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Trauma-Informed Care for Persons With Opioid Use Disorder in Ohio

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Walden University

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Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral study by

Kimberly Toler

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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Walden University
2019

Abstract

Trauma-Informed Care for Persons With Opioid Use Disorder in Ohio

by

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MSW, Ohio State University, 1990

BSW, Ohio State University, 1988

Project Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Social Work

Walden University

July 2019

Abstract

Prevention, social work, and community awareness programs have not led to the successful reduction of opioid overdose deaths nationwide, and particularly in Ohio. This study sought to understand social work perspectives about trauma-informed care (TIC) for persons with opioid use disorder in Ohio. The research questions for this study examined how social workers in Ohio implement TIC when providing outpatient treatment to opioid users and what challenges they face when providing TIC. Using an action research methodology, data were collected through individual semistructured interviews with 5 social work professionals, selected through purposive sampling based on experience in the field of substance use in Ohio and the use of TIC. Contemporary trauma theory and TIC were chosen to frame the research project. Three themes emerged through thematic analysis of the data: appreciation for trauma-informed opioid use disorder treatment, organizational and professional challenges to the use of trauma-informed opioid use disorder treatment, and environmental barriers to successful trauma-informed outpatient opioid use disorder programming. The study aligned with the social work core values of competence and principles of harm reduction. The findings from the study may be used by treatment providers to ignite further dialogue about how TIC interventions could support integrated treatment and holistic approaches to combatting opioid addiction in Ohio.

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Dedication

This work is dedicated to close friends who have personally gone through the trials and tribulations of a loved one partaking in illicit opioid drug use. You were the catalyst to my academic pursuit of a specialization in addictions. A special thanks to my two sons, Shane Michael and Stefan Donis, along with my mother, Arlene, for running my errands, bringing me food, imparting encouraging words, and trying to keep the home orderly while I spent all my free hours in the library completing study development and revisions.

Finally, special acknowledgement and accolades go to my fellow social work professionals who are out in the field tackling the opioid crisis in Ohio.

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Dr. Debora Rice has been a tremendous mentor during this DSW journey. Her calm and assuring demeanor kept me “off the ledge” during trying times. Dr. Rice is a tremendous asset to the Barbara Solomon School of Social Work at Walden University. Also, many thanks to my Walden University DSW peers who offered witty and invaluable words of support.

The pursuit of this doctorate degree has been a very complex juggernaut. Along this academic adventure, often feeling alone, I found solace in the literary works of one of my personal “sheroe,” Maya Angelou. Her words of inspiration taught me despite tough times, self-doubt, and feeling broken, “but still, like air, I’ll rise” (Angelou, 1978).

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Section 1: Foundation of the Study and Literature Review

The opioid crisis in Ohio has become a major clinical social work practice concern (Public Children Services Association of Ohio [PCSAO], 2016). Opioid addiction has reached epidemic proportions in the United States, and particularly in Ohio (Centers for Disease Control and Prevention [CDC], 2016). In 2017, 91 individuals died each day in the United States from opioid overdose (University of New England, 2017). Social workers and other helping professionals are reexamining the strategies used with individuals who have opioid use disorder (University of New England, 2017). The ability of these professionals to engage in effective evidence-based programs and interventions is key to addressing this public health problem.

Social workers, also sometimes known as addiction or substance abuse counselors, undergo specialized training, licensure, and education as it relates to working with this population in rural and urban areas in Ohio (Ohio Chemical Dependency Professionals Board, 2018). The goal of this DSW action research project was to understand social work perspectives on trauma-informed care for persons with opioid use disorder in Ohio. Through the information garnered from this study, I sought to provide scholarly information to social workers that could be used to enhance their work with the specific client population.

The goal of the DSW study aligns with the National Association of Social Workers (NASW) code of ethics' principles and values. The NASW code of ethics seeks to identify and commit to a common core of ethical principles, to develop skills in ethical decision making around the vast array of ethical dilemmas surfacing in everyday practice,

and to recognize the importance of seeking outside help if challenges are too great to address independently (NASW, 2018, p. 3). This project also further aligns with the NASW principles of promoting social justice and advocacy for marginalized, oppressed, and stigmatized populations, for which individuals with substance abuse disorders often fall into one or more of these categories (NASW, 2013).

In the following section, I provide an introduction of the problem and purpose statement, significance of the study, theoretical framework, and scholarly and academic literature review as it pertains to the DSW action research questions.

Problem Statement

The social problem examined is the negative and rising problem of opiate addiction in Ohio. The opioid crisis has become a national concern, requiring revised public policy formation at the federal, state, and local level. The crisis is affecting every subsystem in the society. In this action research study, I examined social workers' perspectives on trauma-informed care for persons with opioid use disorder in Ohio.

Prevailing prevention and evidence-based programming has not been effective in reducing opioid addiction and overdose deaths in Ohio and nationally (NASW, 2013).

The unintentional opioid death rate in Ohio increased by 36% between 2015 and 2016 (Johnson & Candisky, 2017). Ohio ranked 1st in the nation for the number of prescription and synthetic opioid overdose deaths in 2016 (Kaiser Family Foundation, 2017).

According to the Ohio Department of Mental Health and Addiction Services (2017), from 2006 to 2009, on average, approximately four people died each day in Ohio due to drug overdose. In 2016, the daily number of overdose deaths had risen to an average of 11 in

Ohio (Johnson & Candisky, 2017). Poly-substance abuse, including alcohol, marijuana, and cocaine use, increases and contributes to the overdose rates (NASW, 2013).

According to the CDC (2017), the scope and rise in opioid use disorder can be readily explained in the three distinct waves: Wave 1: Rise in prescription opioid overdose deaths; Wave 2: Rise in heroin overdose deaths; and Wave 3: Rise in synthetic opioid deaths. Opioid use disorder in Ohio has followed these distinct waves. The state of Ohio is seeking to find new strategies to treat individuals with opioid use disorder and continues to be concerned with the evolving rate of the opioid epidemic (Ohio Department of Mental Health and Addiction Services, 2016). Individuals in Ohio are being found dead from unintentional opioid overdose in restaurants, theaters, libraries, cars, streets, minimarkets, and their homes (Johnson & Candisky, 2017). Ensuring that individuals with substance abuse issues have access to treatment is a focus of social workers, which is also in line with NASW tenets for social justice with vulnerable and at-risk populations (NASW, 2018).

Current literature on the opioid crisis in Ohio and nationally have cited social workers and other helping professionals' dilemma in finding evidence-based programming that can reduce the number of individuals who are struggling with illicit opioid use (CDC, 2017). Understanding social workers' role in treating individuals with opioid use disorders is imperative to addressing the crisis in Ohio. According to NASW (2013), social work practice is in a unique position to influence the delivery of services to individuals with substance abuse disorders.

Purpose Statement and Research Question

In this study, I sought to improve on the knowledge base of social workers who treat individuals with opioid use disorder using trauma-informed care. I addressed social work perspectives on trauma-informed care for persons with opioid use disorder in Ohio. The research questions were as follows:

Research Question (RQ)1: How do social workers in Ohio implement trauma-informed care when providing outpatient treatment to opioid users?

RQ2: What are the challenges for social workers in Ohio in implementing trauma-informed care when providing outpatient treatment to opioid users?

The clinical social work practice problem is tied specifically to providing a venue to share knowledge that can lead to improved outcomes for the targeted population. Knowledge gained from this action research study shall be shared with social workers working with opioid-disordered clients, key stakeholders, focus group participants, and other helping professionals in hopes of improving the efficacy of outpatient trauma-informed care offered to individuals with opioid use disorder. The study served as an original contribution that advances professional practice where I gathered data from five social workers who had a degree in social work, via individual semistructured interviews. This DSW action research study was formatted as a qualitative study. Social workers who participated in the individual semistructured interviews served as units of analysis. Units of analysis in qualitative studies help to gather data that are systematic (Royse, Thyer, & Padgett, 2016). This action research study was also a vehicle for understanding complex and puzzling issues social workers are attempting to address in the field and interactions

with clients, including putting forth original contributions that advance professional social work practice (see Stringer, 2007).

Social workers and other professionals treating individuals with opioid use disorder are collaborating to find effective solutions to the current predicament in Ohio and nationally (Maloney, 2018). Due to a paradigm shift in American society, addiction as a disease is becoming more acceptable and is moving away from the label of a defective moral character flaw (NASW, 2013). Therefore, social workers are key in providing treatment that encompasses interventions that are empowering, capable of including assessments on comorbidity diagnosis, and providing harm reduction approaches (NASW, 2013). The project's ability to bring forth social change is also inherent in the sharing of data from the individual semistructured interview findings.

Definitions of Key Terms, Concepts, and Definitions

The literature uses substance abuse/addiction, drug abuse/addiction, substance dependence, and substance abuse disorder interchangeably when denoting the tenets of opioid use disorder. Scholarly journals also often interchange heroin and opioids (as heroin is a type of opioid). Substance use disorder (SUD) can include the abuse of opioids, and it is also denoted in the literature as opioid use disorder when speaking directly to the type of drug addiction. For this study, I examined social work perspectives on trauma-informed care for opioid users in Ohio. I used the word choice of opioid use disorder throughout the body of this study.

Action research: A qualitative research paradigm based on localized studies that focus on how things are happening rather than what is happening and to understand the

ways stakeholders perceive, interpret, and respond to events related to the issue investigated (Stringer, 2007).

Evidence-based practice: The use of the best available research with clinical, experience, ethics, client preferences, and culture to guide and inform the delivery of treatment and services (NASW, 2018).

Fentanyl: Opioid pain reliever legally available by prescription only (National Institute on Drug Abuse [NIDA], 2016).

Focus group: A gathering of a deliberately selected diverse group of individuals (treating opiate social workers for this study) assembled to participate in a planned discussion that is intended to elicit their perspectives or feedback (Stringer, 2007).

Heroin: Opioid used for illicit recreational drug use and medically to relieve pain (NIDA, 2018).

Opioid: Substances that have morphine like effects with intended use to medically relieve pain. Drugs in this class include morphine, oxycodone, fentanyl, methadone, naloxone, and hydrocodone (NIDA, 2018).

Outpatient substance abuse treatment: Type of program that allows an individual to live at home (rather than in an inpatient setting) through the course of addiction treatment (NIDA, 2018).

Trauma: Injury to living tissue caused by an intrinsic agent; a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury; very difficult situation leading to emotional distress (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015, Trauma, n.d.)

Trauma-informed care: Strengths-based delivery approach to trauma (SAMHSA, 2014).

Nature of the Doctoral Project

Stringer (2007) stated that “action research is grounded in a qualitative research paradigm whose purpose is to gain greater clarity and understanding of a question, problem, or issue” (p. 19). The study’s design aligns with this DSW action research purpose statement and the research of gathering social work perspectives on trauma-informed care for persons with opioid use disorder in Ohio. Action research seeks to understand how social workers perceive, interpret, experience, and respond to the practice problem being presented (Stringer, 2007). Due to its phenomenological, interpretive, and hermeneutic nature, action research also provides participants the ability to gain a greater understanding of the practice problem (Stringer, 2007). Action research involves participants in a very direct manner. The key tenets of action research include education, social groupings, problem focus, change intervention, improvement, cyclic process, and participant’s involvement and collaboration (Gibbs, 2001).

This action research study involved recruitment via purposive sampling of five Ohio social workers who currently treat opioid users in an outpatient setting using trauma-informed care. The social workers were interviewed individually, seeking responses to seven semistructured questions and subsequent probes. Data collected were coded, analyzed, and synthesized for common themes and patterns using an Excel spreadsheet and NVivo (see Stringer, 2007). Action research used in social work asks for incorporation of a participant’s view, alternatives to the dominant paradigm for applied

social science, development of a shared culture, and a foundation for critical thinking and knowledge (Thiollent, 2011). This is evident in my study through the interaction with the participants and their lens of the social work practice problem.

Significance of the Study

Through this action research study, I sought to contribute to the field of social work by providing scholarly information that can advance the knowledge base and identify challenges of providing trauma-informed care via clinical social workers who treat individuals in outpatient settings with opioid use disorder in Ohio. Drug addiction is a major public health problem that negatively affects society directly and indirectly (NIDA, 2018). Social workers play major roles in treating individuals with opioid addiction from diverse backgrounds due to their holistic approach to problem solving (NASW, 2013). Furthermore, it is hoped that the outpatient clinical services provided by social workers with this population will also lead to social change and enhanced engagement with interdisciplinary team members who are also on the forefront of treating individuals with opioid use disorder.

Theoretical/Conceptual Framework

Theory seeks to explain the real world and practice through scientific inquiry (Stringer, 2007). Trauma-informed care and contemporary trauma theory were used to help me understand social work perspectives on trauma-informed care for opioid users in Ohio.

Trauma-Informed Care

Trauma-informed care (TIC; Bloom, 2007; Bloom & Sreedhar, 2008; Bronfenbrenner & Morris, 1998; SAMHSA, 2014) is a strengths-based service delivery approach, grounded in an understanding of, and responsiveness to, the impact of trauma that emphasizes physical, psychological, and emotional safety for both providers and survivors. TIC creates opportunities for survivors to rebuild a sense of control and empowerment. TIC also emphasizes the importance of consumer participation in the development, delivery, and evaluation of services (Hopper, Bassuk & Olivet, 2010). TIC is holistic in nature and characterizes trauma's role in drug addiction, including the development of coping mechanisms (SAMHSA, 2014). TIC serves to normalize symptoms and behaviors that have traditionally been viewed as examples of personal and social deviance (Kezelman & Stavropoulos, 2012).

TIC was coined in the 1990s and is a service delivery that seeks to understand the biological, psychological, and social sequelae of trauma (Harris & Fallott, 2001; SAMHSA, 2015). TIC is a recommended approach to prevent and treat opioid addiction (SAMHSA, 2015). There is no consensus on a single definition of TIC and, therefore, operational variations are seen nationally (SAMHSA, 2015). However, social workers act as change agents in the TIC process to directly influence clients who have experienced traumatic events (Kawam & Martinez, 2016). Failing to recognize the impact of trauma on individuals and organizations can lead to interventions and/or services that are reactive, hierarchical, coercive, and punitive (Bloom & Sreedhar, 2008).

Contemporary Trauma Theory

Contemporary trauma theory (CTT) is one of the methods used in TIC to treat individuals who have reported childhood trauma (CT) and been given a diagnosis of SUD as an adult. CTT signifies a paradigm shift in how social workers perceive and treat survivors of trauma with an emphasis on healing and the curative influence of coping and resilience as it related to co-occurring disorders (Goodman, 2017).

CTT seeks to provide a conceptual foundation for understanding how SUD affects the bio-psychosocial world of an individual including brain functioning and is based on the following central properties: dissociation, attachment, reenactment, long-term effect on later adulthood, and impairment in emotional capacities (Goodman, 2017). As an emerging trauma-informed care model, CTT seeks to understand the role that resilience plays in individuals with SUD. Goodman (2017) defined resilience in drug addiction to be “the person’s ability to tolerate, adapt, or overcome crisis” (p. 190). Furthermore, the use of CTT as a model gives social workers the ability to proscribe use of a TIC knowledge base that will work effectively into their practice with at-risk populations, particularly during initial assessment, intervention, and prevention work.

CTT aligns with the problem, question, and purpose of this study by its approach to provide psychoeducation, strengths-based interventions to individuals with opioid use disorder to instill a sense of hope in establishing recovery and the way it outlines a platform for treating social workers that can be used to transform and protect the clients from the risk of further harm (SAMSHA, 2014). CTT emphasizes physical,

psychological, and emotional safety for both the treating social worker and opioid use disorder client (SAMSHA, 2014).

The social work profession has an important role in stabilizing the prescription opioid/heroin crisis in the United States due to the profession's familiarity with collaborative multidisciplinary structure, harm reduction principles, integrated care approach, and social justice roles with the designated population (Wilson & Dorn, 2016). CTT and social work principles and professional ethics are intertwined in the improvement of clients' clinical outcomes through respectful interaction, demonstrating understanding of the connectedness of a client's trauma history and its correlation to healing, empowerment, and ensuring that social workers who are treating this population are well-trained and are able to share their innovative practices to others in the field (NASW, 2018; Wilson & Dorn, 2016).

Values and Ethics

This action research study also aligns with the NASW Code of Ethics (2018). The NASW Code of Ethics denotes the importance of social workers being culturally competent, skilled, and aspiring to contribute to the knowledge base of the social work profession. Related to the social worker core value of competence, in this study, I aimed to meet the NASW Standards for Social Work Practice with Clients with Substance Abuse Disorders (2013) "by developing and applying evidence-based approaches that incorporate established interventions and evolving techniques based on emerging research findings, social workers can marketed improve treatment services for clients and their families" (NASW, 2013, p. 6).

The respectful treatment and empowering case management of individuals with addiction are outlined in the professional values of the NASW code of ethics (NASW, 2018). The NASW believes, regardless of a client's character defects, that the individual is to be treated with dignity and respect. The values/principles from the NASW Code of Ethics (2018) that are relevant to my social work problem statement are as follows: 1.03 informed consent, 1.04 competence, 1.05 cultural competence and social diversity, 1.07 confidentiality and privacy, 1.12 derogatory language, 2.01 respect, 2.02 confidentiality, 2.05 consultation, 4.01 competence, 4.02 discrimination, 4.03 private conduct, 4.04 dishonesty, fraud, and deception, 4.06 misrepresentation, 4.08 acknowledging credit, and 5.02 evaluation and research. These standards were my clinical guide and foundation for this DSW research study, particularly the interaction with the participants. Failure to follow a standard of ethics during a research study can be detrimental to the social work community, which depends on research findings to improve the well-being of at-risk clients (NASW, 2018).

The "service principles" of the NASW Code of Ethics act as an additional guide for the ethical conduct of social workers during research, decision making, interaction with colleagues, and clients (NASW, 2018). The NASW Code of Ethics is an important element of my action research project. The volunteer participants were comprised of clinical social workers who were treating persons with opioid use disorder. Licensed professional social workers in Ohio are required to adhere to the Ohio Administrative Code Chapter 4757, code of ethics for social workers and addiction counselors, which is

rooted in the NASW code of ethics, values and harm reduction principles (Ohio Administrative Code, 2009).

Examining the participants' perspectives on implementing trauma-informed care when providing outpatient treatment to opioid users allows for documentation of the diverse trauma-informed clinical treatments in Ohio and ties into the NASW Code of Ethics vision of social justice and advocacy and ensures that the highest quality of social work services is provided to individuals with opioid use disorder (NASW, 2013). Findings and data from the individual semistructured interviews can provide scholarly information to colleagues and other helping professionals.

Review of the Professional and Academic Literature

Literature Review Strategy

I used Walden University, The Ohio State University, and Columbus (Ohio) metropolitan library systems to seek articles of relevance for my social work research questions related to social work perspectives on trauma-informed care for persons with opioid use disorder in Ohio. In these library systems, I used the following search engines for pertinent articles from the past 5 years: *Social Work Research*, *Social Work Databases*, *socINDEX*, *PubMed*, and *ProQuest*. Seeking any information outside of the 5-year range was done to give insight to the history of opioid use disorder and theoretical foundations.

Key terms used to identify relevant articles: *mental health*, *substance use*, *opioid use disorder*, *trauma*, *stigma*, *social worker's role in substance abuse treatment*, *substance use disorder*, *social work theories*, *opioid use disorder treatment*,

pharmaceutical opiates, co-occurring disorders and opioid use, opioid crisis in the United States, opioid epidemic in Ohio, rural social work and opioid treatment, barriers to opioid use disorder treatment, social work perspectives on opioid use disorder/substance abuse, comorbidity and differential diagnosis related to opioid use disorder, and outpatient substance abuse treatment. The results of this search listed over 2,000 articles, resulting in 125 within the scholarly review period for this literature research. Social work perspectives on trauma-informed care for persons with opioid use disorder in Ohio when providing outpatient treatment to opioid users resulted in a smaller percentage of scholarly articles, thus supporting the need to conduct current research on this topic.

Secondary sources were also necessary to use on a limited basis to capture the current crisis state of opioid abuse in Ohio and the nation. Obtaining scholarly information from the fields of psychology, medicine, mental health, and addiction was also required to fully capture the various types of treatment modalities for this population.

History of Opiates and Addiction in the United States

The history of opioid use and its concerns in the United States began many years ago. Opioids are a class of drugs that include illicit heroin and the licit prescription pain relievers such as oxycodone, hydrocodone, codeine, morphine, and fentanyl (American Society of Addiction Medicine [ASAM], 2016). Heroin is an opium derivative. Opium dens in the Wild West were well known in the mid to late 1800s (Narconon International, 2016). In 1810, morphine, a derivative of opium, was developed as a pain killer in Germany and became available to Americans in the 1850s (Narconon International,

2016). The use of morphine was not immediately recognized as an addictive drug and was widely prescribed for injured soldiers during the Civil War. In 1874, heroin was formulated as a drug in Germany, imported to the United States, and identified as a replacement for morphine due to its touted properties of being very safe and nonaddictive (Narconon International, 2016). The properties of heroin were erroneously identified as safe, and subsequently heroin became another addictive drug (like opium and morphine) staple in the drug culture of American society (Narconon International, 2016).

During the past 20 years, the health care system has used opioid painkillers in a significant manner to treat pain (NIDA, 2018). According to Lopez and Frostenson (2017), the United States is the world's leader in opioid prescriptions. As in history, the pharmaceutical companies downplayed opioids' ability to be a trigger to addiction, which has led to the current opioid crisis state in American society (NIDA, 2018). Drug traffickers began producing illegal opioids during the same time frame to address the need for the opioid drugs once a prescription was no longer available via legal means (NIDA, 2018). The heroin crisis is being complicated by the reemergence of illicit Carfentanil, a powerful Schedule II synthetic opioid analgesic more potent than morphine or heroin (Botticelli, 2016). Ohio has seen a significant increase in Carfentanil deaths in the past few years (Ohio Attorney General, 2017).

Prior research from the medical profession on opiate abuse has linked addiction to legally prescribed pain medication (SAMHSA, 2014). When the prescription is no longer medically necessary, the user craves the drug and resorts to illicit drug use. Heroin is now available in pill or powder form, thus reducing the social stigma for its use (NIDA, 2018).

Opioid derivatives such as fentanyl can also be bought inconspicuously online (Khazam, 2018). According to Cicero, Ellis, Surratt, and Kurtz (2014), over the past 50 years, the demographic composition of heroin users has moved from an inner-city minority concern to a wider distribution in the population primarily involving suburban White males and females in their late 20s. The change in who is abusing opioids is being tied to the coincidental increase in prescriptions of opioids during the past 40 or 50 years (Cicero et al., 2014).

Prevalence of Opioid Use

On an average day in the United States, 650,000 opioid prescriptions are given, 3,900 individuals initiate nonmedical use of prescription opioids, 580 individuals initiate opioid use, and 78 individuals die from an opioid related overdose (United States Department of Health and Human Services, 2016). Four of five new heroin users start out by misusing prescription painkillers (ASAM, 2016). Drug overdose is the leading cause of accidental death in the United States (ASAM, 2016). NIDA (2018) provided the following data:

- Around 21 to 29% of individuals prescribed opioids for chronic pain misuse them.
- 2 million people in 2017 from the United States suffer from substance/opioid use disorders related to opioid pain prescriptions.
- Between 8 and 12% develop an opioid use disorder.
- An estimated 4 to 6% who misuse prescription opioids transition to heroin.
- About 80% of individuals who use heroin first misused prescription opioids.

- Opioid overdoses increased 30% from July 2016 through September 2017 in 52 areas in 45 states.
- The Midwestern region (e.g., Ohio) states saw opioid overdoses increase 70% from July 2016 through September 2017.

Heroin was identified as a gateway drug to opioid use disorder in the late 1960s; the current addiction pathway is tied to a person's initial prescription for legal opioid pain medication (Cicero et al., 2014). Opioids sold in an illicit manner are widely seen in society due to illicit opioids being cheap and more accessible than the prescription form, its widespread acceptance amongst peers, and providing a guaranteed high (Cicero et al., 2014).

Opioid Use Disorder – Definition

The American Psychiatric Association (APA, 2013) defined opioid use disorder (also known as opiate addiction) as a problem pattern of opioid use leading to clinically significant impairment or distress. Diagnosis must be evidenced by at least two of the following, occurring within a 12-month period:

- Taking more than the prescribed dose.
- Taking other opioid medications because the prescribed medication is out.
- Taking the medication for reasons other than prescribed.
- Feeling that the medication reduces day-to-day functioning.
- Prioritizing the medication over participation in activities at work, school, or home.
- Running out of medications before the next refill.

- Experiencing a positive emotional feeling or high from the medications.
- Lying or stealing to obtain medication or paying cash for medication that was not prescribed to the intended user.
- Trading medications with others.
- Going to the ER in nonemergency situations or going to less-than-reputable pain clinics to obtain medication.
- Continuing to take the medication even when it causes increasing physical or psychological problems.
- Continuing to take the medication even when it causes problems between the user and his or her family or friends (Provider Clinical Supports System, 2014, p. 1).

Opioid use disorder can begin at any stage of life; however, it is most prominent to start in the late teens or 20s (APA, 2013). According to the APA (2013), relapse is frequent as well as opioid use disorder clients also using alcohol to soothe, which can cause increased risk for suicidality.

According to the APA (2013), opioid use disorder is often interrelated with other SUDs, such as alcohol, tobacco, marijuana, stimulants, and benzodiazepines, as well as mild to severe depression, insomnia, antisocial personality, posttraumatic stress disorder, and childhood diagnosis of conduct disorder. Specifically, “a history of conduct disorder in childhood or adolescence has been identified as a significant risk factor for substance related disorders, especially opioid use disorder” (Provider Clinical Supports System, 2014, p. 8).

Opioids can be used via oral pill, snorting, and intravenously. Opioid use disorders may cause outward symptoms of depressed mood, nausea, vomiting, diarrhea, and abdominal cramps, for example, but are not prone to more mental disturbances than other drugs (APA, 2013). Opioid use disorder includes compulsive symptoms, can last for many years, and causes intense psychological cravings, and some individuals fall in and out of abstinence many times (Dixon, 2018). Opioid use can lead to a variety of medical problems, such as HIV and Hepatitis C, particularly if the individual with the opioid use disorder injects the drug. Infections can incur at the injection site, males may experience erectile dysfunction, females may have irregular menstrual cycles, and both genders risk increased impaired immune function and diagnosis of tuberculosis due to intravenous use (APA, 2013).

Risk Factors

Various risk factors can contribute to opioid use vulnerability (McCarberg, 2015). Opioid use disorder risk can be connected to trauma, an individual's family of origin, peer groups, social and environmental conditions, and genetic factors, which play a very important role directly and indirectly (APA, 2013). Trauma is defined as injury to living tissue caused by an intrinsic agent, a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury, or very difficult situation leading to emotional distress (Substance Abuse and Mental Health Services Administration, 2014, Trauma, n.d.). According to Cicero et al. (2014), medical professionals who have access to the opioid drugs are also at increased risk for opioid addiction. Known risk factors of opioid misuse and addiction include the following:

- Poverty,
- Unemployment,
- Family history of substance abuse,
- Personal history of substance abuse,
- Young age,
- History of criminal activity or legal problems, including DUIs,
- Regular contact with high-risk people or high-risk environments,
- Problems with past employers, family members, and friends (mental disorder),
- Risk taking or thrill-seeking behavior,
- Heavy tobacco use,
- History of severe depression or anxiety,
- Genetics,
- Environmental stressors,
- Marginalized populations (LGQBT – lesbian, gay, bi-sexual, trans-gender, disabled, people of color),
- Psychological stressors,
- Stressful circumstances,
- Prior drug or alcohol rehabilitation,
- Military service/warfare,
- Taking more than the prescribed dose of opioid medication, and
- Taking an opioid prescribed medication for more than 5 days (Mayo Clinic, 2018).

Racial discrimination toward people of color is a significant risk factor for trauma with African Americans being at higher risk for opioid misuse than other minorities (including people with disabilities, women, and LGQBT populations) in the United States (Williams, 2015). Additionally, women have a unique set of risk factors for opioid addiction: more likely than men to have chronic pain, to be prescribed opioid medications, to be given higher doses than their male counterparts, to use opioids for longer periods of time, and may also have biological tendencies to become dependent on prescription pain relievers more quickly than men (Mayo Clinic, 2018).

The Opioid Risk Tool (ORT), the Screener and Opioid Assessment for Patients with Pain Version 1 (SOAPP-R), and Brief Risk Interview are tools used to assess potential risk for OUD (Burcher, Suprun, & Smith, 2018). According to the CDC, existing risk assessment/stratification tools have not proven to be acceptably accurate, and their recommendations, particularly for assessing a patient for pain medication, is to use more robustly a patients personal and medical history instead of just looking at their scores alone as an indicator of risk (as cited in Burcher et al., 2018).

Outpatient Treatment for Opioid Use Disorder

Outpatient substance abuse treatment is defined, according to Braden (2016), as a type of substance abuse program that allows an individual to live at home (rather than in an inpatient setting) through the course of addiction treatment. Outpatient substance abuse treatment programs require regular check-ins for individual or group treatment sessions and a high degree of motivation by the patient to commit to this type of recovery intervention. Substance abuse treatment, opioid use disorder treatment, or drug addiction

are terms seen in the literature when referring to outpatient interventions. For this study, I will use the terms opioid use disorder treatment /programs and substance abuse treatment/programs interchangeably.

Outpatient programs for opioid use disorder are most often structured programs that meet multiple times a week for therapy and counseling with a strong emphasis on relapse prevention (Braden, 2016). An individual participating in an outpatient opioid use disorder programs may be involved in bevy of organizational programming that includes: 12 step, partial hospitalization, dual diagnosis treatment, detox center, group therapy, medically assisted treatment, and family therapy (Braden, 2016). The best outpatient treatment programs offer therapies that can be tailored to the client's individual needs (NIDA, 2018). Individuals participating in outpatient opioid abuse therapy may be stepping down to this type of treatment following inpatient treatment or to address their addiction in a least restrictive settings, which may lead to less disruption in their home and work roles (NIDA, 2018). Individuals who are actively using opioids but are seeking abstinence may elect to be assessed for an outpatient opioid program known as opioid detoxification (Opiate Addiction and Treatment Resource, 2018).

According to Opiate Addiction and Treatment Resource (2018), opioid detoxifications are outpatient programs (also known as medically managed withdrawal programs) that focus on the process from which an individual with opioid use disorder withdraws from the opioid drugs. There are various types of opioid outpatient detoxification programs: medical, rapid, methadone, and in the home with no over the counter or prescribed medications to treat withdrawal symptoms (Opiate Addiction and

Treatment Resource, 2018). Detoxification is coupled with other forms of outpatient treatment such as mental health counseling to address the psychological, social, and behavioral problems that occur with individuals who have substance/opioid abuse diagnosis (NIDA, 2018).

Medication-assisted treatment (MAT) are often paired with outpatient opioid detoxification programs to treat individual with opioid use disorder and utilize the use of: methadone, suboxone, and vivitrol medications (NIDA, 2018). A study by NIDA (2018) found medically managed withdrawal programs are effective in treating opioid addiction and help to reduce criminal activity related to the obtainment of illicit drugs. Medications for opioid detoxification also assist in regaining normal brain functions. Substance and opioid addiction affect the part of the brain that involves reward, motivation, learning, memory and control over behavior (NIDA, 2018).

Many social workers' first encounters with trauma victims are in settings that address mental health or substance abuse concerns. Knight (2015) examined practice considerations in relation to working with trauma victims in outpatient settings and the gap in literature relating to trauma-informed care. One of the lessons in working with patients in outpatient settings for opioid use disorder is to ensure that interventions are evidence-based and effective. Knight (2015) also reports that clients may disclose abuse that happened prior to age 18. This brings up issues of mandatory reporting by the social worker to the appropriate child welfare entities in some cases. Although this may sound like a barrier to engagement, it can help to build a therapeutic partnership (Knight, 2015). Opioid use disorder clients who vocalize their trauma narratives can exhibit increased

feelings of hostility and mistrust toward the social worker (Knight, 2015, p. 33).

Emphasis is placed on trauma-informed care in outpatient settings to help clients understand how the past influences their present (Knight, 2015).

Due to the chronicity of opioid addiction, it is imperative during outpatient programming that the social worker treating the client is well trained and knowledgeable about current medically managed withdrawal programs and its interface with evidenced-based programs dealing with comorbidity and behavioral concerns (NIDA, 2018).

Multidimensional family therapy, motivational interviewing, and contingency management are evidence-based interventions that are routinely used with in outpatient settings with individuals with opioid use disorder, including comorbidity (NIDA, 2018).

In addition to the therapeutic needs of the client, it is also prudent to ensure that the social work staff treating this population are informed on the role that trauma plays in a client's life due to their addiction and how the value of knowing the tools of trauma-informed care can assist in delivering services in a manner that is respectful and empowering (NIDA, 2018).

Trauma Impact and Opioid Use Disorder

According to the Campaign for Trauma Informed Policy and Practice (CTIPP, 2017), there is a significant correlation between opioid addiction and traumatic experiences, especially those in early childhood. Conroy, Degenhardt, Mattick, and Nelson (2009), in a case-control design study with 987 opioid dependent users, cite sexual abuse, physical abuse, and parental separation to be specific adverse childhood experiences that are highly correlated to opioid use. Conversely, studies have indicated

that individuals who have experienced trauma in childhood are more prone to report chronic pain symptoms that interfere with daily activities and are more akin to be given multiple opioid prescriptions for pain relief as adults thus creating a pathway to addiction (CTIPP, 2017). Sansone, Whitecar, and Wiederman (2009) cited a study that used survey methodology to sample 113 adult patients (62 male, 52 female, most high school educated and Caucasian) from the Midwest who were addicted to opioids and were also seeking remedy for the use of buprenorphine. Results of this study found that 60.2% reported having 1 to 3 different forms of CT, 13.3% experience 4 or 5 forms of CT and 65.5% reported seeing violence in addition to their reported CT (Sansone et al., 2009).

The 1998 Adverse Childhood Experience (ACE) Study by Kaiser Permanente and the CDC “demonstrated a powerful connection between multiple adverse childhood experiences and substance abuse disorders during childhood (CTIPP, 2017, p. 1). Felitti, as one of the lead researchers for the ACE study, challenges the established concepts for substance abuse addiction. He conducted a population-based analysis of over 17,000 middle class adults of diverse ethnicity who visited the Kaiser Permanente Health Care Center in San Diego, California. The adults were asked to voluntarily answer 8 questions to allow the medical department to understand how events in childhood might later affect health status in adult life (Felitti, 2003). The ACE epidemiologically study findings report that if there are adverse childhood experiences prior to age 18, those childhood experiences adversely affect adulthood (Felitti, 2003). Felitti (2003) correlates that the basic cause of addiction is “predominately experience dependent during childhood and not substance dependent” (p. 548). The ACE study compares adverse childhood

experiences next to adult health status that are outlined in 8 categories. The score earned can be between 0-8. The categories in the ACE are:

- Recurrent and severe physical abuse
- Recurrent and severe emotional abuse
- Contact sexual abuse
- Growing up in a household with:
 - an alcoholic or drug user
 - a member being imprisoned
 - a mentally ill, chronically depressed or institutionalized member
 - the mother being treated violently
 - both biological parents not being present (Felitti, 2003, p.550)

The higher the ACE score, the more likely the risk for certain maladaptive functioning in adulthood (Felitti, 2003)

In relation to heroin (injected drug use) and ACE, a dose response pattern was found in the study that highlighted the likelihood of injection increased strongly and in a graded fashion as the ACE score rose (Felitti, 2003). The ACE study reports that 78% of drug injection by women were specifically tied to adverse childhood experiences, and for men, it was 67% (Felitti, 2003). The ACE study findings demonstrate that “addiction is best viewed as an understandable, unconscious, compulsive use of psychoactive materials in response to abnormal prior life experiences, most of which are concealed by shame, secrecy, and social taboo” (Felitti, 2003, p. 555). As the social work profession moves to alternative modes of substance abuse assessment, particularly when working with diverse

populations and to address the current opioid crisis nationally, it behooves the profession to consider utilization of the ACE questionnaire as a tool when conducting trauma-informed care interventions.

Allem, Soto, Conde-Garbantim, and Unger (2015) conducted a study on the relationship between adverse childhood experiences and substance abuse with emerging adults in Southern California who identified being from a Hispanic background and demonstrated illicit drug use, binge drinking, cigarette smoking in the past month, and indicated that they had adverse childhood experiences prior to age 18. Participants were a mean age of 22 years, 41% were male, and participants totaled 1420. Each participant completed an ACE survey. A logic regression model was used to examine the survey data. Findings from the study suggest: positive association between adverse childhood experiences and substance use among Hispanic emerging adults; unhealthy coping mechanisms such as smoking, binge drinking, marijuana use, or hard drug use will not end until the individual receives proper treatment and the individual learns effective coping mechanisms to address negative emotions (Allem et al., 2015). Furthermore, the study stated that if the ability to achieve sobriety is not corrected by emerging adulthood, addiction may set in with a physiological need for substances posing as an additional barrier to abstinence in the future (Allem et al., 2015).

Childhood experiences, both positive and negative, have a significant impact on lifelong health and opportunity (CDC, 2016). The National Child Traumatic Stress Network (NCTSN, 2008), reports that numerous epidemiological studies have shown that 45-66% of adolescents develop a SUD after a traumatic exposure. Adolescents in

treatment for substance abuse disorders are more at risk than their peers to experience trauma due to self-harm and 59% of the teen population diagnosed with post-traumatic stress disorder (PTSD) develop substance abuse problems (NCTSN, 2008).

Scholarly literature on trauma expresses traumatic experiences in childhood are also causal factors for problematic mental health and physical concerns, including comorbidity diagnosis in adulthood (Felitti et al., 1998). Behavioral Rehabilitation Services (2018) cite the most common reasons individuals begin using drugs after suffering trauma include: escape memories, soothe pain, stay safe, feel in control, and redefine who they are.

Marcus et al. (2015) conducted a study with 625 adults from diverse backgrounds, 53.4% being female, average age of participants 41, residing in urban and rural outpatient settings in the United States. The study examined the connectedness between trauma history, lifetime endorsement of mental health symptoms, and gender. Participants of the study were given the Addiction Severity Index (ASI) to examine domains of psychosocial functioning in relation to gender, race, and employment related variables. A logistical regression model examined factors in this study and found that trauma did not have a significant impact on employment but did find that individuals, males and females, with SUD are more than likely to have experienced trauma sometime in their life; 50% of sample reported lifetime history of physical and/or sexual victimization and were at significant risk to also be given a mental health disorder diagnosis (Marcus et al., 2015).

PTSD occurs in 15-42% of individuals in the adult population who also have a SUD diagnosis (Coffey et al., 2016). The goal of a study done by Coffey et al. (2016) examined the efficacy of providing outpatient services for PTSD and SUD concurrently, since this kind of comorbidity diagnosis often leads to lack of successful treatment. Participants in the study were primarily male, white, identified multiple trauma experiences, randomly chosen, and totaled 126. Data collection with participants began in a residential program with a 3- and 6-month follow-up on an outpatient basis (Coffey et al., 2016). The use of long-term exposure to 12-step, group, and traditional counseling were the primary clinical interventions used during inpatient and outpatient treatment. Utilizing this type of treatment in a combined manner led to the participants averaging 85% or more abstinence from illicit drugs and alcohol at the 3- and 6-month interviews following residential treatment release and entering an outpatient treatment (Coffey et al., 2016).

The high prevalence of PTSD and trauma in individuals coupled with SUD presents a bevy of treatment challenges for community treatment providers (Killeen, Back, & Brady, 2016). Challenges exist for the client and the community organization. Concerns range from the efficacy of integrated treatment interventions, ability of the client to sustain interventions, cross training for addiction and mental health clinicians, and the community organization commitment to finding a good fit for their population (Killeen et al., 2016).

According to Killeen et al. (2016), TIC programs for the PTSD population should consider philosophical orientation length and format of treatment, adaptations for special

populations, education, background and level of staff training, and resources required to provide quality training and ongoing supervision. The kind of evidence-based programming offered can vary. Most often, treatment for SUD and PTSD/mental health comorbidity is geared toward integrated treatment, combined with other clinical components of the agency, and with sessions that can be delivered in an 8-12-week intensive outpatient programming (Killeen et al., 2016). Patient preferences for treatment are also imperative. “Research in patient as well as provider preference has favored the integrated approach over the traditional sequential practice which defers PTSD treatment until patients are in recovery from their SUD” (Killeen et al., 2016, p. 239).

Social Worker Role in Opioid Use Disorder Outpatient Treatment

Social workers are often the first tier of intervention in the service delivery for clients seeking substance abuse outpatient treatment (Bride, Kintzle, Abraham, & Roman, 2012). Social workers historically have played an important role in providing essential services for substance abuse disorders as well as drug policy reform (Raheb, 2016; Straussner, 2008). Social workers’ perspectives are key to policy discussion, prioritizing prevention, and the outlay of empathy when looking at the “call to action” platforms for opioid addiction reform (Gaudet, 2017). Social workers trained in the field of addiction approach clients via a strengths perspective, along with utilizing their core competencies to treat addiction as a brain disease and a chronic public health (trauma) concern (Szubiak, 2017).

Social workers also help assist other helping professionals determining the correct level of care, access to facilities, and after care (Gaudet, 2017, Lawrence, 2017). A

multidisciplinary approach to treatment is a method of problem solving, drawing from various disciplines that interact, and coordinate their efforts to treat the client in the most efficient manner (Children's Bureau, 2016). Relationships between social work and substance abuse treatment is influenced by the dominant treatment philosophy in any one country (Keene, 2001). One of five social workers specialize in addiction, with two thirds practicing in a private nonprofit organization that treats this population, and another 10% provide services through private clinical practice (Wells, Kristman-Valente, Peavy, & Jackson, 2013). Social workers provide education about the disease of addiction, address stigma and discrimination in relation to this population and inform what long term use or a lack of sobriety can do to their social, personal, and family lives (Caines, 2017).

Evidence-based practices, such as cognitive behavioral therapy, harm reduction medication assisted therapy, ecological model, motivational interviewing, systems theory, developmental models, character logical models, social learning theory, contingency management, cognitive behavioral and dialectical behavior therapy, are effective in working with clients who have SUDs (Bride et al., 2012; Jacobsen, 2013; NASW, 2013; See, 2013; Szubiak, 2017; Wells et al., 2013).

Bride et al. (2012) conducted a mail survey with 1140 private SUD counselors to examine factors that may be associated with "variation in social workers' perceptions of effectiveness, perceptions of acceptability, and use of psychosocial evidence-based practices for the treatment of SUD in comparison to other SUD counselors who are non-social workers" (p. 135). The researchers examined utilizing ANOVA the demographic and professional background and perceptions of the participants regarding motivational

interviewing and contingency management using an analysis of variance. Social workers comprised 25% of the total sample (285), largely female represented (65%) and Caucasian (86%), (54%) of the respondents had at least a master's degree, and (46%) reported being in recovery from a SUD (Bride et al., 2012). One of the study findings suggested that “social workers views of effective evidence-based programs (motivational interviewing or contingency management) were influenced by having an advanced degree and being newer to the field” (Bride et al., 2012, p. 147).

Since social workers interact directly with the community on substance abuse issues, collaboration is of “primordial importance” to tackling issues beyond the scope of any individual organization (Lamin & Teboh, 2016, p. 5). According to NASW, social workers also see themselves as pivotal in conducting research to assist with the development of empirically validated interventions and treatment strategies in relation to drug abuse (as cited in Miller, 2018).

Gaps in Literature/Barriers to Treatment

The literature review cites examples of social workers as a valid force in treating individuals with opioid use disorder, SUDs, and co-occurring diagnoses (Burke & Clapp, 1997; Jacobsen, 2013; Well et al., 2013). A study on individuals who used drugs to deal with their mental illness describes social workers’ interventions as a vital force in improved social functioning, and depression (Gaudet, 2017). The gaps, however, deal with the perspective of the social worker on how to deal with the illicit opioid use and opioid overdose epidemic occurring nationally and in Ohio.

Wells et al. (2013) state that, although social workers are collaborating with others in the work of substance abuse treatment, it remains under identified as a primary (specialty) practice in the field. In addition, most social workers are trained to utilize a very specific range of evidence-based interventions, and one of the weaknesses of evidence-based programs for SUDs has been their inability to have universal application, particularly as it deals with individuals who have diverse cultural and marginalized racial backgrounds (Wells et al., 2013). Research with social workers across the private and public sector is important. Being able to replicate the studies with treatment fidelity must be insured (Bride et al., 2012). As more research studies emerge addressing the opioid crisis, it is imperative that social workers' perspective become part of the process in identifying new and innovative practices.

Summary

Social workers are on the forefront of the opioid crises in the United States. Through this action research study, I sought to provide information and data that enhances the social work profession in implementing trauma-informed care when providing outpatient treatment to opioid users. Due to the rising numbers of individuals using opioids in an illicit manner, research to look at root causes is justified (NASW, 2013). This action research study adheres to the NASW code of ethics (2018) in seeking social justice for at-risk populations and placing social workers in the role of a change agent.

Collaborative efforts are needed to treat this population due to its overarching negative effects on the functioning of the individual in a social, medical, physical, and

neurological manner. State governments, like the Attorney General and Governor's Office in Ohio have considered the collaborative approach as highly needed to address the opioid crisis, particularly since the epidemic has reached all segments of society, rural and urban, causing the needed interventions to be varied and culturally tuned (PCSAO, 2016). Therefore, the social work perspectives on trauma-informed care for persons with opioid use disorder in an outpatient setting are relevant and important to the collaborative efforts needed to address the opioid crisis in Ohio. Section 2 follows and deals with research design and data collection for the study, including subheadings on ethical procedures, background and content, and methodology.

Section 2: Research Design and Data Collection

The purpose of this action research study was to add to the current body of knowledge and practice in relation to social work perspectives on trauma-informed care for persons with opioid use disorder in Ohio. The research questions were as follows:

RQ1: How do social workers in Ohio implement trauma-informed care when providing outpatient treatment to opioid users?

RQ2: What are the challenges for social workers in Ohio in implementing trauma-informed care when providing outpatient treatment to opioid users?

In Section 2, I present the research design and methodology. A description of the data analysis and ethical procedures are also provided.

Research Design

This purpose of this action research study was to seek social work perspectives on trauma-informed care for persons with opioid use in Ohio. The nature of the study and the data collected from the DSW study participants were geared toward informing, enhancing, and expanding the tool kit of outpatient social workers who treat this population in Ohio and adding to the current body of knowledge and practice in the profession.

The research design for my study was qualitative, and action research was the methodology. Per O'Brien (1998), action research aims to contribute to the practical concerns of people in an immediate problematic situation and to further the goals of social science at the same time. Qualitative research designs are interpretivist in nature and strive to understand a phenomenon in its context in greater depth (Lietz & Zayas,

2010). Through individual semistructured interviews (with probes), I strived to gather data that would highlight successful trauma-informed clinical practices and give rise to further and additional interventions for this targeted population. Specifically, NASW (2018) has highlighted the importance of social work professionals having competence when treating clients, including sharing knowledge to improve knowledge in the field. NASW (2013) stated that “standards for social workers who practice with substance/opioid use clients stresses inter-disciplinary and inter-organizational collaboration to support, enhance, and deliver effective service to clients with substance/opioid use disorders and their families” (p. 17). Therefore, the overall approach of this action research study aligned with the NASW (2018) Code of Ethics and NASW (2013) practice with SUD/opioid clients in approach and methodology by improving social work professional roles and responsibilities when working with this population in outpatient settings.

Operational definitions for this DSW action research study included stakeholder, trauma-informed care, participant, and semistructured individual interviews. Additional operating and social work definitions used for this DSW action research study were outlined in Section 1. Stakeholders and participants are used interchangeably in this study. Stakeholders in this study were clinical social workers working with individuals with opioid use disorder, implementing trauma-informed care practice in Ohio on an outpatient basis. The social workers were also participants as their perspective was the main source of qualitative data for this study (see McNiff & Whitehead, 2010).

Methodology

Data Collection

The study participants were five Ohio clinical social workers implementing trauma-informed care when providing outpatient treatment to persons with opioid use disorder. Individual semistructured interviews, with an interview guide including seven questions with subsequent probes, were used to obtain data from participants in relation to their use of TIC in their professional treatment of persons with opioid use disorder. According to Burgess (1984) and KnowHow (2018), a semistructured interview is referred to as a conversation with a purpose and has the following characteristics: the interviewer and respondents engage in a formal interview, the interviewer develops and uses an interview guide, the interviewer asks questions in a particular order, and the interviewer follows the interview guide but is able to follow up with subsequent probes. The semistructured interview also provides freedom for the participants to express their viewpoints in their own terms (KnowHow, 2018). Through individual semistructured interviews, I sought to gather data that highlighted social work perspectives about the use of TIC in outpatient opioid treatment and the challenges encountered as well as give rise to further and or additional interventions for this targeted population.

The individual semistructured interviews were audiotaped to capture discussion verbatim, and the timeframe for the 1-time individual interviews lasted approximately 60 minutes. The semistructured individual interview began with me reviewing the purpose of the action research study, reviewing and ensuring the informed consent was signed, agreement to be audiotaped, and reviewing terms of confidentiality. The identifying

information for participants is confidential for the purposes of the DSW action research study. Each participant also completed a background questionnaire prior to the interviews starting. Obtaining background information on the participants was important to denote for study replication and to highlight their background/ clinical characteristics and experience with the targeted population in the study.

Participants

The criteria for participation in this study included (a) a social work degree (Associates to PhD), (b) actively working on an outpatient basis in Ohio with individuals diagnosed with opioid use disorder, (c) using a focus on trauma-informed care implementation, (d) English speaking, (e) being willing and able to participate in one individual semistructured interview for approximately 90 minutes, (f) voluntarily agreeing to sign the consent and confidentiality, and (g) being audiotaped for the duration of the focus group. Social work participants were recruited through purposive sampling. Purposive sampling is a nonprobability technique wisely used in qualitative research (Laerd Dissertations, 2012). This technique seeks to identify and select participants who are particularly informed, have experience with the target population, are available and willing to voluntarily participate, have the ability to communicate expedience and opinions in an articulate way, are expressive, and have a reflective manner (Palinkas et al., 2015). Flyers were sent via email in relation to the action research study. The first five participants who met participant criteria and interest were selected. Initial contact with the participants was made via email and/or phone. An introductory email was sent with my contact information, copy of informed consent, and background questionnaire.

The individual semistructured interviews were held in places that allowed for privacy and each participant received a \$10.00 Starbucks gift card as a token of appreciation for taking time out of their busy schedule.

The applicant background questionnaire was composed of questions such as age, race, gender, length of time working with opioid addicts, current job title, number of years working as a social worker, setting of their employment, type of social work degree, licensure type, and age category of population they work with – under age 18 or over age 18 (see Appendix A). Completing the Applicant Background Questionnaire prior to the start of the formal semistructured interviews ensured the participants met the qualifications and were from diverse backgrounds.

Validity in a study is very important; therefore, social desirability must be monitored. Social desirability bias is characterized as the human nature to present oneself in a positive fashion to others, and, subsequently, this type of bias can affect construct validity (Neeley & Cronley, 2004). According to Regoniel (2013), having a researcher come from a similar background as the targeted population, coupled with training and monitoring, will lead to more valid results.

Narrowing the sampling to social workers who were employed in an outpatient setting treating persons with an opioid use disorder and using trauma-informed care was purposive and key to setting the stage and alignment to the research study questions. Carlsen and Glenton (2011) searched PubMed for studies that used focus groups and found in the 220 papers published in 2008 in 117 journals, the size of the focus groups varied with the mean being 8.4, median 5, and the range 1 to 96. Having the right

participants to address the research question in a qualitative focus group is characteristically one of the highly important aspects of the research design (InterQ Research, 2018). McClain (2017) stated that, although doctors and law enforcement are collaborating entities in the fight against opioid addiction, social workers are in possession of unique skills that focus on an individual's character defects and needs holistically. Based on education and training of social workers, their tool kit creates a solid foundation for the addressing public health challenges as well. Sampling respondents with rich information is instrumental to establishing trustworthiness (Palinkas et al., 2012).

Instrumentation

The instrument to collect data was a semistructured qualitative interview guide consisting of seven open-ended questions related to the research questions. An example of a question from the interview guide is "What are the challenges for social workers in Ohio in implementing trauma-informed care when providing outpatient services to opioid users?" (see Appendix B). The questions were developed based on the theory selected, the literature review, and the research questions. I established the interview guide with feedback from my assigned DSW committee members. Through the interview questions, I strived to pursue additional scholarly information and views from my fellow social workers in Ohio who are treating individuals with opioid use disorder. I have been a licensed social worker in the state of Ohio for the past 29 years. I frequently have professional contact with individuals and families negatively affected by

opioid/substance abuse. The opioid crisis on Ohio has impacted my profession and other stakeholders who advocate and treat the targeted population.

Key terms/responses to questions were written in a notebook in addition to audiotaping the participant. It is during this phase of qualitative research that the process of saturation was noted. Saturation is a process used to ensure that adequate and quality data are collected to support the research study and research question (Walker, 2012). Depth of the data is vital (Burmeister & Aitken 2012). Saturation also involves eliciting all forms and types of occurrences valuing quality responses (Morse, 1995).

Data Analysis

Data collected for this project examined social work perspectives on trauma-informed care for persons with opioid use disorder in Ohio. Data from the participants were audio recorded to capture info verbatim, transcribed solely by myself, and entered on an Excel spreadsheet for coding, analysis, and synthesizing.

Thematic analysis was used in this study and is a common form of analysis in qualitative research that emphasizes and pinpoints overarching themes, and examines and records patterns within data (Gibbs, 2007). Categorizing, coding, selecting key experiences to identify themes, along with concept mapping were used to look at the information gathered. I used manual coding used with an Excel spreadsheet and NVivo, a computer assisted qualitative narrative analysis software (CAQDAS) during the data analysis phase to assist with transcription of the audio record individual interviews with the participants. Computer assisted software serves to efficiently understand and analyze

non-numerical data and helps to identify patterns from pages of the text (Richard & Morse, 2007). Data coding can be overwhelming, and organization is critical.

Pseudonyms were used to reference participants during coding, semi-structured interview denotation, and analysis of data. Data was kept on a password protected laptop that only the researcher can access. There was no use of any public computers or guest use wireless internet to access information gathered in the study. No flash drive was created to store information.

Establishing trustworthiness in a qualitative study is vital. Trustworthiness is part of the validity and reliability process. Trustworthiness was established in this study by examining four components: credibility, transferability, confirmability, and dependability (Lietz, Langer & Furman, 2006). Establishing dependability and confirmability via an audit trail highlighted data analysis steps and rationale for the study. Confirmability was also examined in this study by reviewing my action research interview questions with assigned committee members to monitor bias. Dependability was addressed by ensuring that the design of the study was fully explained in detail. Credibility was measured by triangulation. Triangulation of data was estimated to take place via the collection of perspectives from the study participants, which allowed the principle researcher to clarify meaning by identifying various ways the opioid crisis is being perceived (Stringer, 2007). The use of thick description was the basis for establishing transferability. This helped to demonstrate data findings were applicable to other contexts. It was important to establish that the data gathered was true and based on participants information and not researcher bias. The operationalization of this study produced good face validity due to the focus

group compositions (Trochim, 2006). Authenticity was maintained due to the recording of the participant's responses, which lead to determining accuracy of findings (Herry, 2017).

Ethical Procedures

The goal of this DSW action research proposal was to obtain social work perspectives on trauma-informed care for person with opioid use disorder on Ohio when providing outpatient treatment to opioid users. Data collection and contact with chosen participants did not commence until IRB approval was given. Each participant was treated with professional courtesy and respect.

Chosen participants were given information on the study and asked to confirm informed consent prior to the focus group meeting. Participant's identity was kept confidential by assigning a participant code ID. I am the only person with the identifying information related to participant selection, thus safeguarding confidentiality.

The informed consent form given to each participant also outlined confidentiality. This consent form gave each voluntary participant information needed to understand why the action research study was being done and why they are being invited to participate. It also described what was being asked of the participants during the study, any known risks, inconveniences, or discomforts. Signing the consent was required by each participant before any research and data collection occurred. A copy of the consent was given to each participant and acted as a record of their agreement to participate. During session closing, participant was reminded they would receive an executive summary of the study and a statement of thanks for their time and participation.

Prior to the individual semistructured interviews, I obtained IRB approval. Data gathered from the participants was secured via audio recording/transcription and analyzed, and synthesized to identify themes in relation to the research question(s). I am the only person who has access to the password protected laptop and raw data. This information was only shared with my capstone research committee members. All data compiled for this DSW research study is stored in a locked cabinet for the next 5 years, which follows Walden University standards. After 5 years, the information will be shredded and disposed.

Summary

The primary objective of this action research study was to examine the clinical practice problem related to social work perspectives on trauma-informed care for opioid users in Ohio and the challenges they face. The action research questions addressed were “How do social workers in Ohio implement trauma-informed care when providing outpatient treatment to opioid users?” and “What are the challenges for social workers in Ohio in implementing trauma-informed care when providing outpatient treatment to opioid users?” Data were collected via 5 clinical social workers in individual semistructured interview. Data was analyzed through thematic analysis to determine codes, categories, and relevant themes. In the next section of this study, I discuss my findings.

Section 3: Presentation of the Findings

The purpose of this study was to understand social work perspectives on trauma-informed care for persons with opioid use disorder in Ohio. The research questions were as follows:

RQ1: How do social workers in Ohio implement trauma-informed care when providing outpatient treatment to opioid users?

RQ2: What are the challenges for social workers in Ohio in implementing trauma-informed care when providing outpatient treatment to opioid users?

Action research methodology was used to collect data, via individual semistructured qualitative interviews, with five purposively selected degreed social workers who treat individuals with opioid use disorder in Ohio on an outpatient treatment basis. Purposive sampling is a nonprobability technique used in qualitative research with the intent of identifying and selecting individuals who are knowledgeable and experienced with the phenomenon of interest (Creswell & Clark, 2011; Laerd Dissertations, 2012). Thematic analysis was used to identify themes and patterns across the data set. According to Braun and Clark (2013), thematic analysis also helps to identify patterns of meaning in relation to a research question. I used NVivo and manual processing to transcribe the audio recordings. NVivo is a qualitative data analysis software frequently used by academia and professional researchers globally (QSR International, 2019).

In Section 3, I outline the data collection/analysis process and techniques that were used. In this section, I also provide a description of the findings along with themes that emerged from the data and a summary.

Data Analysis Techniques

Upon approval by the Institutional Review Board of Walden University (814:18:53-06'00), in January of 2019, I began the recruitment of social workers with an associate or above degree in social work who treated opioid use disorder individuals in an outpatient setting, focusing on trauma informed care in Ohio. I invited eight social workers to participate via email. Purposive sample selection was used. The first five participants who met participant criteria and interest were selected. Participants were interviewed via a semistructured format.

The semistructured interviews were held over the month of February 2019. Five of the eight recruited participants showed interest in volunteering in the DSW action research study. Each interested applicant was sent a copy of the applicant background questionnaire (Appendix A) in advance of the interview as well as the informed consent. One sent the background questionnaire back before the interview; the other four completed the information prior to the start of the recorded interview. The semistructured individual interviews lasted approximately 60 minutes with social workers who met the participant criteria at a location of their choice or by phone. Each study participant was given a pseudonym to ensure anonymity and to assist with data collection and analysis. The volunteer participants were social workers whose experience with the target population ranged from 8 to 27 years.

Upon meeting with each participant, I provided a packet with informed consent, applicant questionnaire forms, definition of TIC (Appendix C) as outlined by the SAMHSA (2018), and a copy of the semistructured seven qualitative interview questions (Appendix B). I went over the informed consent with each participant; the TIC definition and list of the semistructured questions were provided for their keeping. All participants readily agreed to be audio recorded for the interview. Participants were given 5 minutes before the interview began to complete the applicant background questionnaire, if not done in advance. Additionally, participants were asked if they had any questions prior to the beginning of the interview, and this was again repeated at the end of the interview.

Participants were encouraged to speak freely and in their own vernacular. The interview questions were open ended. Open ended questions in qualitative methods can evoke responses that are culturally conspicuous to the participant, unanticipated by the researcher, and explanatory in nature (Mack, Woodsong, MacQueen, Guest, & Namey, 2005). During the semistructured interviews, I was mindful to actively paraphrase and summarize the participants' responses to ensure clarity and meaning for the data collected. There was no indication that the participants felt uncomfortable during the interview or displayed any level of untruthfulness in their responses.

During the individual interviews, a digital recorder was present; I took notes and had a digital clock present to ensure that ample time was given for all questions to be discussed and expounded upon within the interview timeframe. After the individual interview was concluded, I asked if there were any additional comments or questions in relation to the interview. I thanked the participant, gave a token of appreciation, a \$10.00

Starbucks gift card, and advised that a copy of the DSW executive summary would be provided. Triangulation was established by using the same questions, in an individual semistructured interview, with all five participants. If the researcher can substantiate that the same procedures were used through the individual interviews, the interpretations and conclusions drawn from the participants are likely to be trustworthy (Carlson, 2010).

At the end of the final individual semistructured interview, the audio recording was transcribed using NVivo transcription. The files were transcribed by a computer analysis program and were not seen by any human for this process. All materials for this study were stored in a password protected and secure encrypted laptop, and/or in a locked cabinet to which only I have access.

Thematic analysis was used for this qualitative design method. According to Braun and Clark (2013), thematic analysis is comprised of a 6-prong approach: familiarizing yourself with the data, generating initial codes, searching for themes, reviewing potential themes, defining and naming themes, and producing the report.

I familiarized myself with the data by reading the interview transcription at least 3 times, listening to the audio recording 2 times, checking it to the transcription of the interviews for accuracy, and making notes on the data as I read in the margins of the transcription or in a notebook. According to Braun and Clarke (2013), reading the words actively, analytically, and critically assists in thinking what the data mean.

After becoming familiar with my dataset, I began the precoding/initial coding process. Precoding involves circling, highlighting, bolding, and/or underlining significant quotes from participants that are worthy of attention (Saldana, 2009). A code book was

used and developed during this process. Coding is a key step in the process and conceptualizes data (Holton, 2007). Specifically, I manually coded the data using an inductive approach. In vivo coding was used. In vivo coding helps to capture participants' specific words or phrases that might not be otherwise understood when using other forms of coding and is useful in highlighting the voice of participants and their meaning in the collected data (Manning, 2017).

Codes help to identify and provide a label for key features of the data that are potentially relevant to the research questions and provide a pithy summation of the data content (Braun & Clark, 2013). There are two types of codes: descriptive and interpretative. Codes from the transcription were highlighted to ensure they were inclusive, thorough, and systematic. The data set included 142 codes. Coding also involved micro splitter, smaller text strings, and macro lumping, lumping text into larger codes. Coding is also heuristic and a cyclical act (Saldana, 2009). Key experiences and important information verbalized by the individual participants were also collectively outlined and put into a thematic map or spreadsheet to assist in capturing cohesive categories.

My next step in analysis involved reviewing potential themes and comparing them to the entire data set. Reviewing potential themes is recursive and done to ensure that the coded data and the entire data set are developed fully (Braun & Clark, 2013). I re-read and reviewed the themes in relation to the data set to ensure that the most important data and themes were captured and related to the research questions presented for this study.

A good thematic analysis will have themes that can be summed up in a few words, do not try to do too much, are related but do not overlap, and address the research question directly (Braun & Clark, 2013). During this phase, I used extracts from the transcription to tie the data narrative to a theme. Three themes were identified: (a) appreciation of trauma-informed opioid use disorder treatment, (b) organizational and professional challenges to the use of trauma-informed opioid use disorder treatment, and (c) environmental barriers to successful trauma-informed outpatient opioid use disorder programming.

To validate my interpretation of the data, I conducted member checking. Member checking is most often done by providing the participants a copy of their individual transcripts and asking for their feedback to aide with accuracy (Carlson, 2010). Each participant was given a copy of their transcript for review and asked to provide feedback to me. I did not receive any feedback; however, this was an important step to assist in validating accuracy of the participants' statements. Member checking set the foundation for establishing credibility for the study as well.

Outside of member checking, Creswell and Miller (2000) stated that the procedures for trustworthiness should include the researcher, participants, and external readers of the final report. In my action research study, the participants played a role by volunteering to complete semistructured interviews and obtaining a copy of their transcripts for accuracy and feedback. I kept an audit trail, code book, and reflexive journal to reduce bias and denote thoughts, feelings, uncertainties, values, beliefs, and assumptions that can come to light during the research. I also reviewed my action

research study with my assigned DSW committee members. Reflexivity is important to self-scrutiny throughout the process (Austin & Sutton, 2014). Carlson (2010) stated that reflectivity addresses the influence on the research, engagement with participants, and the transparency about the influence. The audit trail serves to additionally assess conformability and dependability. An audit trail entails keeping careful documentation for all parts of the study, which includes notes, audio recording, and drafts for a minimum of 3 to 5 years (Carlson, 2010). I am required by Walden University IRB to keep such records for a minimum of 5 years.

Triangulation was established by using the same questions, in an individual semistructured interview, with all five participants. If the researcher can substantiate that the same procedures were used through the individual interviews, the interpretations and conclusions drawn from the participants are likely to be trustworthy (Carlson, 2010).

Limitations

Qualitative research is well matched to a study when the researcher seeks to understand a prominent issue (Jamshed, 2014). In this study, I focused on social work perspectives of TIC for persons with opioid use disorder in Ohio. Data collection consisted of semistructured individual interviews, which is one of the most common qualitative research methods (see Mack et al., 2005). The sample size consisted of five participants who worked in specific geographic markets: urban, central Ohio, and rural, southern Ohio outpatient settings. However, despite the small sample size, it is my hope that the information and data received from the participants for this study can be deemed as educative by other social work professionals who treat individuals with opioid use

disorder. Ultimately, transferability is subjective in nature and can best be determined by the reader (Morrow, 2005).

Findings

Ohio is considered ground zero for the opioid epidemic wrenching the nation (Ohio State University Extension, 2019). Through this study, I sought to understand the perceptions, attitudes, and challenges of social workers who use trauma-informed practices when treating individuals with opioid use disorder in outpatient settings in Ohio. Based on participants' responses, it appears there is a need for continuing education in relation to TIC as a best practice, working within their organization on the utilization of a trauma screening tool, securing long-term supports for clients in their community, addressing environmental barriers and past trauma of a client, and examining further the usefulness of MAT programming.

Demographics

There were five participants for this research study. All were given pseudonyms to protect their identity. Tom was a 48-year-old White male. He has a bachelor's degree in social work, is currently enrolled in a Master of Social Work program, is a Licensed Social Worker (Ohio), and holds an Ohio Peer Recovery Supporter certification. He has approximately 8 years of experience in the field of opioid/substance abuse treatment. He is employed as a social worker/mental health counselor in a public, non-profit drug addiction and mental health outpatient center that treats adults in rural Ohio. He also specializes in case management and the delivery of medication-assisted treatment (MAT) services with individuals who have an opioid use disorder and or co-morbidity diagnosis.

Cleylin was a 45-year-old Latino female. She has a bachelor's in social work and has 8 years of experience in the field of opioid/substance abuse treatment. She is employed as a social worker in a private, non-profit adult outpatient mental health and addiction services center in rural Ohio. Her specialization was rural community addiction services. She speaks both English and Spanish).

Maria was a 48-year-old Latino female. She has a Bachelor of Social Work and is a licensed social worker. She has 4 years of experience as an adult community outreach social worker for an alcohol and other drugs (AOD), public – nonprofit outpatient center in an urban setting in Ohio. She is fluent in English and Spanish and has a specialized skill set in working with diverse/immigrant/refugee populations who have an opioid use disorder/substance abuse diagnosis.

Angela was a 48-year-old African American female. She has a Bachelor of Social Work and is a Chemical Dependency Certified Assistant. She has approximately 27 years in the field of adult opioid/substance abuse treatment. She is employed as a social worker in a public nonprofit mental health/addiction center in an urban setting in Ohio. She specializes in individuals with mental health and an opioid use disorder/substance abuse diagnosis.

Seth was a 36-year-old Caucasian male. He has a bachelor's degree in social work, is an Ohio Licensed Social Worker, and is a Licensed Chemical Dependency Counselor III. He has 12 years of experience in the field working with individuals with opioid use disorder as a social worker/counselor in a public nonprofit in an urban center

in Ohio. He specializes in working with adult males who are homeless and have an opioid use disorder/substance abuse diagnosis.

All the participants graduated from universities that were accredited by the Council on Social Work Education (CSWE). *Profiles of the Social Work Workforce* (2017) is a report used by CSWE to present a profile of the current social work workforce in the United States. I compared national social worker demographics in the report to the participants in the research study (see Figure 1) to validate their credentials.

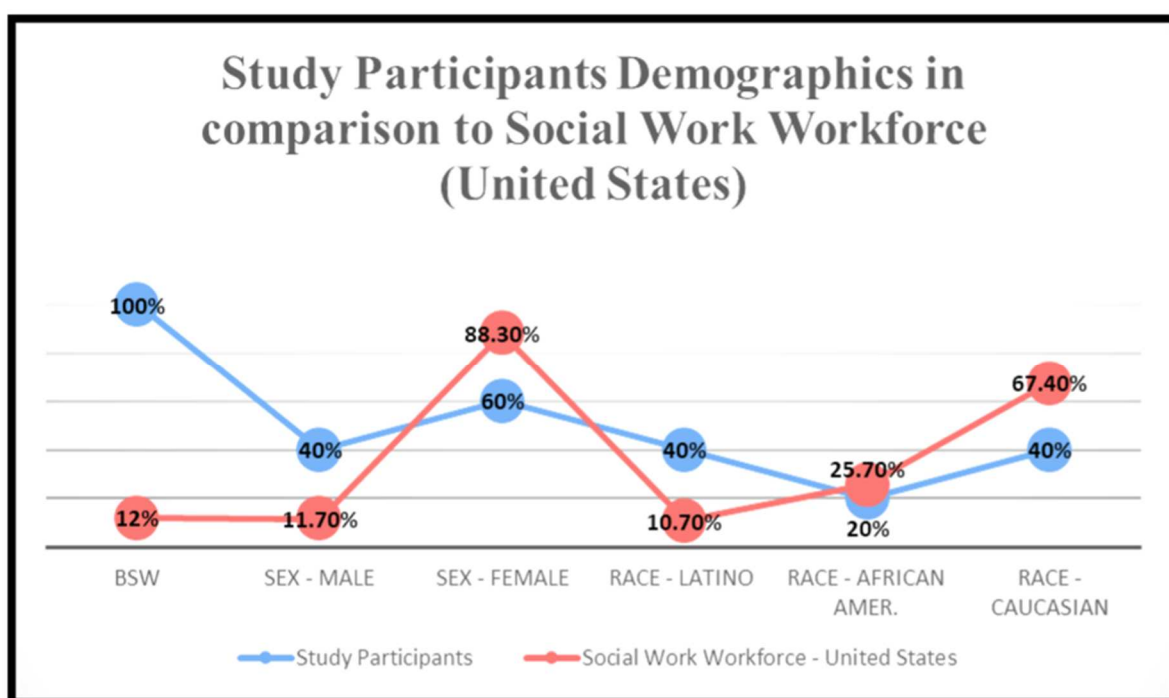


Figure 1. Study participants' demographics in comparison to Social Work Workforce (United States). Data from Social Work Workforce (United States) from Profile of the Social Work Workforce (2017).

Themes

Data collection and analysis from the semistructured interviews revealed 3 emergent themes. The following 3 themes emerged from the synthesizing of the data collected from the individual semistructured interviews: (a) appreciation for trauma-informed opioid use disorder treatment, (b) organizational and professional challenges to the use of trauma-informed opioid use disorder treatment, and (c) environmental factors as challenges to trauma-informed opioid use disorder. These themes have a direct connection to the research questions for this study. The data collected supported a further understanding of the social work perceptions of the opioid crisis in Ohio, and the literature review conducted prior to the individual semi-structured interviews. The identified themes are outlined in further detail below. Participant reflections are denoted to support each theme. Minor editorial changes were made to participant reflections as needed for readability.

Theme 1: Appreciation for Trauma-Informed Opioid Use Disorder Treatment

TIC was reported by all study participants as a critical component to effective treatment of individuals with opioid use disorder. All participants stated that their agencies used TIC practices/approaches, however there was still a need for their employers to (a) provide training for staff on a regular basis in relation to TIC practices; (b) ensure training consisted of updated information on successful evidenced-based programming; and (c) commit to the consistent use of TIC practices including examination of a trauma screening tool. Only two of the five participants reported using a formalized trauma screening tool. Angela stated the following:

My agency is not educated on the true tenets of TIC; we need training updates on it, as well as the value in using a trauma screening. Agency is more geared toward assessing dual diagnosis concerns – i.e. depression, for which we use a Beck inventory at the time of initial meeting.

Seth stated the following:

Men in our program seem reluctant to disclose trauma. So, we choose to ask trauma questions as we build engagement. A screening tool has not been properly tied to our curriculum training and perhaps this can be explored further. We are given training on TIC when first hired at the agency.

Maria verbalized,

No trauma assessment is given at initial assessment. Our initial assessment is focused on assessing the clients use of drugs. I am aware of the concept of TIC approaches as my former professors spoke about it in my bachelor of social work classes.

Cleylin shared,

At initial assessment, a Beck Depression Inventory, is given. If the client shows signs of needing mental health treatment of their depression, then I refer them to the onsite mental health social worker. I hear that the mental health social worker will examine or utilize a trauma assessment, however, that info is not readily passed down to me. Clients often talk during my contact with them about trauma in their life. I have taken it upon myself to learn more about trauma screenings. I

plan to talk more about the need for use of a screen during upcoming supervision with my boss.

Tom remarked,

A trauma screening is done at initial assessment via dialogue between the client and the social worker. We find this more helpful in getting detail in relation to their trauma. My agency routinely speaks at length about TIC practice and approaches.

Recognizing the importance of TIC practices aides not only the client but also the social worker. Training provides the tools for which the social worker learns how to mitigate against retraumatizing clients as they establish rapport (U.S. Department of Health and Human Services, 2014). Although participants had varied ideas of how and when to capture trauma information, all felt they would like to know more about the efficacy of screening tools reported in scholarly research and or via their colleagues.

Theme 2: Organizational and Professional Challenges to the Use of Trauma-Informed Opioid Use Disorder Treatment

Participants openly discussed the variety of factors that prevented client's from seeking trauma-informed opioid use disorder treatment: (a) lack of long-term supports; (b) agency funding that was not based on statistics as a sole means of measuring success; (c) worker competency/caseload; (d) the utilization of MAT programming (Suboxone versus Vivitrol), and (e) the clients' readiness to change. Participants all spoke on the effect that social worker caseloads and competency have on client outcomes. They also dually noted the importance of sober housing resources collaborating with outpatient

programming to address not only addiction needs but also trauma experiences and other mental health. All participants spoke on the need for long-term supports for clients with agencies who utilized trauma-informed practices. The need for long-term supports per the participants were tied to the client's need to have healthy connections with their family and friends, that also lent to keeping the client sober. Also, the availability of 12-step or other types of support groups were thought to be imperative to sustaining sobriety for their client's long term. The utilization of MAT treatment was known to all participants. Four of the 5 participants said MAT clinics were on site at their employer, another one said they help link the clients to an offsite MAT clinic. MAT is popular in the literature to treat substance abuse/opioid use disorder with medications. Tom said the following:

Money is often designated to specific programming, maybe tied to community need. Money can also go away causing programs to cease. Lack of money can affect the number of social workers we have on hand, thereby making the amount of time I can spend with clients limited due to the demand of client's who need to be seen for treatment in our small community.

Maria remarked,

The clients see me as "family." They have no other reliable or stable person in their lives. Many are isolated and become over dependent on me in a social way. When it is time for me to terminate my involvement, they start to decompensate emotionally. When working with my clients, their environments are not safe, and so they need to be able to find people and places that are positive. Hard to measure sobriety progress when clients are in MAT programs.

Cleylin remarked long-term needs as

Having a sponsor. The groups in my county are widely available, but some individuals need to have a good sponsor. This person can be involved with them for life and, therefore, it assists with their maintenance of sobriety. With the number of folks in treatment due to the opioid crisis, the number of available sponsors is not meeting the demand.

Tom stated the following:

Suboxone is the most common drug used in MAT treatment. The down side is, it is an opioid partial, thus the client continues a maintenance plan for life in most cases. They are trading one dependency on a drug for another. The clients don't seem to look at other avenues to regulate their life when sober and see this as a panacea, most government programs who regulate MAT programs support Suboxone. Suboxone appears to be cheaper than other alternatives and heavily marketed to entities who have MAT clinics. I believe that the big pharmaceutical companies want the Suboxone treatment to be touted as highly effective for this population for their own benefit of making money. Vivitrol is what I hope becomes more commonly used. Vivitrol is also used to treat alcohol dependency. Vivitrol contains no opioids. The initial cost of Vivitrol (1 time a month shot) appears to be costlier in the beginning than the start up the Suboxone program, however, not so in the long run when compared to the many years an opioid user is on Suboxone. Vivitrol is typically a 12-month program. I have seen great

success with my clients who utilize a medication treatment with vivitrol versus suboxone.

Cleylin remarked,

Clients often are not faring better in MAT programs and continue to have maladaptive thoughts on how to maintain their sobriety. Individuals with co-morbidity issues often are taking various medications and the treating physicians need to look at how the medications affect the client. Often the side effects of the medication lead to the client's inability to hold a job and/or care for themselves in a manner that leads to dependency on social service/substance abuse agencies.

Angela said the following:

The use of MAT programs continues to affect their brain functioning in an abnormal manner; therefore, the process to "rewire" their functioning and thoughts is not fully able to be recognized in such a program. I think Vivitrol is a good alternative to Suboxone programming. I have been supporting this program at my agency.

Maria verbalized,

Client's wiliness to change affects the outcome of their treatment. They have not bought into the need for treatment even when it has had negative effects on their life. If they are linked due to involvement with the court, they still struggle to be sober or follow agency practices. Sober housing is also very stringent on their rules and so some clients avoid it.

Tom noted the following:

Clients often have co-morbidity issues and so it is not clear if they have a mental illness and have been using drugs to cope or if the drug use created the presence of a mental illness. Knowing what medications, they are on and getting a good assessment after sobriety is important.

Angela felt sober housing was helpful:

Without sober housing linkage, clients struggle with sobriety and meeting their basic needs. They continue to be out in the community with peers using drugs if they don't have the means for stable housing, and many linger in a homeless status situation. We see a lot of homeless folks at our agency. Also, individuals who cannot afford their mental health medication are using illicit drugs to deal with the thoughts in their head.

Seth, who has a direct resource link for his clients to sober housing, stated,

The sober housing resource leads to success, most often when the client is open to change and is willing to fully engagement in the program. We have very proscribed outpatient programming when coupled with sober housing. It keeps the client accountable to be active in their treatment and is strength based. The clients who fail in our programs often just want to do it their way and do not believe clinical interventions as proscribed. I am aware it can take a few times in sober housing or rehab to make a client see the value of outpatient treatment, which is why I continue to believe in the programming at my agency. Release prevention programs are not readily known or available in the community. Release programs do not have to be at the substance abuse office, they can be in the community in

such places as churches, other entities that keep clients sober over time, and it's a long-term support once clinical treatment has ended.

Angela felt the competency of the social worker plays a pivotal role in client's treatment success:

The clinical abilities of the social worker are very important. If the social worker is not properly educated and trained, then the clients struggle to build engagement. I personally feel like all social workers who interact with opioid use disorder clients need to have a license. The licensure requires them to get updates on training yearly. Some agencies are hiring associate level social workers, but they are getting limited training after hire. My agency has begun to hire folks without social work degrees to allow for more folks to come on board to act as case managers, but case managers are not social workers and, therefore, their ability to elicit change is problematic in my eyes. Personal bias can also creep in with social workers who do not have exposure in working with diverse population and this can also affect communication. The caseload size of a social worker can also affect the successful treatment of a client.

Cleylin stated the following:

Many rural social workers are in the car 4 of 5 work days and, therefore, this can be very taxing. In rural areas you can be driving half of the day. You don't get into the office often. I must monitor myself for worker burnout.

Maria stated the following:

I see the need for more “street outreach” programming in the communities - nontraditional methods. Prevention programming needs to start with youth at the grade and middle school level. The stress of the job causes worker burn out. I must do activities to keep myself in a good emotional and physical state. If I am not in a good place mentally, then I don’t feel I can give my best to the clients.

Study participants vocalized a bevy of organization challenges to TIC being delivered in a successful manner. Some of their agencies were not licensed to perform co-morbidity services, which led to the client being involved in numerous community agencies to meet their needs. All participants could readily enroll their clients in a MAT program, however a couple felt strongly that there was an overreliance on Suboxone treatment. Additionally, some felt that despite the client’s linkage with MAT programming, problems with maintaining sobriety are still prevalent.

Participants did comment that all their employers were concerned about worker burnout and increased caseloads due to the opioid crisis in Ohio. Additionally, the funding for agencies who treat opioid use disorder clients is highly dependent on Medicaid billing. Per the participants, problems persist in their agencies in relation to obtaining full reimbursement from Medicaid due to complicated coding processes. Both urban and rural workers spoke on the need for long term supports for their clients that would support client’s sobriety. A few recommended putting more emphasis on developing frameworks for increased prevention programming that may lead to less first time use of opioids in an illicit manner. According to SAMSHA (2014), an organization’s

culture must clearly understand and address how trauma can be a barrier to effective treatment outcomes.

Theme 3: Environmental Barriers to Successful Trauma-Informed Outpatient

Opioid Use Disorder Programming

Environmental factors have a significant influence on the success of a client in opioid use disorder programming. Influencing and problematic environmental factors include: (a) social media portrayal of drug use and addiction; (b) poverty; (c) trauma prior to age 18 and as an adult (human trafficking and prostitution); (e) parent attitude toward youth using drugs; (f) peer pressure; and (g) lack of affordable housing and jobs that allow the client to earn a living wage. All the participants verbalized that trauma (prior to age 18 and in adulthood) in a client's life has played a significant role in their brain functioning and seeking the use of illicit drugs to cope and self soothe. Tom relayed the following in relation to environmental barriers:

Many clients talk about trauma that is categorized as abuse and neglect as children, generations of their adult caregivers also have alcohol and drug abuse.

Some parents have allowed their teenager to smoke marijuana, which then has led the youth to use other drugs with their peers.

Maria commented,

Environmental factors affect clients via the lack of stable housing and job insecurity. Not being able to make enough to pay bills keep clients in despair, poverty for which they turn to drugs as comfort.

Seth stated the following:

Clients in sober housing often relapse when they go home on pass from sober housing or visiting friends. They have not been able to master the triggers that come about in their environment. Now that Narcan is available in the communities, some of the clients are involved in “Lazarus parties.” The drug of choice during these parties is often Carfentanyl. If an individual has an overdose, there is a designated sober person who will stand by with Narcan with the intent of bringing party-goers “back to life.” However, Carfentanyl is known to have unpredictable levels of potency, which can lead to terminal consequences. Also, there is an overreliance or believe from illicit opioid users that Narcan is always foolproof in reviving individuals who overdose, and it is not. Furthermore, the stigma associated with drug addiction in our society is still very negative, there is a lot of shaming, which also prevents individuals from seeking formal/clinical assistance.

Angela commented,

Parents and other support persons for clients need to be in a group themselves. They are just as affected by the loved one’s drug use (emotionally). If the support person can be in connection with a support entity, they can continue to find means and strength to also support their loved one who is struggling with sobriety.

Tom said the following:

Clients have an “addict mentality”; I want what I want now. We watch TV and it promotes our ailments can be solved by taking a pill. In the substance abuse community, we need to examine practices that do not lead to the person forming

another habit tied to a drug. I really like to promote a variety of ways to build coping mechanisms. Parents are so busy now, they also just want the youth to take a pill to get better, to behave, when in fact the youth may need to just have some of their time. We do not teach activities to “regulate” emotions - mindfulness comes to mind as well as healthy eating and exercise. The rewiring of the brain due to trauma as a child or in adulthood places individuals at risk for drug use. They continue to lack the needed mechanisms to combat triggers and see value in their lives. Knowing the length of time to look at brain changes is also something that seems to be unknown.

Angela commented,

Clients often involve themselves in antisocial behaviors to obtain the illicit opioids. Clients she sees are often involved in prostitution and domestic violence situations. The ones involved in prostitution have also developed such health problems as hepatitis C and HIV. Clients have also alienated themselves from their families. Some have been involved with child welfare agencies as they were not able to care for their minor children.

Maria stated the following:

I have noticed that low functioning adults are often taken advantage of and end up in human trafficking and using drugs. Those involved in human trafficking did not originally use illicit opioids but were forcefully given the drugs to make them compliant with sex acts and, therefore, they end up being dependent.

A client's inability to handle triggers in their environment, per the participants, is a significant barrier to the clients participating in services that offer trauma-informed care. Trauma affects not only the opioid use disorder client but also their family and other supports. Many times, the client's families are providing for their basic needs. When this is no longer a viable support for them, clients turn to antisocial behaviors per the participants, which can lead to further degradation of their wellbeing. A few participants felt that the provision of TIC supportive services to the client's families would be beneficial.

Unexpected Findings

Treatment of opioid use disorder often includes a TIC approach and a client being involved in a MAT program as a standard method of treatment (SAMSHA, 2014). Therefore, the participants' apprehension with the MAT drug Suboxone (buprenorphine and naloxone) was not a specific concern I had readily heard in the field. During the semistructured interviews, the participants had varied attitudes in relation to the value of MAT programs for individuals who have the diagnosis of opioid use disorder. Specifically, there were concerns of long-term dependence on Suboxone, and the lack of promotion, from their perception, for use of Vivitrol. The use of Suboxone in a MAT program is long term (SAMSHA, 2019). Some participants felt Suboxone continues the cycle of dependence on opioids. Another concern with the use of Suboxone (pill form) is its availability to be obtained in an illicit manner as it is not required to be administered by a doctor or in a MAT clinic (New Hope Recovery Center, 2013). Now that more is known scientifically about the ill effects of trauma and drug use on the brain, the

participants who expressed concern, felt that the long-term utilization of an opioid derivative drug via a MAT program did not lead to the brain resetting itself for healthy functioning.

Vivitrol (naltrexone), is an opioid blocker, not an opioid compound, and is a MAT alternative drug option to Suboxone (New Hope Recovery Center, 2013). Vivitrol can also be used to treat alcoholism and is a treatment option only after the individual has been free from opioid use within the past 7-10 days (Alkermes, Inc., 2013). According to Alkermes, Inc. (2013), Vivitrol is a monthly injectable shot that is only administered in a medical setting or at a MAT clinic, which makes the drug quite unlikely to be resold on the street. However, a complicating factor is that Vivitrol is an opioid antagonist used to block cravings and does not deal with withdrawal symptoms, while Suboxone is a mixed agent that blocks cravings, but also prevents the opioid addict from experiencing withdrawal symptoms (SAMHSA, 2005). Which drug to use in a MAT treatment program therefore should be openly discussed between the client and their treatment team to achieve optimal results.

The lack of a standard trauma screening was also another unexpected finding. All participants spoke that their agencies used TIC practices, however, only 3 of the 5 stated that a trauma screening was routinely used as part of the initial assessment process for clients. According to SAMSHA (2014), screening for trauma during initial assessment can benefit clients and the clinicians by: serving as a reminder that trauma can influence a client's engagement and interaction with services across the continuum of care, helping

the clients to become aware of the impact of trauma in their lives, and stressing the importance of addressing trauma related issues during treatment.

Summary

Currently, there is an opioid crisis in Ohio and nationally (United States Department of Health and Human Services, 2019). The purpose of this study was to explore social work perspectives on trauma-informed care for persons with opioid use disorders in Ohio. The participants were able to openly discuss how trauma-informed care practices were used in treatment with individuals diagnosed with opioid use disorder, along with professional challenges and client-based environmental factors, that also impeded successful treatment. The themes that emerged from the semistructured individual interviews answered the study's two research questions by highlighting social work perspectives on their implementation and challenges of providing TIC to opioid use disorder clients in Ohio. Specifically, the participants were able to verbalize barriers to providing TIC practices within their own organizations as well as how environmental factors affected the efficacy of evidenced-based interventions. Section 4 will outline the application of professional ethics in social work practice, implications for social change, recommendations for social work practice, and a summary of the research study.

Section 4: Application to Professional Practice and Implications for Social Change

The purpose of this research study was to understand social work perspectives on trauma-informed care for persons with an opioid use disorder. I used a qualitative design in the action research project, with purposive sampling of outpatient social workers who treat clients with opioid use disorder in Ohio. Data were collected from five social workers who met recruitment criteria during individual semistructured interviews. This qualitative approach was used to explore social workers' subjective perceptions. The following themes emerged out of the data collection: (a) appreciation for trauma-informed opioid use disorder treatment, (b) organizational and professional challenges to the use of trauma-informed opioid use disorder treatment, and (c) environmental barriers to successful trauma-informed outpatient opioid use disorder programming.

In the summary of the findings, I described social work perceptions and client barriers to trauma-informed care within opioid use disorder treatment. The participants' data may help to inform the role of TIC practices with clients. I also highlighted the role of the environment and trauma prior to age 18 in relation to successful treatment. These findings may assist in identifying successful tenets that can be used in their work, lead to further examination in relation to treatment planning and organizational structure of treatment services with opioid use disorder clients, and enhance social work knowledge that can promulgate social worker perceptions and attitudes in the social work field.

In Section 4, I describe the application for professional ethics in social work practice, recommendations for social work practice implications for social change from the findings, and a summary of the research.

Application for Professional Ethics in Social Work Practice

The NASW Code of Ethics is intended to serve as a guide to the daily professional conduct of social workers (NASW, 2018). This research study supports the NASW Code of Ethics promotion of advocacy and improved practices and sharing of knowledge with peers for better outcomes for the clients served. The following values and principles from the NASW code of ethics are related to the social work practice problem of my study: helping individuals in need, enhancing clients' dignity and worth, and addressing social problems. Social workers are actively involved in seeking solutions to social problems (NASW, 2018). Understanding barriers to successful treatment helps to guide social work practices by leading to increased competency, service, and awareness. These principles/values are also tied directly to the underpinnings of TIC practices.

TIC is known to social workers as being strengths-based and client centered; therefore, TIC aligns well with the NASW Code of Ethics (Kawam & Martinez, 2016). According to SAMHSA (2018), TIC practices also seek to understand the widespread impact of trauma and potential paths for recovery; integrate knowledge about trauma into policies, procedures, and practices; and work collaboratively with clients in a manner that empowers. Findings from this study may help to solidify the need and usefulness of TIC practices within organizations that serve opioid use disorder clients, expound upon successful evidenced-based programming, and highlight and acknowledge the perspectives and challenges of social workers who treat this population.

Recommendations for Social Work Practice

After a review of the findings, there are two action steps recommended. These recommendations relate to identified challenges for social workers in Ohio in implementing TIC when providing outpatient treatment to opioid users.

The first action step is that social workers in TIC programs incorporate the use of an evidenced-based trauma screening tool during intake assessment. Through this strategy, a trauma screening tool becomes normalized in the service array provided (Kawam & Martinez, 2016). Only two of the five study participants verbalized using a formal trauma screening tool, although all confirmed following trauma-informed care principles in their work. All the participants noted that trauma does play a prominent role in the client's illicit use of drugs and sobriety as well as how the clients perceive and respond to triggers in their environment. According to Ogden, Minton, and Pain (2006), the frequency, chronicity, and intensity of the trauma events must be considered in determining the impact on a person. TIC causes a shift in analysis in relation to how a treating social worker views individuals and social problems, and it can be added to any existing therapy (Kawam & Martinez, 2016). Consistent use of an evidence-based trauma screening tool, such as the Trauma History Questionnaire (Hooper, Stockton, Krupnick, & Green, 2011) or Brief Trauma Questionnaire (Schurr, Spiro, Vielhauer, Findler, & Hamblen, 2002) would help gather trauma details that can help to formalize a treatment plan that meets the individual needs of the client.

The second action step is to advocate and promote continuing education for social workers in Ohio who treat opioid use disorder clients on TIC practices. TIC practices and

key principles benefit the client and social worker through promoting resilience, organizational safety, trustworthiness, transparency, and cultural sensitivity (SAMHSA, 2014). All localities in Ohio, urban and rural, are faced with how to provide effective and successful treatment (Ohio Department of Mental Health and Addiction Services), 2016) to opioid use disorder clients. Through continuing education, social workers can share perspectives and experiences leading to better outcomes for clients; addressing macro issues; improving knowledge in relation to harm reduction, trauma informed care practices, and evidenced-based programming; and addressing secondary trauma in social workers. Knowledge of interventions applicable to one's specialty is extremely vital to not only understand in theoretical terms but also in practical application (Human Services Educational Guide Organization, 2018). Shared knowledge can also lead to social workers acting as change agents and social advocates for clients with opioid use disorders, particularly with governmental, regulatory, and community entities.

Usefulness of the Findings

Currently, I am in the role as a lead child welfare administrator overseeing the implementation of a new program in Ohio called Ohio START. According to PCSAO (2018), Ohio START is an intervention program that provides specialized victim services to children who have suffered victimization, with substance abuse of a parent being the primary risk factor, and assists parents of children referred to the program with their path to recovery from addiction. Ohio START requires the partnering of county child welfare agencies, behavioral health providers, and juvenile/family courts (PCSAO, 2018). The program is funded by a state grant. The goals of Ohio START include creating an

opportunity for a new best practice model designed to lead to better outcomes for children and families impacted by opioids and other drugs, stabilizing families harmed by parental drug use so that children and their parents can recover, and moving forward with abuse free and addiction free lives (PCASO, 2018).

The findings from this study will aide my work with Ohio START peers around the state by sharing social work perspectives on work with opioid use disorder clients from a TIC lens, as well as enhance my role as a change agent as I partner with peers on funding and policy reform to address needs of this population. The Ohio START program also has a research team that elicits information from me in relation to the program participants and intervention model effectiveness. I have gained valuable knowledge concerning qualitative methodology through my action research study process that has allowed me to interact with the researchers in a competent manner. Additionally, the findings from my action research study has further expanded my knowledge base of social work perspectives in relation to trauma-informed opioid use disorder treatment. The findings of this study will allow me to speak with specificity about the barriers and gaps in services that social workers and clients face in relation to successful trauma-informed opioid use disorder treatment in Ohio.

Transferability of the Findings

Subject selection in qualitative research is purposeful (Sargeant, 2012). This research was specific to social work perspectives on TIC with opioid use disorder clients in Ohio and, therefore, cannot be generalized. However, the information gained can be shared with the social work profession to address critical gaps in the continuum of care

and be a platform for further focused work. I also aimed to inform interprofessional multidisciplinary team base care models to help combat the opioid epidemic, inclusive of the social work profession. This action research study had a diverse group of participants, and their cumulative years of practice experience was 59 years working with opioid use disorder individuals. According to Zubin and Sutton (2014), qualitative research provides unique opportunities for expanding a clinician's knowledge about the social and clinical environment of practice.

Limitations of the Findings

This research study addressed social work perspectives on TIC for persons with opioid use disorder in Ohio. The limitations of this study are due to the small, purposive sample size ($N = 5$) and participants' background info. Therefore, the design of the study may be replicated, but the external validity of the study is limited; results may not be generalizable to all social work practitioners working with opioid use disorder clients. The study participants all worked with opioid use disorder clients for a range of 4 to 27 years in rural and urban areas of Ohio, were very diverse in terms of gender, race, and age, had at a minimal of a bachelor's degree in social work, and most had some form of state licensure. In the United States, each state has a unique set of requirements for social workers who treat individuals in the substance abuse field that includes exams, college degree education for specific levels of licensure, and certification. Therefore, social workers with different characteristics than the study sample of participants may have different outcomes (Human Service Education Guide Organization, 2018).

Recommendations for Further Research

The opioid epidemic is a national crisis in the United States (United States Department of Health and Human Services, 2019). In this action research study, I recruited five social workers through purposive sampling with specific educational backgrounds, work roles, and geographic location criteria. To gain further data and widen knowledge of social work perspectives on TIC for persons with opioid use disorder, research is recommended with additional practitioners inside and outside of Ohio. Subsequently, action research studies on this topic could contribute to a growing body of scholarly information increasing awareness, barriers, gaps, and services to the opioid use disorder population.

Dissemination of the Research

The first opportunity to share the findings of this study will be with the study participants in an executive summary via U.S. postal service or email. The second opportunity is to seek publication of my action research study in social work journals. Publications in social work journals help to advance theoretical understanding, shape policy, and inform practice (Shardlow, 2019). There may also be opportunities to present the findings of this study in state and national conferences focused on treatment of persons with opioid use disorders.

Implications for Social Change

This action research study has promise for positive contribution to the field of social work in relation to practice, research, and policy on a micro, mezzo, and macro level due to the rich data provided. According to Austin and Sutton (2014), qualitative

research offers unique opportunities for understanding complex, nuanced situations, for which interpersonal ambiguity and multiple interpretations exist.

Social workers help individuals, families, and communities restore their capacity for social functioning and work to create societal conditions that support communities in need (Forenza & Eckert, 2017). On a macro level, this study may lead to increased awareness about opioid use disorder and encourage policy and practice changes that benefit social work practitioners and clients. Mezzo level change, because of the dissemination of this study, could serve as an impetus for localities to address trauma-informed drug prevention programming and hold community forums to outline supports that are needed to properly address the needs of the targeted population. Social workers on a micro level work seek to stabilize dysfunctional families. Parents who have substance abuse issues place their children at risk of removal from their home, thereby causing additional hardship and trauma for the entire family. With information for this study, it is hoped that barriers and challenges to trauma-informed services offered to parents with opioid use disorder can be understood and addressed in a manner that allows for the children to stay in their home safely, rather than being placed in congregate care.

I have been a social worker for 30 years in the child welfare field. The opioid crisis in Ohio has led to increasing numbers of youth and families being referred to the child welfare system (PCSAO, 2017). Child welfare is not able to combat this societal problem singularly. In my professional role, I work collaboratively with community social workers who are specially trained in chemical dependency and addiction services.

Our meetings review how to best serve adults with opioid use disorders including discussions on barriers, gaps and use of trauma informed care practices. These discussions were the catalyst for me conducting this study.

Summary

Over 5,000 Ohioans died from an opioid overdose in 2017 (CDC, 2018). Nationally, 115 Americans die daily from an opioid overdose (NIDA, 2018). According to CSWE (2018), social workers are one of the largest providers of professional substance use services in the United States, placing them in a unique position to battle addiction across the continuum of treatment modalities. The social work participants for this study voiced a passion and readily gave their perceptions as they pertained to the opioid use disorder population and the use of TIC. They actively practiced TIC principles despite challenges and barriers that present themselves. Thematic analysis was used for this action research study for determining social work perspectives on TIC for persons with opioid use disorder in Ohio. Three themes that also highlighted answers to the two research questions were identified from the data analysis: (a) appreciation for trauma-informed opioid use disorder treatment (b) organizational and professional challenges to the use of trauma-informed opioid use disorder treatment, and (c) environmental barriers to successful trauma-informed outpatient opioid use disorder programming. I plan to disseminate the findings of this study to enhance the profession's knowledge of how social workers implement TIC when providing outpatient treatment to opioid users and the challenges that go along with providing clinical services to this population.

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Appendix A: Applicant Background Questionnaire

This information will be gathered by the principle researcher with the prospective applicant prior to conducting the individual semi-structured qualitative interview. The sole purpose is to ensure that the volunteer participants involved in the semi-structured qualitative interviews meet the study participant qualifications. All information is kept confidential.

Name:

Best way to contact you:

Age:

Race:

Gender:

Education: (name type of degree and designation):

List type of Ohio licensure or certification:

Number of years in the field working with individuals with opioid/drug addiction:

Numbers of years post Associate degree working in the social work field:

Current work title:

Is your work role in a private or public outpatient entity?

Are you in private practice?

Employer setting: (i.e. rural, urban):

Employer type: (i.e. mental health, drug addiction, (both) etc.):

Are you currently a social worker treating clients an opioid use disorder?

Population age group you work with: (circle one)

Under age 18

Over age 18

Both

Do you professionally practice and work in an agency that follows the below definition of trauma-informed care approach and trauma-specific interventions?

(circle one): Yes No

Appendix B: Individual Semistructured Qualitative Interview Questions

The following questions are related to your perspectives on trauma-informed care for opioid users in Ohio outpatient treatment centers. Your responses are being recorded and will be transcribed later. If you are uncomfortable with any of the opened-ended questions with subsequent probes, please let the researcher know. All information will be kept strictly confidential.

1. What trauma-informed care implementation challenges do social workers in Ohio incur when providing outpatient treatment to opioid users?
2. How do social workers in Ohio implement trauma-informed care when providing outpatient treatment to opioid users? Does your agency utilize any of kind of trauma assessment or scale with clients and if so, which one?
3. What is your perspective on the interrelationship between trauma, mental health, and drug use among individuals with opioid use disorder?
4. From your clinical perspective, how does trauma exposure prior to age 18, play a role in opioid addiction?
5. What clinical interventions(s) have led to successful outcomes for individuals with opioid use disorders in an outpatient setting?
6. What environmental factors do you see as playing a significant role in opioid use disorder?
7. From your clinical perspective why has the number of opioid overdose deaths significantly increased in Ohio over the past 5 years?

Thank you for your participation!

Appendix C: Trauma Definitions

Substance Abuse and Mental Health Services Administration (2018) defines “trauma- informed care approach as a program, organization or system that is trauma informed:

1. Realizes the widespread impact of trauma and understands potential paths for recovery;
2. Recognizes the signs and symptoms of trauma in clients, families, staff, and other involved with the system;
3. Responses by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist re-traumatization.”

Trauma-specific intervention programs recognize the following:

1. The survivors need to be respected, informed, connected and hopeful regarding their own recovery.
2. The interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression and anxiety.
3. The need to work in a collaborative way with other survivors, family and friends of the survivors, and other human services agencies in a manner that will empower survivors a consumer (SAMHSA, 2018).