part of resident care. Each Ambassador works with all departments to ensure the residents' physical, emotional, social, spiritual, and intellectual needs are met. Though they aren't medically certified, part of their duties also includes providing safety reminders for residents, supervision, assisting with everyday tasks and non-clinical psychosocial support and companionship. Review this video to learn more: https://youtu.be/JNpEhIAOMOI

Substance Use Disorder (SUD) Counselors/Social Worker

SUD Counselors/Social Workers can help provide direction and work collaboratively with the care team to guide the best possible care for residents with SUD. SUD Counselors/Social Workers should be familiar with the latest treatment methods and collaborate with other mental health care specialists. Candidates have excellent clinical knowledge and demonstrable counseling experience.

Potential SUD Counselor/Social Worker Responsibilities:

- Managing all aspects of a case from admission to date of discharge.
- Evaluating residents' physical and mental behaviors.
- Collaborating with the care team in the development of care plans.
- Facilitating individual and group therapy sessions.
- Monitoring residents over time to assess progress towards their goals.
- Collaborating with doctors, nurses, social workers, and others.

SUD Counselor/Social Worker requirements could include:

- Associate degree in chemical dependency counseling, or a bachelor's degree with coursework in chemical dependency.
- Master's degree in counseling (or social work)
- LCSW licensed clinical social worker or LCP licensed clinical psychologist or LADC licensed Alcohol and drug counselor.
- Previous experience with the treatment of SUD.
- Familiarity with electronic health record systems.
- Experience with co-occurring physical and mental health needs.
- Application of the Substance Abuse and Mental Health Services' (SAMHSA) best practice indicators.
- In-depth knowledge of drug and alcohol testing to monitor treatment plans and medical instructions.
- Exceptional interpersonal skills and a compassionate nature.
- Ability to teach staff and support their ability to provide behavioral interventions.
- Knowledge of harm reduction best practices.