Welcome To the Stigma and Substance Use Disorder Training!

RCORP-Eastern Tennessee Consortium Meeting
Friday July 24, 2020 1:00 – 3:00 PM
Via Zoom

Training Lead By

Robert Childs

Co-Presenters

Andrew Bell

Donald McDonald

Rev. Michelle Mathis

Event Facilitator

Yanika Lewis

RCORP-TA

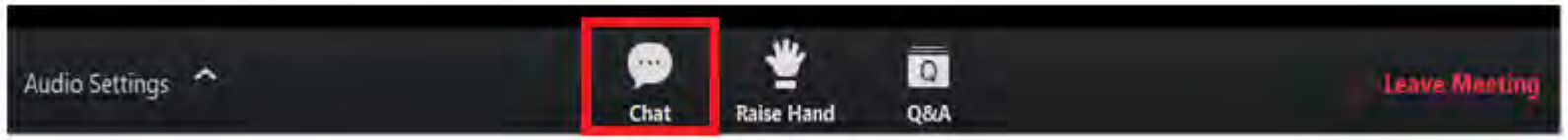
RURAL COMMUNITIES OPIOID RESPONSE PROGRAM - TECHNICAL ASSISTANCE

Housekeeping Items

We ask that everyone keep their lines muted during presentations.

There will be a 30-minute Q&A segment at the end.

Submit questions by using the chat feature. To open your chat window, click the chat icon on the bottom center of your Zoom window.



You will receive a satisfaction evaluation email after this training via email. We thank in advance for the for your participation in this training and the evaluation.

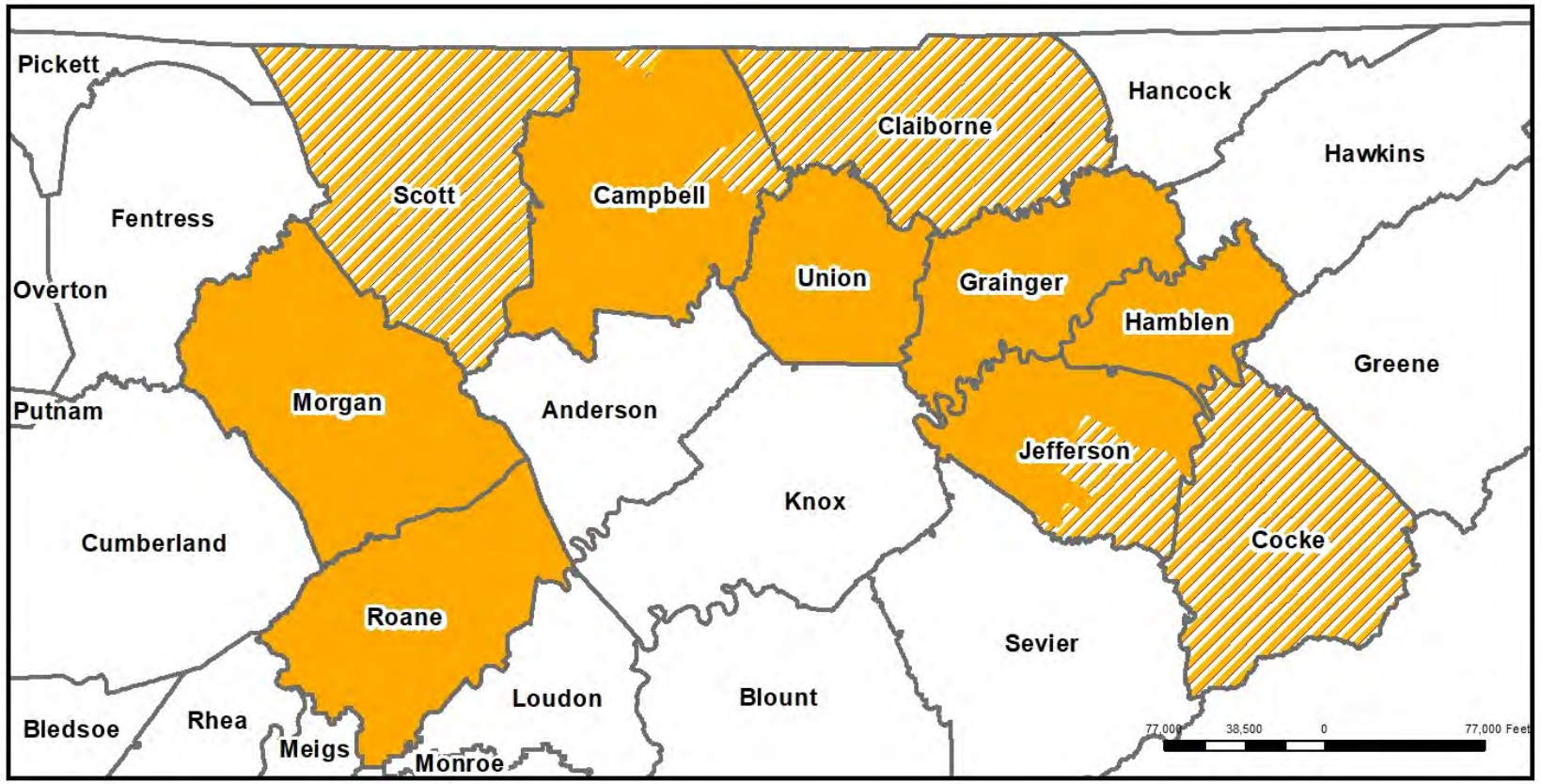
- Initiated in 2018 with RCORP-Planning grant from HRSA
- Developed
  - Assessment report
  - Strategic plan
  - Workforce development plan
  - Sustainability plan
- Top priorities
  - Stigma
  - Mental health promotion
  - Quality and quantity of substance use service providers

RURAL COMMUNITIES OPIOID RESPONSE PROGRAM FOR EAST TENNESSEE CONSORTIUM

RCORP-ETC

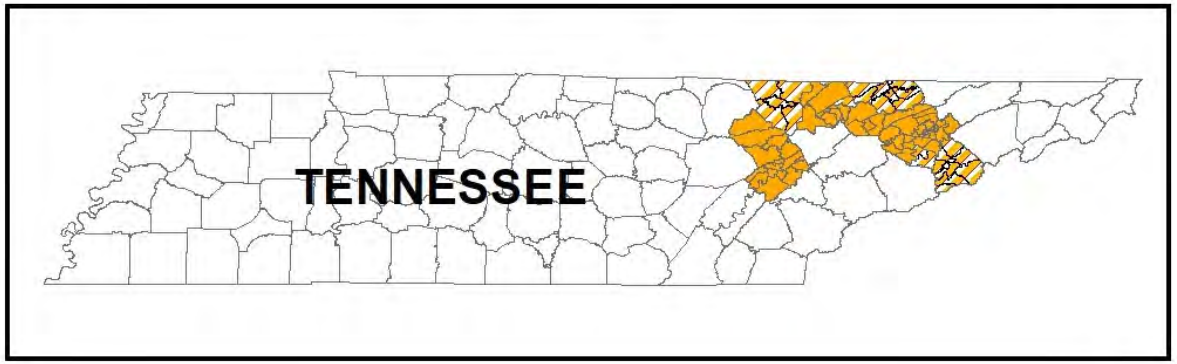
Project HOPE

HEALING OUD THROUGH PREVENTION AND EXPERTISE



Service Area

Non-Service Area



Project HOPE

HEALING OUD THROUGH PREVENTION AND EXPERTISE

- 2019-2022 RCORP-Implementation grant from HRSA
- Quarterly meetings
- Monthly working groups
  - Community
  - Provider
  - Youth
- Training, resources, youth programming, community capacity building

RURAL COMMUNITIES OPIOID RESPONSE PROGRAM FOR EAST TENNESSEE CONSORTIUM

RCORP-ETC

Project HOPE

HEALING OUD THROUGH PREVENTION AND EXPERTISE

Vision

To eradicate opioid use disorder, the Rural Communities Opioid Response Program – East Tennessee Consortium strives to create healthy communities by enhancing health promotion and prevention, collaboration, and access to health services and care. Together these efforts will promote safety, physical and emotional wellness, and economic security.

For More Information

- Laurie L Meschke at LLMeschke@utk.edu
- Jennifer Tourville at jtourvil@utk.edu
- https://tnopioid.utk.edu/

Addressing Adverse Childhood Experiences (ACEs)

Andrew Bell

Technical Expert Lead

JBS International

What are Adverse Childhood Experiences?

Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0–17 years).

ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood. ACEs can also negatively impact education and job opportunities. However, ACEs can be prevented.

https://www.cdc.gov/violenceprevention/acestudy/fastfact.html

The Original ACEs Study

The original ACEs Study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection. Over 17,000 Health Maintenance Organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences and current health status and behaviors.

More detailed information about the study can be found in this article.

https://www.cdc.gov/violenceprevention/acestudy/about.html

Examples of ACEs

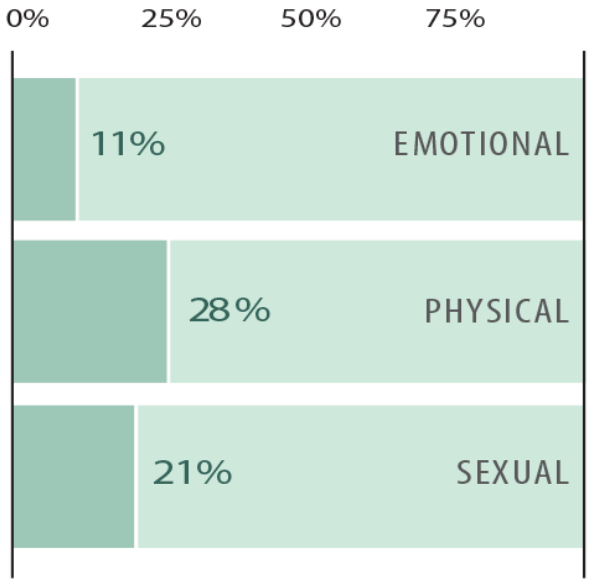
- Experiencing violence, abuse, or neglect
- Witnessing violence in the home or community
- Having a family member attempt or die by suicide:
- Parental substance misuse
- Parental mental health issues
- Instability due to parental separation or household members being in jail or prison

https://www.cdc.gov/violenceprevention/acestudy/fastfact.html

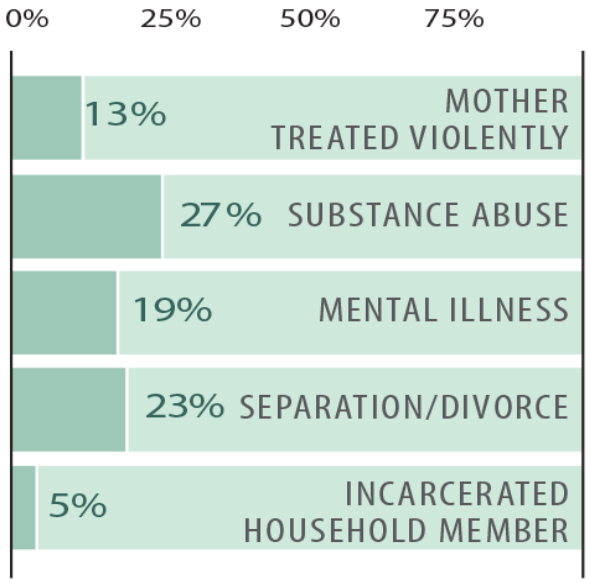
TYPES *of* ACES

The ACE study looked at three categories of adverse experience: **childhood abuse**, which included emotional, physical, and sexual abuse; **neglect**, including both physical and emotional neglect; and **household challenges** which included growing up in a household were there was substance abuse, mental illness, violent treatment of a mother or stepmother, parental separation/divorce or had a member of the household go to prison. Respondents were given an **ACE score** between 0 and 10 based on how many of these 10 types of adverse experience to which they reported being exposed.

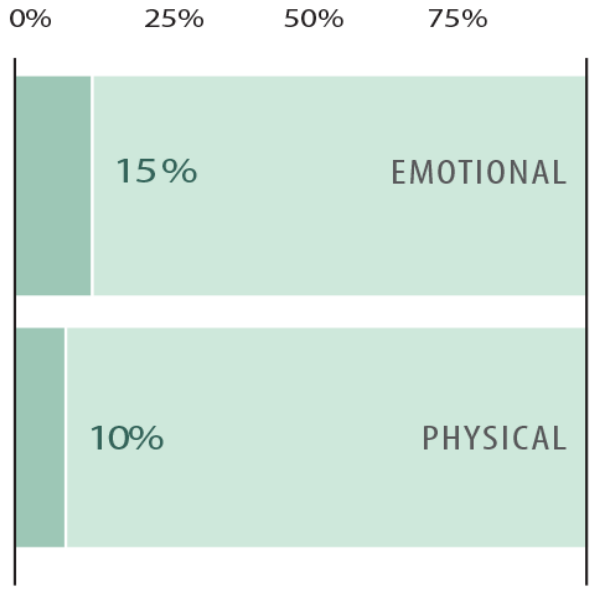
ABUSE



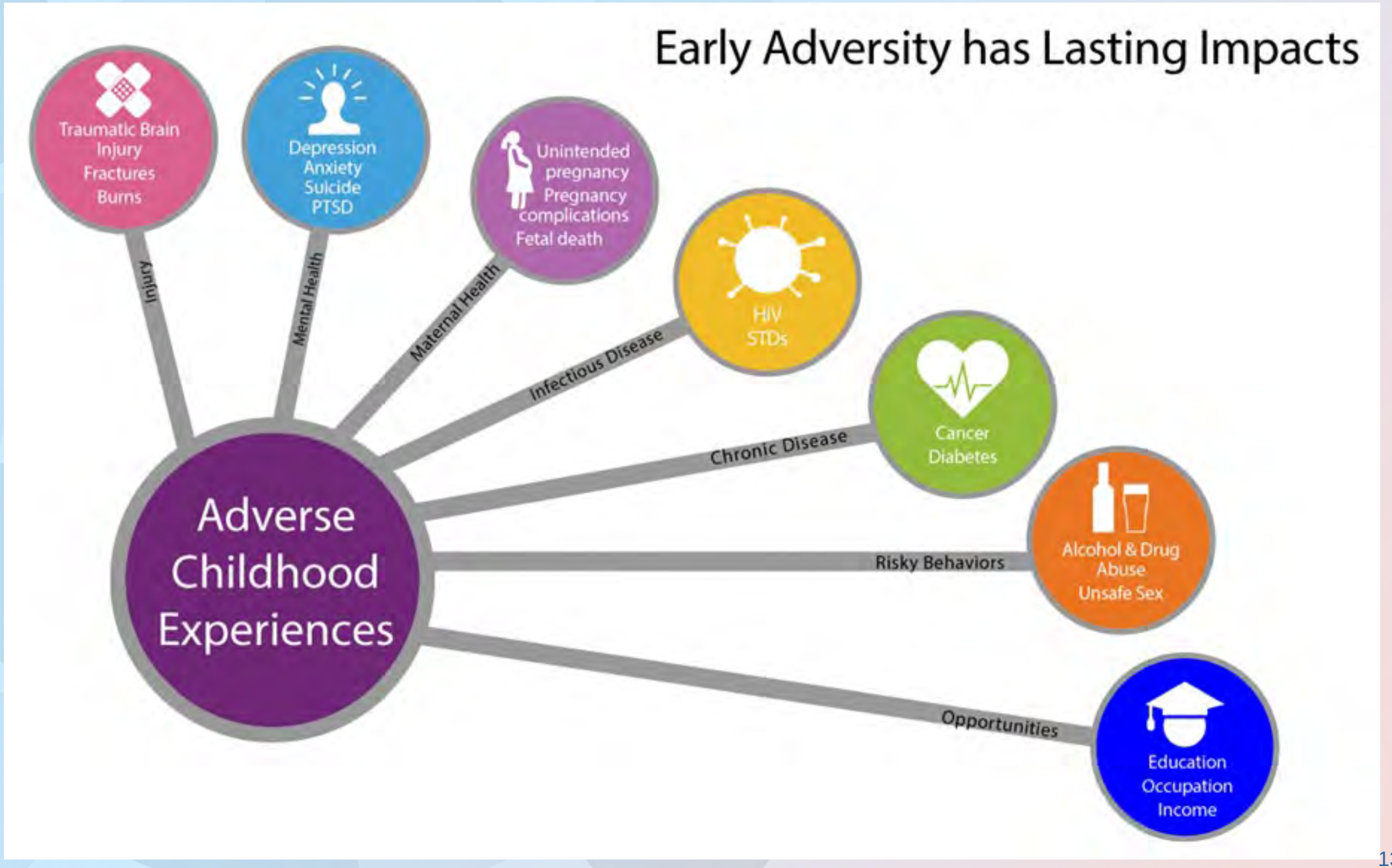
HOUSEHOLD CHALLENGES

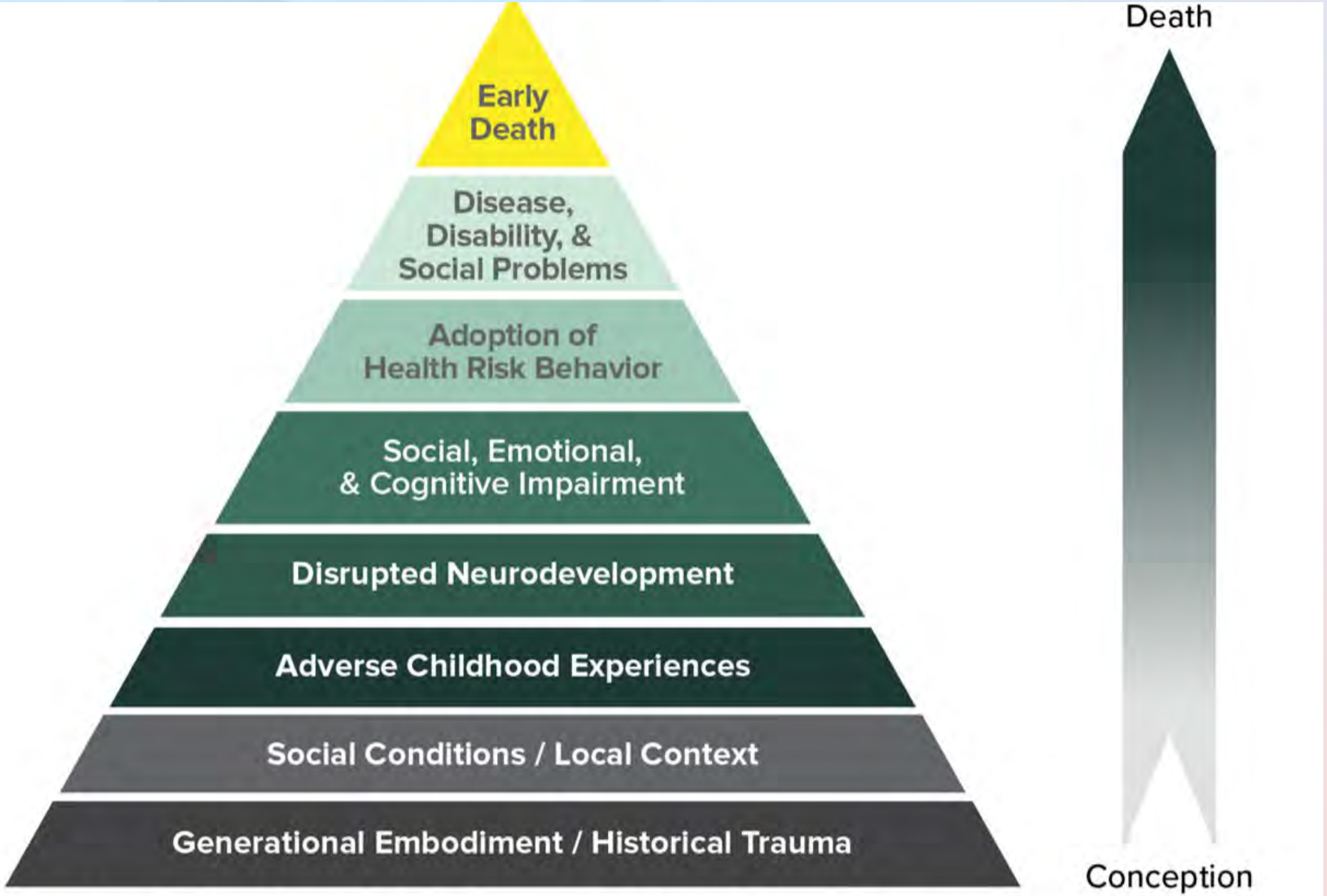


NEGLECT



Source: Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016.


Early Adversity has Lasting Impacts
Traumatic Brain Injury
Fractures
Burns
Depression
Anxiety
Suicide
PTSD
Unintended pregnancy
Pregnancy complications
Fetal death
HIV
STDs
Cancer
Diabetes
Alcohol & Drug Abuse
Unsafe Sex
Education
Occupation
Income
Injury
Mental Health
Maternal Health
Infectious Disease
Chronic Disease
Risky Behaviors
Opportunities
Adverse Childhood Experiences



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

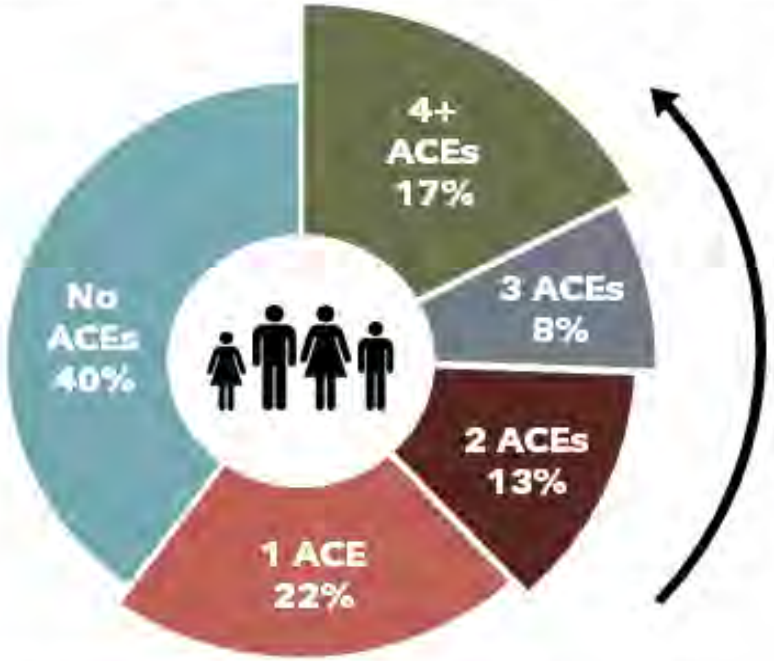
ACEs Can Be Prevented!

Source: Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

ACEs Are Common: The TN Example

Over Half of Tennesseans Reported At Least One Adverse Childhood Experience Between 2014 and 2017

Adverse Childhood Experiences Among Tennessee Adults (2014-2017)



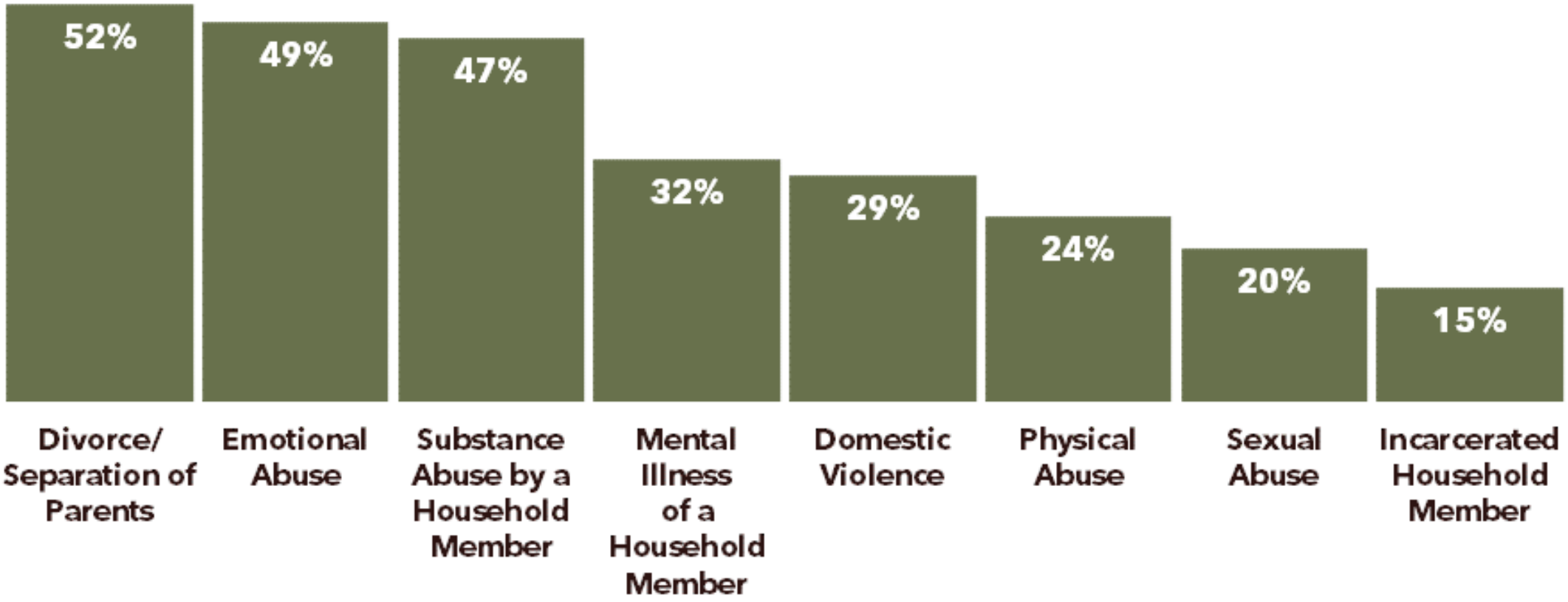
The risk of long-term health and social problems increases as the number of adverse childhood experiences (ACEs) increases.

Note: Numbers do not add up to 100% due to rounding.
Source: The Sycamore Institute's analysis of 2014-2017 CDC BRFSS data provided by the TN Department of Health's Division of Policy, Planning and Assessment, Office of Health Statistics.

SycamoreInstituteTN.org

The Most Common Adverse Childhood Experiences Among Tennesseans Are Divorce/Separation and Emotional Abuse

Prevalence of Common Adverse Childhood Experiences Among TN Adults Reporting 1 or More ACE (2014-2017)



Source: The Sycamore Institute's analysis of 2014-2017 CDC BRFSS data provided by the TN Department of Health's Division of Policy, Planning and Assessment, Office of Health Statistics

SycamoreInstituteTN.org

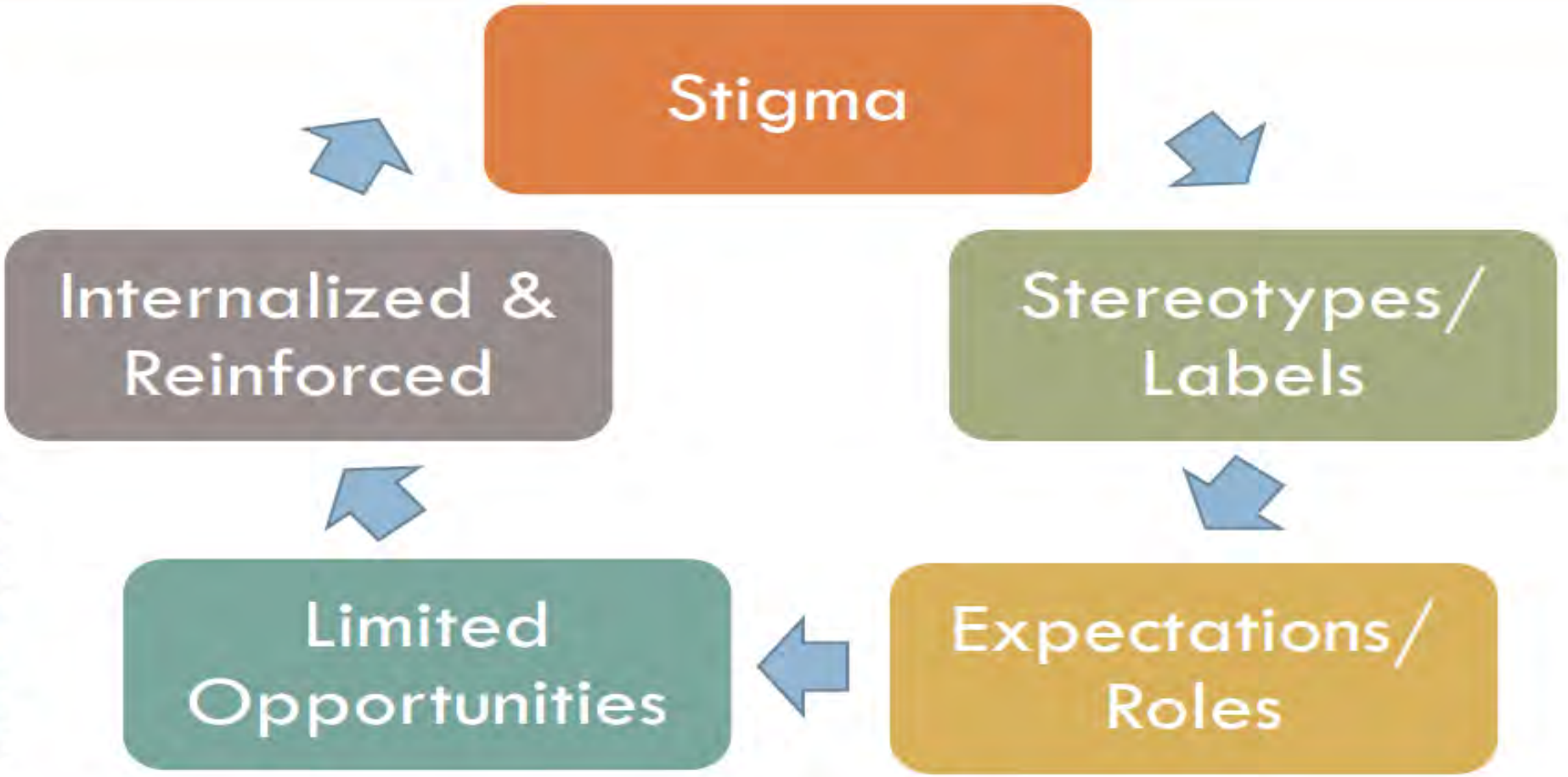
What Does this Mean About Stigma, SUD/OUD, and Overdose?

Surgeon General Dr. Jerome Adams

"Preventing substance misuse requires that we all change our perspective. We must start to see addiction not just as a disease, but as a symptom. Often, addiction is a product of suffering. To really have an impact, you must go to the source of that suffering. For all too many people, that source is trauma…. In particular, childhood trauma has repeatedly been shown to increase the risk of not only addiction, but other health issues."

Recovery, Prevention,& Hope: National Experts on Opioids Equip Faith and Community Leaders: https://www.youtube.com/watch?v=maUSojVyfgo

Cycle of Drug-Related Stigma



Julian Buchanan, Social Inclusion Unit, Glyndwr University, Wrexham, LL11 2AW

https://harmreduction.org/wp-content/uploads/2012/02/Slides.pdf

ACEs & Risk of Illicit Drug Use: 2003 Study

- For every increase in someone's ACE score, they became **two to four times** more likely to **engage in early initiation of use**.
- The ACE score had a **strong graded relationship** to **initiation of drug use** in all three age categories as well as to drug use problems, drug addiction, and parenteral drug use.
- Compared w/people with 0 ACEs, **people with ≥5 ACEs were 7- to 10-fold** more likely to report **illicit drug use problems, addiction to illicit drugs, and parenteral drug use**.

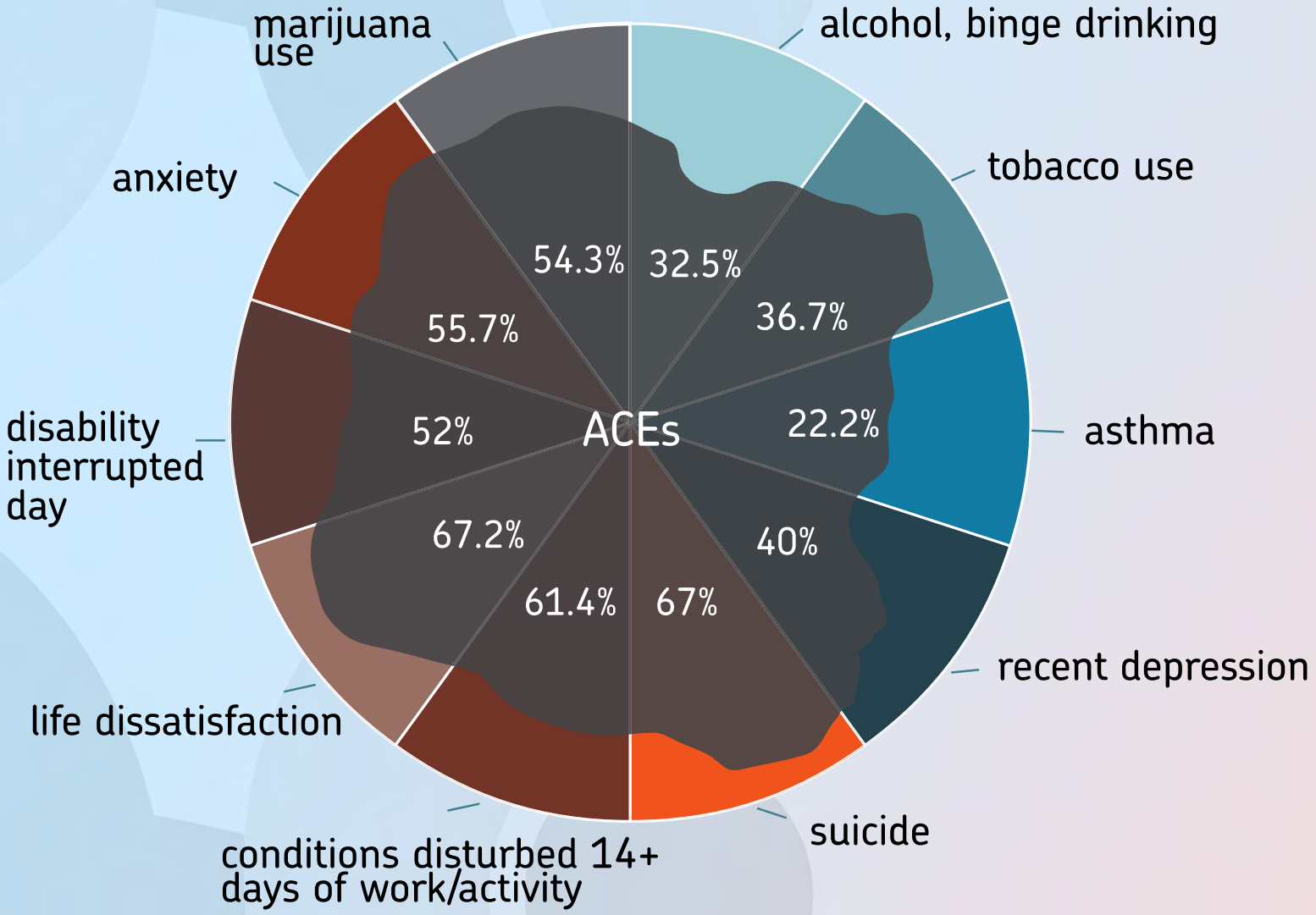
Source: Childhood Abuse, Neglect, and Household Dysfunction and the Risk of Illicit Drug Use: The ACEs Study: https://pediatrics.aappublications.org/content/111/3/564

ACEs Predict Opioid Relapse For Rural Adults In Medication Assisted Treatment (MAT)

- Opioid relapse occurred in 54% of study participants.
- Results indicated that for every unit increase in ACE score, there was an increase of 17% in the odds of relapse.
- Additionally, each treatment visit was associated with a 2% reduction in the odds of opioid relapse.
- Study concluded: ACEs may ↑ risk for poor response to MAT due to high relapse rates during the 1st treatment visits.
- Consistent adherence to treatment is likely to reduce the odds of opioid relapse → 2% decrease for each visit

Source: Adverse childhood experiences predict opioid relapse during treatment among rural adults.
https://www.ncbi.nlm.nih.gov/pubmed/31102882

Population Attributable Risk



Controls: gender, age, income, education, race-ethnicity

94% of respondents in a 2014 survey of people in treatment for opioid addiction said they chose to use heroin because prescription opioids were “far more expensive and harder to obtain.”*

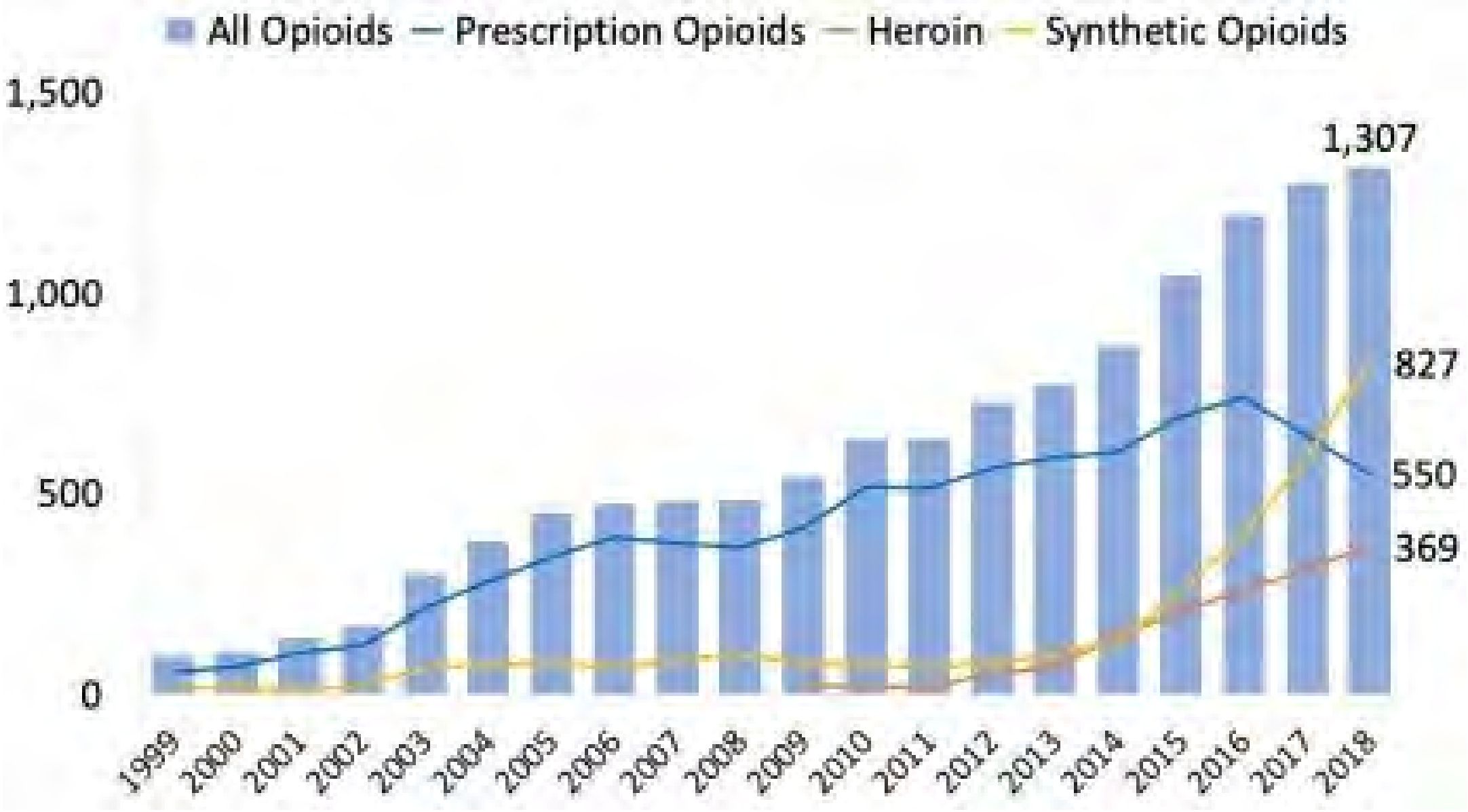
*Source: The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years. https://www.ncbi.nlm.nih.gov/pubmed/24871348

MD SCCANN 2016 Annual Report: Dr. Sumrok

"[Addiction] is a normal response to the adversity experienced in childhood, just like bleeding is a normal response to being stabbed. He says: the solution to changing the illegal or unhealthy… behavior of opioid addiction is to address a person's adverse childhood experiences (ACEs) individually and in group therapy; treat people with respect; provide [MAT;] and help them find a… comfort-seeking behavior that won't kill them or put them in jail."

Maryland State Council on Childhood Abuse and Neglect Annual Report: 2016 (p. 51)

Tennessee: Opioid-Involved Deaths and Related Harms

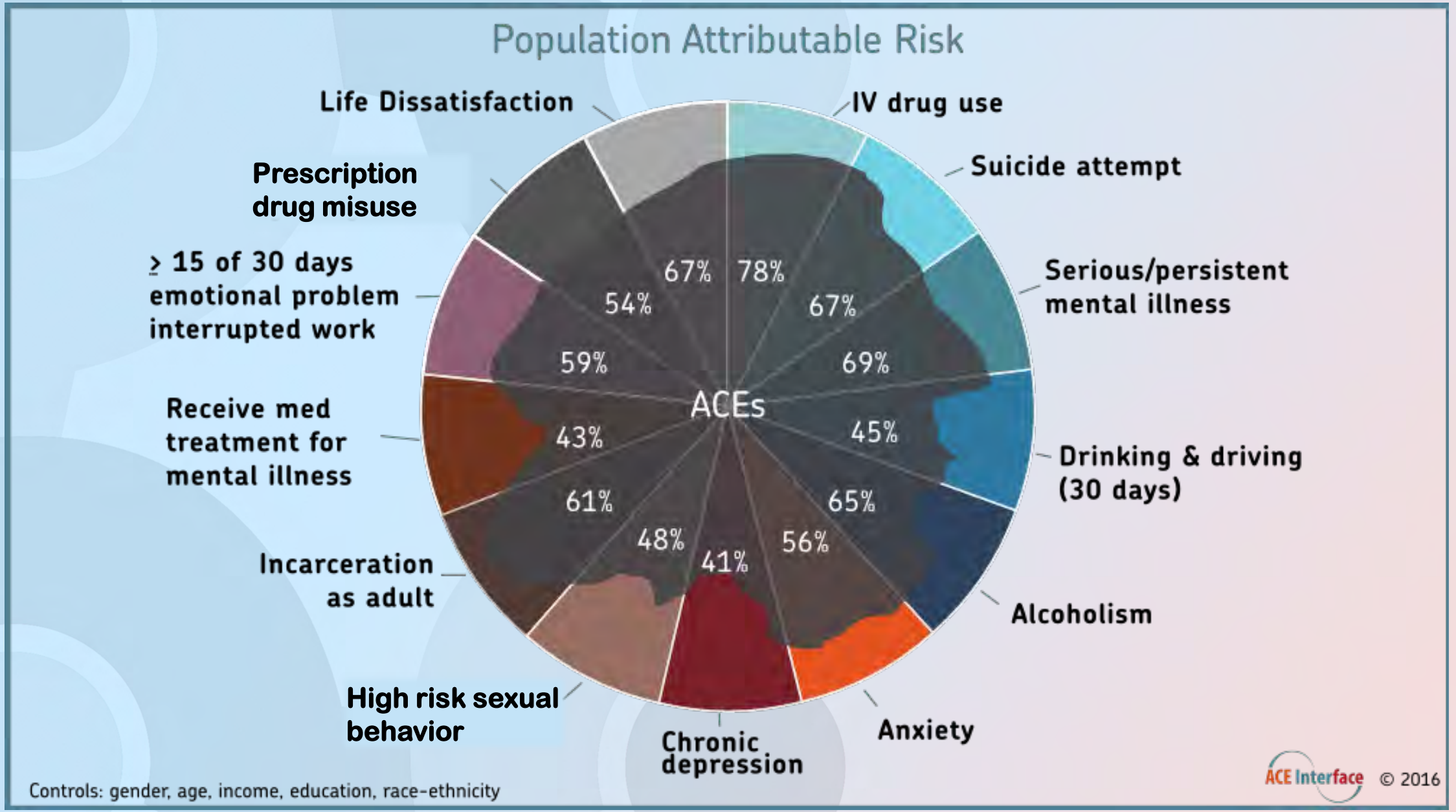


Number of ACEs: Harm Reduction Clinic Compared to ACE Study

Number of Adverse Childhood Experiences (ACE Score)	Women	Men	Total	Harm Reduction Clinic N=199
0	34.5	38.0	36.1	33.7
1	24.5	27.9	26.0	12.6
2	15.5	16.4	15.9	6.5
3	10.3	8.6	9.5	8.0
4 or more	15.2	9.2	12.5	**39.2**

- 66% of patients reported at least one ACE.
- 39% of patients had a score of 4 or more.
- ACEs are more common and severe among patients in the Harm Reduction Clinic than in the referent population.

Credit: Michael Brumage, Former Health Officer, Kenawha County, currently WVU/Cabin Creek


Population Attributable Risk
Life Dissatisfaction
IV drug use
Prescription drug misuse
Suicide attempt
≥ 15 of 30 days emotional problem interrupted work
Serious/persistent mental illness
Receive med treatment for mental illness
Drinking & driving (30 days)
Incarceration as adult
Alcoholism
High risk sexual behavior
Anxiety
Chronic depression
67%
78%
54%
67%
59%
69%
ACEs
43%
45%
61%
65%
48%
56%
41%
Controls: gender, age, income, education, race-ethnicity
ACE Interface © 2016

Addressing Stigma Against People Who Actively Use Drugs, Including Family Member(s)

Robert Childs, MPH

Technical Expert Lead

JBS International

Off Site Worker- Chattanooga, TN

Overview

- Why do people use drugs?
- Why don’t people go to treatment?
- Stigma that people who use drugs face
- Language matters
- Changing the way we treat people who use drugs
- Addressing Stigma in Families
- Resource Support List

Photo Source:
Casey Roman, WECT News

Why Do People Use Drugs?

Why Do People Use Drugs?

Personal Coping

- Pleasure
- Drug dependence
- Trauma history
- Pain management
- Mental health
- Sleep (insomnia or trying to stay awake)
- Fitting in
- Love
- Money
- Criminal record
- Employment stress

Law Enforcement Issues

- Criminal record
- Leaving jail/prison

Barriers to Treatment

- Lack of access to methadone/buprenorphine
- Lack of health insurance
- Criminal record
- Money for treatment (transportation, cost of program, job loss, housing loss)
- Childcare
- Love

Societal/Institutional Disparities/Discrimination

- Racism
- LGBTQI (lesbian, gay, bisexual, transgender, queer, questioning, intersexual)
- Housing
- Culture
- Exposure to drug use practices
- Supply issues around drugs
- Cost of drugs (legal and illegal)

Source: People Who Use Drugs in NC & TN, Robert Childs, JBS International

Why Don’t People Go to Drug Treatment?

Why Aren't People Going to Treatment?

- Cost
- Loss of labor (your job)
- Loss of housing
- Stigma/shame
- Transportation barriers
- Lack of childcare options
- Lack of access to healthcare coverage
- Loss of partner/family relationships
- Lack of treatment options that provide for chronic pain management strategies
- Personal or a friend's negative experience or negative perception of treatment
- Lack of medication-assisted treatment (MAT) options
- Lack of information that treatment exists
- Criminal history or pending criminal charges
- Ambivalence/lack of confidence about change
- Untreated mental health/trauma issues
- Gender/racial/cultural bias
  - Lack of services to female populations
  - Lack of services to trans populations
  - Lack of appropriate language services
  - Lack of culturally competent services/providers
  - Lack of LGBTQI-specialized services
- Hours of treatment service conflict with obligations
- Law enforcement/criminal justice practices that discount treatment diversion or treatment referral after incarceration
- Geographical access barriers
- Knowledge of sites
- Extended waiting lists for services

Source: People Who Use Drugs in NC and TN, Robert Childs (JBS), John Roberts (JBS)

How Does Stigma & Discrimination Impact People Who Use Drugs?


10 AREAS of
DISCRIMINATION
against people who use drugs*
1. EMPLOYMENT
Exclusion/dismissal
Unfair drug testing
2. WELFARE
Drug testing of claimants
Welfare restrictions
3. EDUCATION
School suspension/exclusion
Restricted grant/loan eligibility
4. TRAVEL
Refusal of visas
Constraints on scripts
Passport confiscation
5. HOUSING
Refusal of tenancy applications
Eviction of tenants
6. FINANCES
Refusal of loans/contracts
Rejection of life insurance
7. DRIVING
Removal of driving license
Invalidation of insurance
8. PARENTHOOD
Prosecution
Child removal
Adoption restrictions
9. JUSTICE
Criminalisation
Conspiracy / incitement charges
Discredited evidence
Confiscation of assets
Incarceration
Cruelty in detention
Corporal punishment
Death penalty
10. HEALTH
Poor/no access to treatment
Mandatory treatment
Drug testing
Inadequate harm reduction
* This non-exhaustive list focuses on areas of discrimination against people who use scheduled/controlled drugs. Based on: Russell Newcombe (2013), INTOXIPHOBIA - A Review of the International Literature on Discrimination against People who Use Drugs and A Charter of Rights for People who Use Drugs. With thanks to the Guyanese Harm Reduction Association for sharing!
#supportdontpunish

Language Matters

Language

NO!

- Substance Abuse
  - The word abuse implies violence and criminal behavior. Substance Use Disorder is a health condition.
- Drug Abuse
- Addict
- Abuser
- Junkie
- Druggie
- Dirty/Clean

YES!

- Health and justice terminology that is accurate, clinical, and not prejudiced
- Respect people's preferences
- Person-first language *(Person-first language confirms people's independence and self-worth. It promotes the message that a person is more than just their drug use).*
  - Person who uses drugs
  - Person with substance use disorder
  - People in recovery
  - People involved in the justice system
  - People who have been incarcerated
  - People with lived experience in the justice system
  - Used syringe/pipe, sterile syringe/pipe

SOURCE (right 5th sub-bullet): JCOIN, "Advancing the Use of Person-First and Non-Stigmatizing Language"

Changing the Way We Treat People Who Use Drugs

Changing the Way We Treat People Who Use Drugs

- Communicate with organizations of people who use drugs about barriers and challenges that they face.
  - Share opportunities to partner
  - Share resources
  - Pay people for their time
- Do not ban people who use drugs and those with criminal records from employment, hire them!
  - Promote fair hiring/Ban the Box
  - Hire people with the expertise
  - Have SUD-friendly workplaces

Changing the Way We Treat People Who Use Drugs

- Advisory/Service Boards
  - Acknowledge gaps in one's own experience and address discomfort
  - Invite more than one person to a meeting
  - Understand that having law enforcement/EMS/Child Welfare present may lead to people not wanting to attend meetings, since they may have caused harm to them
  - Have flexible times, locations
  - Train new people
  - Designate a certain amount of seats for people who use drugs
  - Protect confidentiality
  - Assist with travel

Changing the Way We Treat People Who Use Drugs

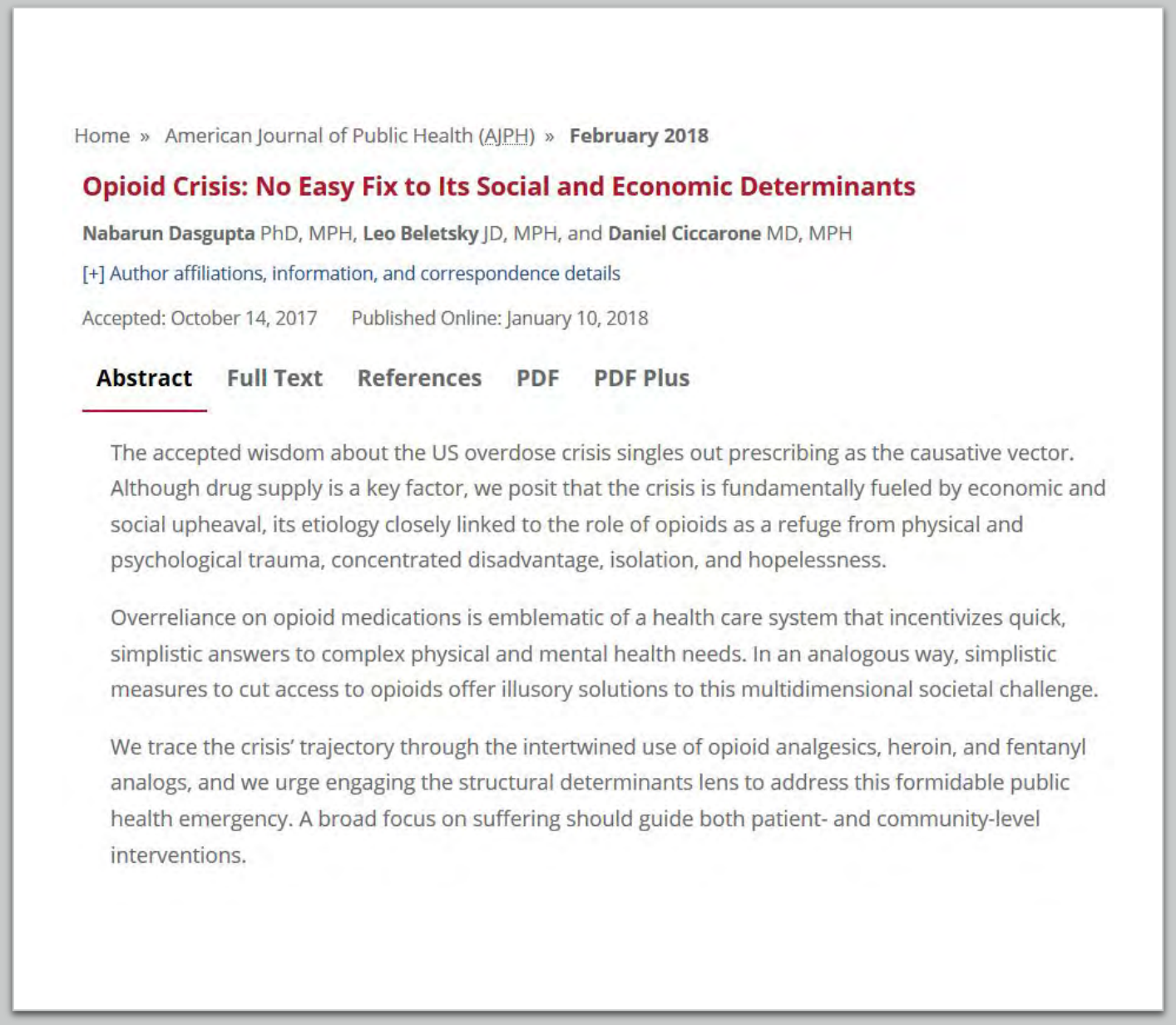
- Break bread and learn what challenges and binds us
- Training! Training! Training!
- Legal reforms
- Company/CBO policy reform
- Language
- Speaker’s bureau
- Media storytelling
  - News stories, letters to the editor
  - Photo voice
  - Self-produced media
  - Targeted media campaigns

Fighting Stigma and Building Support for Families

Pictured: GRASP Member Diannee Carden Glenn (NC)

Fighting Stigma in Families: Evidenced-Based, Peer-Reviewed, Easily Digestible Information

- Get the facts about SUD
- Get the facts about behavioral health
- Get the facts about the social and economic determents
- Set realistic expectations



Home » American Journal of Public Health (AJPH) » **February 2018**

Opioid Crisis: No Easy Fix to Its Social and Economic Determinants

Nabarun Dasgupta PhD, MPH, **Leo Beletsky** JD, MPH, and **Daniel Ciccarone** MD, MPH

[+] Author affiliations, information, and correspondence details

Accepted: October 14, 2017 Published Online: January 10, 2018

Abstract **Full Text** **References** **PDF** **PDF Plus**

The accepted wisdom about the US overdose crisis singles out prescribing as the causative vector. Although drug supply is a key factor, we posit that the crisis is fundamentally fueled by economic and social upheaval, its etiology closely linked to the role of opioids as a refuge from physical and psychological trauma, concentrated disadvantage, isolation, and hopelessness.

Overreliance on opioid medications is emblematic of a health care system that incentivizes quick, simplistic answers to complex physical and mental health needs. In an analogous way, simplistic measures to cut access to opioids offer illusory solutions to this multidimensional societal challenge.

We trace the crisis' trajectory through the intertwined use of opioid analgesics, heroin, and fentanyl analogs, and we urge engaging the structural determinants lens to address this formidable public health emergency. A broad focus on suffering should guide both patient- and community-level interventions.

Support for Families
Setting Realistic Expectations

Not Realistic

- No drug use
- Cured
- On their own
- If they relapse, they failed
- Response to shame
- Going to just treatment solves the matter
- Just quitting and going cold turkey
- Not being ready for a potential overdose

Realistic

- Reduced drug use
- Got treatment
- With help and support
- Return to use occurs and is normal
- Response to support
- Most people will need medications for opioid use disorder (MOUD)
  - Some people require MOUD for longer periods of time than others
- Prepare for a potential overdose, get naloxone for each family member
  - Choice Health Network, Tennessee Recovery Alliance, University of Tennessee, ROPES Statewide Program

What Works for Families? Connection

Connection is vital to families, who should find support.

- Broken No More, Moms United Against the War on Drugs, GRASP (if there is previous loss), Families for Sensible Drug Policy, Learn to Cope, other local support groups

Connection is also important for the person who uses drugs.

- Positive connection for the person who uses drugs—families give us meaning
- “Support, don’t punish”
- Rebel Recovery: support group to keep our loved ones safe until they are ready for what’s next

Talking to the People We Love

- Create a judgement-free and loving environment to foster conversation and openness.
- Discuss family history of SUD and BH so they know they are not alone.
- Show compassion.
- Take care of the caretaker.
- Seek support.
- Assist them with many pathways:
  - Active Users:
    - Harm Reduction, Support Services, Mental Health Care/Counseling, Meaning/Belonging
  - People ready for treatment
    - MOUD, Support Services, Mental Health Care/Counseling, Meaning/Belonging
  - Support Communities
    - Find a support community that meets the needs of your loved one. Remember not all support communities are supportive of people who use drugs, may return to use or people who use the gold standard of medications for opioid use disorder (methadone and buprenorphine).

Family Support Curriculum and Peer Services

Learn2Cope

- Learn to Cope is a non-profit support network that offers education, resources, peer support, and hope for parents and family members coping with a loved one addicted to opiates or other drugs.
- https://www.learn2cope.org/

Additional Resources

- Meaningful Inclusion of People Who Use Drugs (MIPA)
  - https://www.aidsunited.org/resources/meaningful-involvement-of-people-who-use-drugs
- Modernizing Public Health to Meet the Needs of People Who Use Drugs
  - https://www.nastad.org/sites/default/files/resources/docs/ModernizingPublicHealth-NASTAD.pdf
- Support Group for Active Users
  - https://www.facebook.com/RebelRecovery/
- Support Groups/Resources for Families
  - Broken No More
    - http://broken-no-more.org
  - Families for Sensible Drug Policy
    - http://fsdp.org/
  - GRASP
    - http://grasphelp.org/
  - Learn to Cope
    - https://www.learn2cope.org/
- SAMHSA
  - Family support guide
    - https://www.samhsa.gov/sites/default/files/samhsa_families_family_support_guide_final508.pdf
  - How to have a conversation
    - https://www.samhsa.gov/sites/default/files/samhsa_families_conversation_guide_final508.pdf

Addressing Stigma In Treatment And Recovery Spaces

Donald McDonald

Technical Expert Lead

JBS International

Internalized Stigma

“Internalized” stigma… occurs when a person cognitively or emotionally absorbs stigmatizing assumptions and stereotypes… and comes to believe and apply them to him- or herself.

Drapalski, et al., (2013)

Internalized Stigma Negative Outcomes

- Increased Depression
- Avoidant Coping
- Social Avoidance
- Decreased Hope & Self-Esteem
- Worsening Psychiatric Symptoms
- Decreased persistence in accessing mental health services & other supports

Drapalski, et al., (2013)


LIPS THAT
TOUCH LIQUOR
SHALL NOT
TOUCH OURS

That Pernicious Label

- Technically inaccurate
- Morality-based
- Implies choice
- May cause harm

Contributes to the social and professional stigma attached to substance use disorders and may inhibit help-seeking and may negatively impact the rendering of appropriate services.
(*N* =728) *Smoking Gun*

White, W., Kelly, J. (2010)

That Pernicious Label

- Rooted in Religion
- Morality-based
- Implies choice
- Promotes shame

Lapse of faith, lapse in grace, lapse in judgment, lapse into bad habits, lapse in payments… Entered medical lexicon during temperance movement.

Grace & Grit or Something More?

- Immediate access to adequate and appropriate treatment services
- Continuing care, including access to outpatient treatment, psychiatric services, professional counseling, medical care, etc.
- Robust choice among recovery support services and mutual aid in one's community
- Family, friends, and allies supporting one's recovery lifestyle
- Recovery-supportive employment
- Safe housing and reliable transportation
- Recovery visibility to provide hope and inspiration
- Freedom to go back to school, seek more meaningful employment, and discover purpose
- Opportunities to be of service and feel part of

A Call for Clinical Humility

“There are many components involved in the broad issue of substance use disorders and recovery. Employers, first responders, the criminal justice system, policy makers, politicians, companies, advertisers, treatment providers, addiction professionals, the recovery community, families, and the individual with the substance use disorder. Of all these components, individuals with substance use disorders face the greatest scrutiny, stigma, discrimination and blame. For too long they have stood alone bearing the full brunt of this responsibility while systems of care and policies impacting housing, education, and employment have largely conspired to undermine any chance of sustaining recovery.” (Recovery Communities of North Carolina, 2016)

– Chris Budnick, Executive Director, Healing Transitions, Raleigh, NC

A Call for Clinical Humility

- I apologize for expecting that you will provide all the motivation to initiate recovery when I have assumed no responsibility for enhancing your readiness for recovery.
- I am sorry for creating unrealistic expectations of you.
- I'm sorry that I have discharged you from treatment for becoming symptomatic. I'm even more sorry, though, for abandoning you at your time of greatest vulnerability. And I am sorry for how this failure has contributed to the heartbreak of your loved ones.
- I am sorry for the irritation in my voice when you have returned following a set-back because you didn't do everything that I told you to do.
- I am sorry for privately finding satisfaction in your failure because it reinforces the fallacy that I know best and if you just do as I say, you'll recover.
- I am sorry for not celebrating as enthusiastically your successes when you have achieved them through a pathway or style other than mine.

A Call for Clinical Humility

- I’m sorry for turning you away from treatment because you’ve “been here too many times.”
- I’m sorry for not referring you to different services when you have not responded to the services I offer.
- I am sorry for allowing you to take the blame when treatment did not work instead of defending you because you received an inadequate dose and duration of care.
- I’m sorry for not calling to check on you when you don’t show up for treatment. I’m sorry for not calling to support you after you leave treatment.
- I’m sorry for letting society maintain the belief that you used again because you chose to.
- I’m sorry that systems of control and punishment has been the response to communities of color during drug epidemics.
- I am sorry that through my silence and inaction that I have contributed to belief that persons with substance use disorders are criminals and should be punished.

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Harm Reduction & Faith: Service Without Stigma

Rev. Michelle Mathis
Executive Director
Olive Branch Ministry

Olive Branch Ministry

What does love look like?

It has the hands to help others.

It has the feet to hasten to the poor and needy.

It has eyes to see misery and want.

It has the ears to hear the sighs and sorrows of men.

That is what love looks like.

-Saint Augustine

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Stigma As A Barrier To Faith

- Change begins with leadership
- Words matter
- Service without requiring a theological conversation or commitment is key

Olive Branch Ministry

The Golden Rule

Service without the requirement of a theological conversation or commitment is key to removing stigma.

Olive Branch Ministry

Breakdown Stigma By Getting Involved

Olive Branch Ministry

Traditional and Non-Traditional Supports

- Support Groups for:
  - Families Who Are Directly Impacted
  - Grief Support Groups
  - 12-step/Celebrate Recovery
  - People in Active Addiction
- Harm Reduction as a Ministry
- Educational Opportunities

Olive Branch Ministry

National Faith In Harm Reduction Movement

Our Mission:

Co-create a healing justice movement in partnership with faith communities and people who use drugs to develop resources that center harm reduction messages, principles, and practices.

FAITH IN HARM REDUCTION

Olive Branch Ministry

A Messy Ministry In The Wake of A Miracle

"Unbind him, and let him go."

It's a **charge**.
It's a **commission**.
It's a **command**.

Olive Branch Ministry

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Extending Hope.

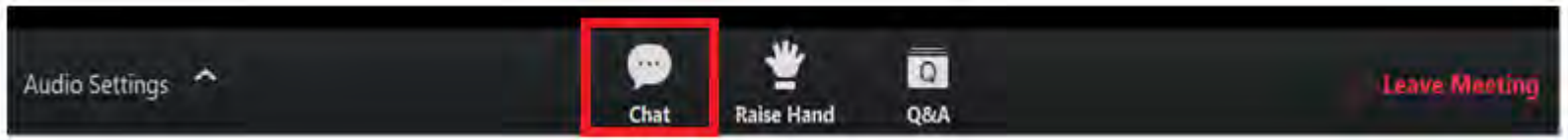
Extending Life.

Olive Branch Ministry

Submitting Questions and Comments

Submit questions by using the chat feature.

To open your chat window, click on the chat icon on the bottom center of your Zoom window.



Thank You!

The purpose of RCORP is to support treatment for and prevention of substance use disorder, including opioid use disorder, in rural counties at the highest risk for substance use disorder.

RCORP-TA

RURAL COMMUNITIES OPIOID RESPONSE PROGRAM - TECHNICAL ASSISTANCE