Stigma as Discrimination: Impact on Treatment and Strategies for Success
REMINDERS

FOR ZOOM CALLERS

- Review sign-on instructions carefully to assure a good audio experience.
- **Enter audio code** when using both computer and phone for better audio quality for all.
- **Please mute audio**
- **Please note your name**, then add your comment or question

FOR IN-PERSON ATTENDEES

- Please speak towards the microphones

Use the Zoom Mute, Start/Stop Video, and Chat Box if needed
WELCOME

FELICITY BERNARD, LCMHC, MA
Project Director, NH Citizens Health Initiative
AGENDA

WELCOME & INTRODUCTION
Felicity Bernard, LCMHC, MA, NH Citizens Health Initiative

ADDRESSING STIGMA TO IMPROVE THE TREATMENT OF OPIOID USE DISORDER
Lisa Letourneau, MD, MPH, Senior Advisor, Delivery System Change, Maine DHHS

HARM REDUCTION APPROACHES IN ADDRESSING SUBSTANCE USE
Kerry Nolte, PhD, FNP-C, Department of Nursing, University of New Hampshire

QUESTIONS & ANSWERS
Felicity Bernard, LCMHC, MA, NH Citizens Health Initiative

CLOSING REMARKS
Felicity Bernard, LCMHC, MA, NH Citizens Health Initiative
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- **Planner: Frederick Kelsey, MD, FACP, retired Medical Director**, Mid State Health Center
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- **Planner: Laura Remick, MEd, CHES**, Education and Workforce Coordinator, North Country Health Consortium
- **Planner: Jill Gregoire, RN, MSN, Lead Nurse Reviewer**, North Country Health Consortium
- **Planner & Presenter: Felicity Bernard, LCMHC, MA** Project Director, Institute for Health Policy and Practice, UNH
- **Presenter: Lisa Letourneau, MD, MPH, FACP** Senior Advisor, Delivery System Change, Maine DHHS
- **Presenter: Kerry Nolte, PhD, FNP-C**, Assistant Professor of Nursing, UNH
LEARNING OBJECTIVES

After participating in this activity, learners will be able to:

1. Recognize the importance of addressing stigma to promote access to and quality of integrated care delivery for patients and families affected by behavioral health (BH) challenges, especially opioid use disorder (OUD).

2. Summarize current evidence about the etiology and effective treatment of OUD and how stigma can impact delivery of evidence-based care.

3. Describe strategies to reduce stigma in BH/OUD care delivery such as changes in language and addressing misconceptions about BH/OUD causes and recovery.
FELICITY BERNARD, LCMHC, MA
Project Director, NH Citizens Health Initiative
Self - Stigma

Awareness
The public thinks that people with mental illness are weak

Agreement
That is right. People with mental illness are weak.

Apply
I am mentally ill so I must be weak.

Harm
Because I am weak, I am not worthy or able

SO WHY TRY...

(Corrigan and Rao, 2012)
LISA LETOURNEAU, MD, MPH
Senior Advisor, Delivery System Change, Maine DHHS
Addressing Stigma to Improve the Treatment of Opioid Use Disorder

Lisa M. Letourneau MD, MPH
April 1, 2019

A Tri-State Collaborative Program
Managed by Maine Quality Counts
Disclosures

- No commercial interests
Learning Objectives

1. Understand role of stigma in caring for people with SUD
2. Recognize neurobiology of addiction in treating SUD with chronic disease model
3. Identify role of stigmatizing language and compassion fatigue as potential barriers in caring for people with SUD
Who’s Heard?...

- He’s just another addict...
- She doesn’t deserve another chance...
- You’re just substituting one drug for another...
- You’re just another drug dealer...
- Is he going to be on Suboxone forever?....
- Medications aren’t recovery...
### Moral Model of Drug Use
- Drugs are bad
- People choose to use drugs
- People who use drugs are bad
- Drug use is moral failure
- People who use drugs can choose to stop
- We can make people stop using drugs if we make their lives uncomfortable (e.g. jail)
- Medications to treat SUD are just trading one addiction for another

### Behavioral/Med Model Drug Use
- People learn to use drugs to cope with suffering
- Early exposure & trauma are strongly related to dev of SUD
- SUD alters brain structures & chemistry & becomes med condition
- Physical dependence/cravings with some drugs (e.g. opioids) creates neg cycle of cont’d use
- Medications are effective in treating SUD; abstinence only is often ineffective
Current State of Affairs: Do Clinicians...

- Think SUD is different from other chronic conditions because using substances is a choice?
- Think treatment with opioid agonist is replacing one drug w/ another?
- Feel people who use drugs are committing crime & deserve punishment?
Current State of Affairs?

- 31% felt SUD is different from other chronic conditions because using substances is a choice
- 14% thought treatment with opioid agonist is replacing one drug with another
- 12% said people who use drugs are committing crime & deserve punishment

Wakeman S et al, Attitudes, practices & preparedness to care for SUD: Results from survey general internists, *Sub Abuse*, 2016
Stigma

▪ Strong feelings of disapproval or disgrace that sets a person apart from others
▪ Associated with negative attitudes & beliefs
▪ Can lead to negative actions, discrimination
▪ Self-stigma also significant challenge in SUD
Stigma & SUD: Many Targets

- The person
- The disease
- The treatment
- Overdose rescue
- The “right” pathway to recovery...
Neurobiology of Addiction

- Stages of addiction:
  - Use/ binge \(\rightarrow\) intoxication, dopamine release ("reward system")
  - Withdrawal \(\rightarrow\) negative effect
  - Preoccupation / anticipation \(\rightarrow\) pursuit

- Addiction changes brain structures & neurochemistry, resets brain’s reward system

- Depicting addiction:
  
  **Nuggets**

A Tri-State Collaborative Program Managed by Maine Quality Counts
Anatomy of Addiction

Brain's Reward System

Cerebral cortex
Nucleus accumbens
Amygdala
Hippocampus

www.drugabuse.gov
Neurobiology of Addiction

- Addiction changes brain structures, brain chemistry
- Resets brain’s reward system
  - Over time, drug consumption triggers less dopamine, more reactivity to stress, negative emotions
- Changes disrupt...
  - Executive functioning
  - Decision making
  - Self-regulation
SUD Treatment with Medications (MAT) Works, AND Still Greatly Underused

▪ Strong evidence for effectiveness of medications for OUD treatment - i.e. methadone, buprenorphine, naltrexone
  – Save lives, decreases OD deaths
  – Reduce harm from illicit drug use
  – Reduce craving, allowing more focus on recovery
  – Decrease risk of relapse, increases rates of recovery

• AND, strong evidence that MAT still widely under-utilized – in Maine & nationally
FDA-Approved Medications for OUD

- **Methadone**
  - Opioid agonist, FDA-approved since 1971
  - Can only be administered by federally-recognized “Opioid Treatment Program” (OTP/methadone clinic)

- **Buprenorphine**
  - Partial opioid agonist, FDA-approved in 2002
  - Can be administered in office-based treatment programs by prescribers with DEA X-waiver or OTP
  - Can be prescribed X3 doses by any DEA licensed physician

- **Naltrexone**
  - Opioid antagonist/blocker, FDA-approved in 1984 (tabs), 2010 (IM)
  - Can be administered by any prescribing clinician
  - Available as IM, tablet (poor adherence, not widely used)
"Abstinence" vs. Buprenorphine

Maintenance: 75% Abstinent at 1 year
0% mortality

No meds ("Detox"): 0% Abstinent at 1 year
20% mortality!

HR = 58.7, p .0001

Kakko, Lancet 2003
Defining Addiction

▪ “A chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences

▪ Considered brain disease because drugs change the brain... structure and how it works... that can be long lasting and lead to many harmful, self-destructive behaviors”*

*NIH National Institute of Drug Abuse
Addiction is Chronic Disease

COMPARISON OF RELAPSE RATES BETWEEN DRUG ADDICTION AND OTHER CHRONIC ILLNESSES

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percent of Patients Who Relapse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Addiction</td>
<td>40 to 60%</td>
</tr>
<tr>
<td>Type 1 Diabetes</td>
<td>30 to 50%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>50 to 70%</td>
</tr>
<tr>
<td>Asthma</td>
<td>50 to 70%</td>
</tr>
</tbody>
</table>
Does Language Matter?

- Randomized trial used case vignettes test impact of specific language on clinicians’ assessment of pts
- Using “substance abuse” vs. “SUD” strongly correlated with negative clinician beliefs - i.e.
  - Individuals personally culpable for their disease
  - Punitive measures should be taken
- Many words can trigger negative associations – e.g.
  - Relapse vs. recurrence of use
  - Pharmacotherapy vs. Medication Assisted Therapy


Language Matters

**SAY THIS**
- Person with a substance use disorder
- Person in recovery
- Person living with an addiction
- Person arrested for a drug violation
- Chooses not to at this point
- Medication is a treatment tool
- Had a setback
- Maintained recovery
- Positive drug screen

**NOT THAT**
- Addict, junkie, druggie
- Ex-addict
- Battling/suffering from an addiction
- Drug offender
- Non-compliant / bombed out
- Medication is a crutch
- Relapsed
- Stayed clean
- Dirty drug screen

**IN YOUR CONVERSATIONS**
- Frame the conversation as a health issue
- Use examples of people who have reached long-term recovery
- Discuss the fact that people can and do change.
- Share Hope!
<table>
<thead>
<tr>
<th>USE</th>
<th>DON’T USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person who uses drugs</td>
<td>Drug user</td>
</tr>
<tr>
<td>Person with non-problematic</td>
<td>Recreational, casual, or experimental users</td>
</tr>
<tr>
<td>drug use</td>
<td></td>
</tr>
<tr>
<td>Person with drug dependence,</td>
<td>Addict; drug/substance abuser; junkie; dope head, pothead, smack head,</td>
</tr>
<tr>
<td>person with problematic drug use</td>
<td>crackhead etc.; druggie; stoner</td>
</tr>
<tr>
<td>person with substance use disorder;</td>
<td></td>
</tr>
<tr>
<td>person who uses drugs (when use is not problematic)</td>
<td></td>
</tr>
<tr>
<td>Substance use disorder;</td>
<td>Drug habit</td>
</tr>
<tr>
<td>problematic drug use</td>
<td></td>
</tr>
<tr>
<td>Has a X use disorder</td>
<td>Addicted to X</td>
</tr>
<tr>
<td>Abstinent; person who has stopped using drugs</td>
<td></td>
</tr>
<tr>
<td>Actively uses drugs; positive for substance use</td>
<td>Dirty (as in “dirty screen”)</td>
</tr>
<tr>
<td>Respond, program, address,</td>
<td>Fight, counter, combat drugs and other combatant language</td>
</tr>
<tr>
<td>manage</td>
<td></td>
</tr>
<tr>
<td>Safe consumption facility</td>
<td>Fix rooms</td>
</tr>
<tr>
<td>Person in recovery, person in</td>
<td>Former addicts; reformed addict</td>
</tr>
<tr>
<td>long-term recovery</td>
<td></td>
</tr>
<tr>
<td>Person who Injects drugs</td>
<td>Injecting drug user</td>
</tr>
<tr>
<td>Opioid substitution therapy</td>
<td>Opioid replacement therapy</td>
</tr>
</tbody>
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QC Substance Use Conversation Guide

▪ Effort to address stigma by improving care conversations
▪ Promotes...
  – Language that promotes self-esteem and self-efficacy
  – Use of motivational Interviewing to engage patients with SUD
  – Use of scripting to support better conversations
  – Coordination of treatment providers
▪ Suggested uses:
  – Introduce in staff meetings
  – Laminate tools and hang in break rooms
  – Identify practice team to pilot scripts
### Sample Scripts

#### 3) Office Visit Conversations Specific to Health Risks

<table>
<thead>
<tr>
<th>Situation</th>
<th>Provider Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicating that a procedure may be affected by substance use</td>
<td>&quot;When I do this procedure, I want to be sure you will have the best possible outcome. My worry is that there are signs that your procedure may be complicated by (substance x) use. I’d like to explain what these signs are and have you weigh in so we can best plan your procedure.&quot;</td>
</tr>
<tr>
<td>High health risks of using a substance</td>
<td>“Based on the screening results, you are at high risk of having a substance use disorder. It is medically in your best interest to stop your use of (substance X). I am concerned that if you do not make a change, the consequences to your health may be serious.”</td>
</tr>
<tr>
<td>Moderate health risks of using a substance</td>
<td>“Based on the screening results, you are at moderate risk of having or developing a substance use disorder. It is medically in your best interest to change your use of (substance x).”</td>
</tr>
<tr>
<td>Low health risks of using a substance</td>
<td>“Your screening results show you are unlikely to have a substance use disorder. However, people with any history of substance use can be at some risk of developing a disorder especially in times of stress or if they have just started to use recently. It is impossible to know in advance whether or not a person who will develop a severe substance use disorder. As your health provider, I encourage you to only use alcohol moderately (e.g. # number of drinks a week) and avoid using other substances”</td>
</tr>
</tbody>
</table>
Addressing Compassion Fatigue

- Use the team
- Have a partner
- Build in time for relationship
- Use trauma-informed approaches
- Celebrate the victories (recovery is energizing!)
- Recognize the humanity in everyone
Obituary: Madelyn Linsenmeir, 1988-2018

“Our beloved Madelyn Ellen Linsenmeir died on Sunday, October 7. While her death was unexpected, Madelyn suffered from drug addiction, and for years we feared her addiction would claim her life. We are grateful that when she died, she was safe and she was with her family...

...If you are reading this with judgment, educate yourself about this disease, because that is what it is. It is not a choice or a weakness. And chances are very good that someone you know is struggling with it, and that person needs and deserves your empathy and support.

If you work in one of the many institutions through which addicts often pass — rehabs, hospitals, jails, courts — and treat them with the compassion and respect they deserve, thank you. If instead you see a junkie or thief or liar in front of you rather than a human being in need of help, consider a new profession.”

What if We Treated Diabetes Like Addiction?

Would we...

• Imply (or say) that poor lifestyle choices have caused the disease?
• Say elevated blood glucose makes blood “dirty”?
• Plan to treat with insulin for only 2 years, then insist on changing lifestyle enough to taper off?
• Or... decline to treat at all?
• Insist that patients must go to diabetes education classes to continue treating them?
• Discharge patients from treatment if they choose to eat poorly, don’t lose weight, and/or have a persistently high blood sugar?
Busting the Myths

▪ SUD/OUD is hopeless – there’s no point in treating it
  – SUD/OUD is chronic condition that responds to tx
  – Recovery is possible

▪ I/We don’t believe in MAT
  – Evidence is strong for effectiveness of MAT
  – This is science, not a religion

▪ Isn’t it just substituting one drug for another?
  – Recognize huge difference between addiction and physical dependence
  – SUD tx/MAT allows people to return to functional lives
Changing Hearts & Minds

- The illness is not the person
  - Remember the humanity in everyone
  - No one would choose a life of addiction
  - This could be your son or daughter

- Treatment works & recovery is possible
  - Evidence for MAT effectiveness better than most other chronic conditions we treat
Addiction as Chronic Disease

- Comments?
- Questions?
- Suggestions?
NNE-PTN Organizational Partners

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Harm Reduction Approaches in Addressing Substance Use

Presented By:

KERRY NOLTE, PhD, FNP-C
The following individuals have responded that they have nothing to disclose:

- Kerry Nolte
Objectives

- Recognize multiple pathways into substance use and into recovery
- Describe harm reduction approaches to effectively support people who use drugs
Continuum of Excess, Moderation, and Abstinence

—Any steps toward decreased risk are steps in the right direction—

Graphic credit: Harm Reduction Coalition, adapted by Kevin Irwin
Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Mutual Support
• 12 Step Fellowships (Gamblers Anonymous, Narcotics Anonymous, Alcoholics Anonymous)
• Celebrate Recovery
• Faith Based Recovery
• Fit 2 Recover
• Life Ring Secular Recovery
• Moderation Management
• Nature & Buddhism
• Phoenix Multisport
• Red Road to Wellbriety
• SMART Recovery
• Volunteerism
• Women for Sobriety
• Yoga

Medication Assisted Recovery
• Methadone
• Buprenorphine
• Naltrexone
• Acamprosate
• Disulfiram
• Functional Medicine, NTR, and Nutrient Therapies
A Continuum of Substance Use

Abstinence Chaotic

Experimentation - Occasional/Social

Regular

Heavy - Chaotic

Adapted Graphic credit: Kevin Irwin
Reframing the Starting Point: Engagement in Care

Acceptance

- Provider Humility
- Curiosity to Learn About SUD

→ Supportive and Pragmatic Conversation
Less About What You Say

More About Your Approach
Every Interaction Can Be An Opportunity to Engage

- Client goals are most likely be achieved
- Untimely push for abstinence only goals is likely to result in lower engagement
- Goal: provide support and resources for client’s self defined goals
- PWUD are interested and capable of making changes to improve health and safety
  - Safety messages shared could be rapidly spread through a social network
- Recognize and support readiness to change, whether safer injecting or recovery
Drug
- The drug itself: what it does and how potent it is
- What it is cut with
- How it is used: smoke, snort, absorbed, swallowed, injected
- Whether it is illegal or legal

Set
- Person’s unique physiology
- Person’s physical health
- Person’s mental or emotional state
- Person’s cultural identity, culture of origin, sense of belonging
- Expectation of the drug and motivation for using the drug

Setting
- Stressors in a person’s life: Social, Economic, Environmental
- Support in PWUD’s life
- With whom and where a person uses
- Social and cultural attitudes toward the drug and its users
Syringe Service Program Engagement

OVERVIEW OF SERVICES

- Health Insurance Enrollment
- Opiate Overdose Prevention
- HCV & HIV Testing
- Woundcare
- Crisis Intervention
- Anonymous Services
  - Syringe Access
  - Sterile injecting supplies
  - Education & supplies
  - Referral to health & social services
  - Overdose prevention
  - Harm reduction

CARE COORDINATION

- Medical Case Management
- Non-Medical Case Management
Evidence for Syringe Service Programs and Harm Reduction

**How Do SSPs Benefit Communities and Public Safety?**

**SPPs Increase Entry Into Substance Use Disorder Treatment:**
SPPs reduce drug use. People who inject drugs (PWID) are 5 times as likely to enter treatment for substance use disorder and more likely to reduce or stop injecting when they use an SSP.

**SPPs Reduce Overdose Deaths:**
SPPs reduce overdose deaths by teaching PWID how to prevent and respond to drug overdose. They also learn how to use naloxone, a medication used to reverse overdose.

**Prevention Saves Money:**
SPPs save health care dollars by preventing infections. The estimated lifetime cost of treating one person living with HIV is more than $400,000. Testing linked to hepatitis C treatment can save an estimated 320,000 lives.

**SPPs Reduce Needlestick Injuries:**
SPPs reduce needlestick injuries among first responders by providing proper disposal. One in three officers may be stuck with a needle during their career. Increasing safe disposal also protects the public from needlestick injuries. SPPs do not increase local crime in the areas where they are located.

**3,600 HIV Diagnoses Among PWID in 2015:**
SPPs reduce new HIV and viral hepatitis infections by decreasing the sharing of syringes and other injection equipment. About 1 in 3 young PWID (aged 18-30) have hepatitis C.

**SSPs DON’T INCREASE DRUG USE OR CRIME.**
Safer Supplies

- Ask: “Are you able to get clean supplies (needles, cookers, cottons)?”
- If needles have to be reused, HCV can be reduced and HIV eliminated with bleach.7
  - Risk dramatically reduced with rinsing 3 times with water
- Advise using clean, single use works
  - Cottons, cookers, and clean water (sterile)
DISC ERNNE Preliminary Results

Drug Injection Surveillance and Care Enhancement for Rural Northern New England

N = 421

- 52% Shared Injection Equipment
- 44% Obtaining Syringes from Dealer, Street Seller, or Friend (NH)
  - 15% in VT
  - 13% in MA
- 42% in NH reported easy access to clean syringes
  - 80% in VT
  - 92% in MA
Safer Use

- Ask: “What steps do you take to keep yourself safe when using?”
  - Advise to not use alone and only with trusted people who can provide care if needed
  - Caution with all drug supplies and new sources
  - Avoiding taking all the drug at once and avoid rushing
    - Starting with a “test shot” may help prevent overdose as drug cannot be taken back once injected.6
  - Problem solve around a safer environment and/or opportunities to decrease frequency.
Microscope View of Needle After Use

https://imgur.com/Rh7RY
Safer Injecting Practices: Safer Use

Ask: “How do you prevent injury to your veins and infections?”

- Wash hands or use hand sanitizer/ alcohol
- Tourniquet improves vein access (fewer needle sticks, less risk for infection)
- Bevel up to avoid going through the vein
- Recognize valves in veins and inject above
- Recognize infections and when to seek care for wound/ illness/ infection
Safer Injecting Practices: Safer Disposal

- Bring them back to SSP!
- Some health, fire departments, and transfer stations provide safe places to dispose of syringes
- If sharps container unavailable use hard plastic detergent bottles, seal, and mark “DO NOT RECYCLE”

FDA RECOMMENDS ALWAYS USING AN FDA-CLEARED SHARPS CONTAINER.

If you cannot get a sharps container, use an empty household container with these features:

- Tight-fitting lid that cannot be punctured
- Stays upright
- Made of heavy-duty plastic
- Does not leak

Dispose of a household sharps container when it is 2/3 full:

2. Dispose using a sharps collection or mail back program.

OR

If you cannot find a disposal program, put container in center of household trash and discard in regular trash.
Overdose Prevention

- 68,000 OD deaths 2017 (U.S.)
- 2017 OD Deaths: 488 in NH and 418 in ME
Overdose Prevention

- Fentanyl Test Strips
  - Much of the opioid supply in the area has fentanyl
  - Great for those want to check their heroin supply or other drugs
  - Approx 68% with a positive test took measures to reduce risk and 23% who were negative also took measures to reduce risk
Health Promotion

- Offer Preventative Care: Screening, Testing, and Education
  - HIV testing is recommended at least annually for PWID
    - Include HIV 1/2 antibody and HIV 1 p24 antigen testing (positive 21 days after infection).\(^9\)
    - Consider discussing PreExposure Prophylaxis (PrEP) for HIV prevention. \(\text{(CDC, 2017)}\)
  - Hepatitis C antibody testing is recommended periodically for PWID.\(^{10}\)
  - Check immunization status
  - Discuss safe sexual practices
  - Review pregnancy prevention options
FOR MORE ON SAFER INJECTION PRACTICES

Find at HarmReduction.org
**OBJECT**

**ATTITUDE**
"I know best for person/group"

"I have the right to determine circumstances for P/G"

**RECEPTION**

**ACTION**
Deny care
Narrow the scope of care
Provide substandard care
Target for arrest/harass

**OUTCOMES**

---

**RECIPIENT**

**ATTITUDE**
"I know best" for person or group
(But I’ll ‘give’ opportunity to participate in my decision)

**RECEPTION**

**ACTION**
’Sell’ on particular ‘product’/idea
Offer narrow scope of options
Lying/withholding truths

**OUTCOMES**

---

**RESOURCE**

**ATTITUDE**
“You know better than me. Let me help you decide/improve/get you where you want to be.”

“I can learn from you.”

**RECEPTION**

**ACTION**
Educating
Goal-Setting
Offer accountability

**OUTCOMES**
A Continuum of Harm Reduction Integration

- Consistent
- Occasional

- Heavy
- LOVE
- GOLDEN RULE
- Public Health Model

- Disbelief
- Suspicion
- Resistance
- Apathy
- Negligence
- Homicide

Public Health Model
QUESTIONS ➤ ANSWERS
Harm Reduction Education and Technical Assistant Project

Provide education and support to NH providers on integrating harm reduction in practice:
- Academic detailing 1-on-1 visits with providers who connect with people who use drugs:
  - 150-200 providers in healthcare, community service agencies
- Provide technical assistance on integrating harm reduction:
  - 1 hour trainings at practice sites led by NHHRC
  - Resource provision and research
  - Biweekly case conferencing sessions
- Beginning June 2019
- Recruiting for:
  - Advisory group members
  - Academic detailers
  - Practice site participants
- For more info email HRETA.Project@unh.edu
Interested in Learning More?  
Getting Involved?  

www.nhhrc.org  

info@nhhrc.org
QUESTIONS & ANSWERS
CLOSING REMARKS
RESOURCES

<table>
<thead>
<tr>
<th>Staff Name</th>
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<td><a href="mailto:kelsi.west@unh.edu">kelsi.west@unh.edu</a></td>
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</tbody>
</table>
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