OREGON HEALTH AUTHORITY

Opioid Prevention Toolkit: Helping our Communities Heal Safely

heal SAFELY



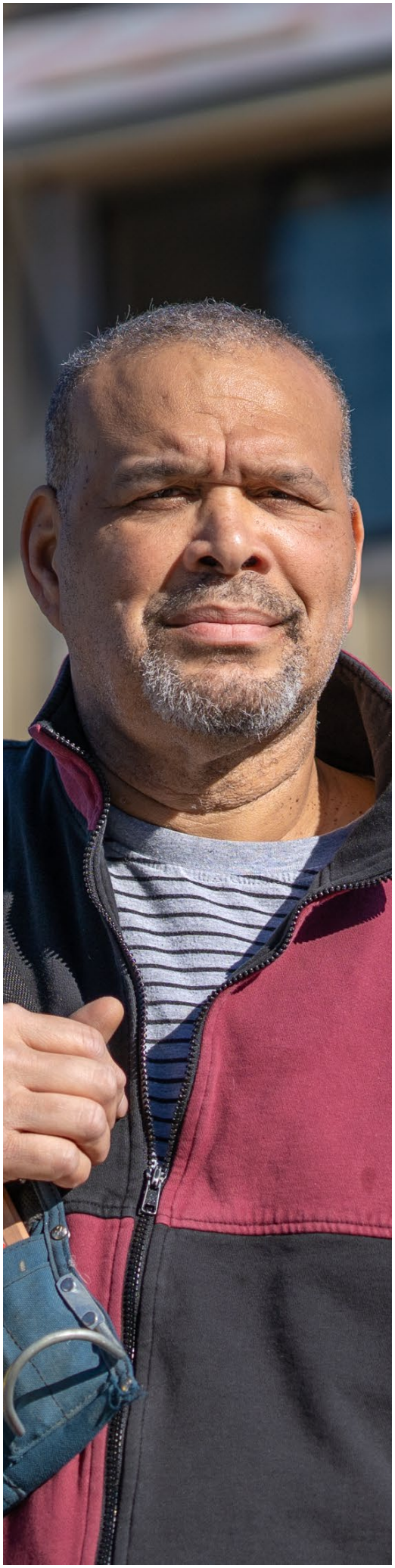


Table of Contents

PURPOSE OF THIS GUIDE:

With support from the Oregon Health Authority, Brink Communications and Goodwin Simon Strategic Research have created this toolkit as a resource to inform public education and engagement campaigns focused on pain management and opioids. It also provides helpful messaging guidance for other stakeholders communicating with people about pain.

The guide provides:

- Insights into commonly held beliefs about opioids and pain
- Understanding about how these beliefs affect people's decisions about their pain management options
- Key learnings around effective, research-tested language and message frames
- Strategies for adapting educational and outreach materials about opioids and pain management to better reflect the experiences and concerns of communities of color

While this toolkit was primarily designed to support comprehensive public education and engagement campaigns, learnings from this toolkit may be applied to communications about opioids and pain management across multiple contexts and channels—from social media content, newsletters and brochures to media coverage and patient-provider conversations. The narratives and message guidance contained in this guide provide a powerful pathway to help people of many walks of life and in many settings think differently about their options for managing pain without opioids.

Oregon Health Authority

BRINK Communications for Good

GOODWIN SIMON STRATEGIC RESEARCH

Goal

The research summarized in this guide culminated in our development and launch of "Heal Safely"—a statewide social marketing campaign to empower people to choose safe, effective options to heal safely after injury or surgery.

The goal of Heal Safely and the focus of this guide is predominantly to reduce upstream demand for opioids before people begin taking them or, in cases where people have taken prescription opioids for pain management in the past, to reduce or prevent future use.

In the first section of this guide, we summarize the key findings of the research. In the second, we provide messaging recommendations drawn from the research, as well as examples of how these recommendations were brought to life in Heal Safely. And throughout, we include quotes from research participants to illustrate key points in their own words.

Toward A New Narrative About Pain

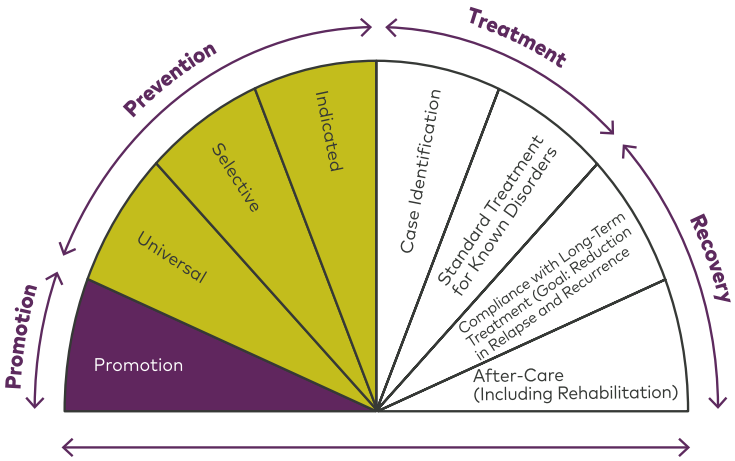
The opioid crisis is everywhere: in our newspapers, emergency rooms, neighborhoods and in our families. We see and feel its impact deeply.

It is a complex issue, with multiple causes and implications, affecting millions of people—and we know that addressing it requires intervention at every step of the *continuum of care*.

Reducing opioid over-prescription

In the prevention space, health care providers, public health professionals, communicators and many other stakeholders are working hard to reduce the over-prescription of opioids for pain. A variety of public awareness campaigns have emerged over the past 10 years, all with the intention of letting people know that prescription opioids are addictive and that there are safer options for pain management. Yet new prescriptions are written every day and people continue to struggle with addictions that start with a provider's prescription.

CONTINUUM OF CARE



Growing research and resources

Driven in part by this crisis, the science and practice of pain management have taken significant leaps forward in recent years. From research into the physiology of pain and the efficacy of non-opioid treatments to the development of multi-modal approaches for pain management, a growing wealth of resources—videos, websites, books, clinical modules—are available to help patients.

But when we talk to providers and public health professionals, many of them express frustration that patients aren't using these resources. They tell us that if people only knew this information, they wouldn't be using opioids.

Asking the right questions

When we feel stuck in our efforts to tackle a crisis that feels as intractable as this one, it is helpful to start by looking for the elephant in the room: What is the challenge we're not talking about because it seems too complex and too difficult to solve?

While there are multiple challenges in this case, the one at the center is pain—physical pain, emotional pain, community pain and trauma.

The history of pain in America

As a society, we have a complex history and relationship with pain. In the U.S., pain was introduced as the "fifth vital sign" in the medical field in 1996 and this led to health-care providers highly prioritizing the elimination of pain.[1]

Opioids are by definition designed to deal with pain. Is it possible that the way we think and talk about pain is part of the problem? Could changing the way we talk about pain and pain management help our audiences think differently about it, too?

Is it possible that the way we think and talk about pain is part of the problem? Could changing the way we talk about pain and pain management help our audiences think differently about it, too?

1. Levy, N. et al. "'Pain as the fifth vital sign' and dependence on the 'numerical pain scale' is being abandoned in the US: Why British Journal of Anaesthesia, Volume 120, Issue 3, 435 – 438.

Going deeper

We are already taught to listen with empathy, but our work is about more than that. It requires going a level deeper to understand our audience's mindset, to uncover the messages and information that are directly meaningful and impactful for them, and to identify the most successful path to help them think and act differently when it comes to managing pain.

Doing so requires that we center ourselves in their reality: their lived experience, values and beliefs. We must learn what they care about and want to know, then allow this understanding—rather than our own assumptions—to inform our communication.

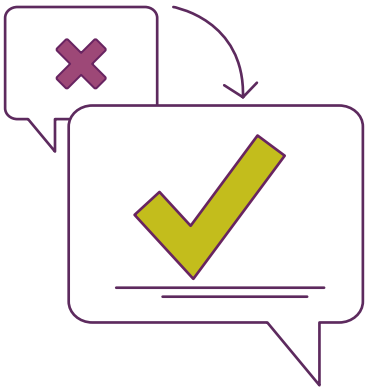
Understanding the landscape

It also requires that we understand the landscape in which this crisis and our audiences are situated. Particularly for communities of color and rural communities, inequities in health and health care services, historical trauma, and past negative experiences with the health care system all influence the way people respond to pain and understand their options for pain management.

Empathy-based and audience-centered approach

The good news is that our research shows an empathy-based and audience-centered approach can actually serve to transform a negative dialogue into a positive one. We have the opportunity to shift the conversation away from one of caution and warning to one of resilience and agency.

And, ultimately, by creating empowering and relevant paths to behavior change and upholding our audience's desire to live a life of health and wellbeing, we can help turn the tide on the prescription opioid crisis.



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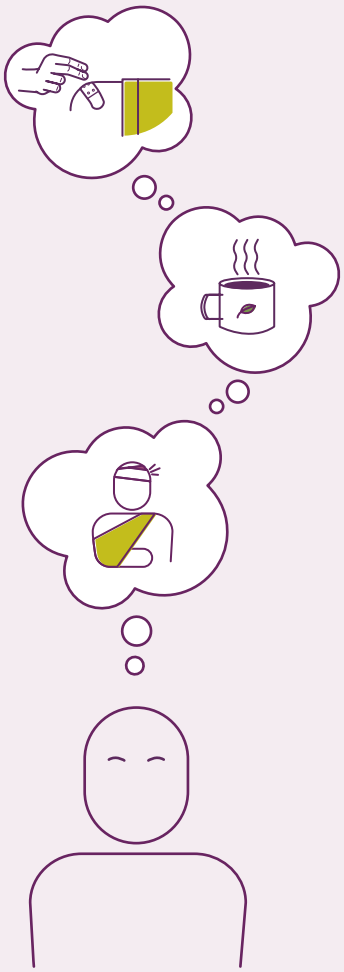
Quick Reference Guide: Findings and Recommendations

In this quick reference guide, you will find a brief overview of our key findings and recommendations. We discuss each of these in detail later in this guide.

Understanding the Audience Mindset



1. Pain is shaped by identity.
How people experience and respond to pain is personal and closely connected to their identity. Many factors, such as family, culture and community history inform people's identities and serve to influence how they perceive messages related to pain and pain management.

2. People want to have agency over their own health.
Across demographics, people share a common desire to be self-sufficient, informed and proactive when it comes to their health and pain management. They want and often prefer home remedies, home-treatment, self-treatment or "natural" remedies that don't make them feel out of control or disconnected, which is how many describe the way opioids make them feel.

3. Lived experiences influence how people understand pain.
While pain is universal, people's lived experiences are vastly different. Their past experiences with pain, or those of their loved ones, significantly influence their beliefs and responses to pain and pain management.

4. People do not know what we mean when we talk about "opioids" and have little understanding of the risks.
People's information about prescription opioids is often flawed or incomplete. For example, many think of opioids as heroin or street drugs, or may not know which prescription pain medicines are opioids. Few report having discussed opioids or pain management with their providers and, as a result, base their knowledge about their risks and side effects on their own past experiences or that of family and friends.

5. Unless they have direct lived experience with addiction, most do not believe they can become addicted to prescription opioids.
Most people believe that information about the risk of becoming addicted to prescription opioids is important for "others" to know, but do not see it as personally relevant because they do not see themselves as potential addicts. This can cause them to dismiss information related to the risk of addiction to prescription opiods.

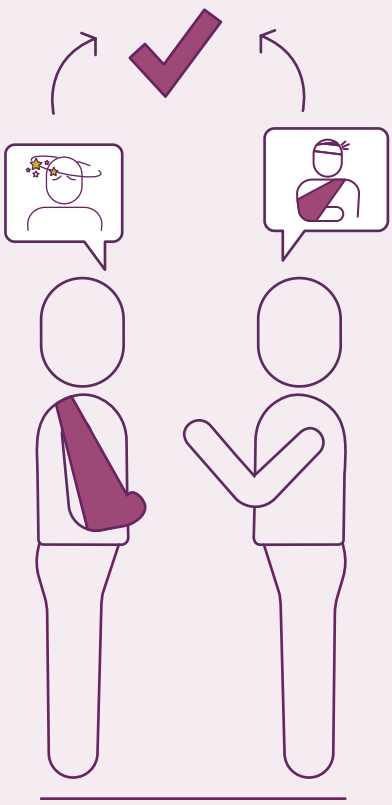
6. Pain and pain management are not top of mind.
Unless they are actively experiencing pain, few people think about it or plan for how they will manage it in the future. It is often not until they are facing a surgery or experiencing intense pain that they consider their options.

7. Many report positive experiences with using doctor-prescribed opioids for pain management in the past and do not want their future options to be limited.
Many participants assume they are not at risk for addiction or side effects because their previous experiences with prescription opioid use after an injury or surgery have not been problematic. This leads them to believe that any future use will be similarly positive and that they are equipped to take opioids safely.

8. Many feel ill-equipped or afraid to have conversations with their health care provider about pain and pain management.
Prior negative experiences cause people to feel reluctant to ask questions of their provider about their pain and how to manage it. Many also believe that their provider knows best and feel like it is not their place to ask questions or request more information.

9. People are genuinely interested in non-opioid options but are concerned about access, affordability and effectiveness.
While many people express interest in non-opioid options, they have an underlying fear that these options won't provide the same immediate pain relief, healing or aid in resting as opioids. There is also a common misconception that alternative pain medications are too experimental or won't be covered by insurance.

Key Messaging Recommendations



1. Build connection.
Because pain is so personal, people need to see and hear from people like themselves—people with whom they can identify—in order to believe that their personal experience matters and that their pain is being taken seriously. Validating people's experiences and mirroring their emotions and beliefs creates connection and helps them more openly receive information about pain about pain management.

2. Define acute pain, and frame the goals of pain management.
It is important to help audiences situate the kind of pain we are talking about—serious, short-term pain resulting from injury or surgery. It's also important to shift the goal of pain management away from being "pain-free" (which may lead audiences to select opioids) and to instead talk about "addressing pain," "managing pain" and "aiding in recovery and healing."

3. Define "opioids."
Many people have limited or flawed understanding of opioids. To avoid confusion, it is crucial to clearly define the term "opioids" as "prescription pain medication." It is also helpful to include examples of brand names with which audiences may be more familiar.

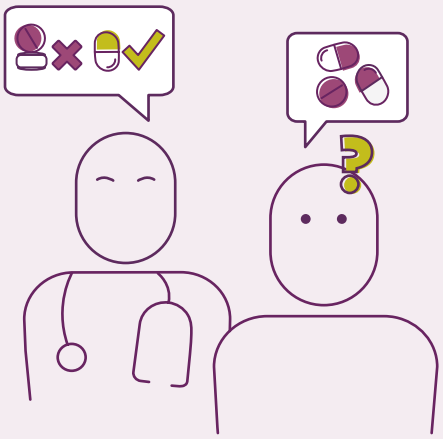
4. Emphasize the risk of physical dependence and serious side effects rather than addiction and overdose.
People often discount warnings around addiction and overdose because they do not see themselves as at risk. Messages focused instead on serious side effects and physical dependence prove to be much stronger and more effective in motivating people to think twice about opioid use.

5. Raise awareness of non-opioid options that credibly meet people's needs for rest and healing.
Providing clear, concrete and proven non-opioid options is highly effective in motivating people to consider other approaches, especially when they see their needs for holistic healing addressed.

6. Calm skepticism and concerns.
When people feel that their concerns are legitimate and understood, they are more open to hearing messages that might contradict their existing beliefs about opioids. Mirroring their skepticism and then expanding their understanding about non-opioid pain management is an effective way to help them remain open to other options.

7. Equip and empower people to develop a plan.
When people are experiencing pain, many have difficulty remembering what questions to ask their provider. Equipping them with a plan before a surgery and a guide for questions to ask during an appointment empowers people in their health care journey.

8. Position providers as partners.
People need to see providers as their partners in their health care decision-making. It's not enough to tell people they can ask questions of their providers or to prepare in advance for their appointment. It's important to model what this looks like, providing concrete examples of the kinds of questions and interactions people can have with their providers. Sharing stories featuring messengers with whom audiences can identify, and who can model the behavior and attitude change we are seeking to create, can be an effective way to meet this need.



Project Overview

In 2017, as part of a multi-tiered strategy to tackle the opioid epidemic in our state, the Oregon Health Authority (OHA) identified the need for a patient-centered campaign to reduce the demand for prescription opioids to manage pain.

This effort was driven by the belief that to really create change, we need to fundamentally reshape how people think about pain, pain management, treatment options and opioid painkillers themselves—*before* people are in pain. And at the outset of this project, we recognized there was a gap in understanding how people think about their own pain and options for treatment.

We also understood there are many motivations for what might lead people to use, or choose not to use, prescription opioids to address their pain.

PROJECT OVERVIEW

There is No Silver Bullet

When it comes to emotionally complex and deeply personal issues such as decisions about health care and pain management, there is no silver bullet.

For people working in public health, drug prevention and medicine, this can feel frustrating. One solution may work wonders for one person and yet make things worse for another. And what one person hears as helpful, another might experience as dismissive or judgmental.

Our audiences carry complicated—even conflicting—and often subconscious perspectives on pain, informed by their values, emotions, lived experiences, identity and beliefs. To see real and lasting change and to help facilitate the choices and actions we want people to embrace in their own health care, we have to be willing to look at the problem through many different lenses. This means connecting several different messaging strategies together.

A nuanced approach

No one approach is enough by itself. There is no single talking point, no simple hashtag or one-liner that, alone, will move people to manage pain without prescription opioids. Our response has to be as nuanced as the problem before us, our messaging as diverse and complex as our audiences.

With this understanding, in the spring of 2018, Brink Communications and Goodwin Simon Strategic Research (GSSR), on behalf of OHA, partnered to conduct deep research into attitudes about pain and opioids among key populations. Over the course of eighteen months we conducted multi-faceted, iterative research in communities across the state. Through in-depth interviews, online and in-person focus groups and an online message testing survey, we sought to understand how people approach pain and the many factors that motivate them in seeking treatment. For details about the research methodology, please see Appendix A.

We developed this toolkit directly from our research as a resource for stakeholders engaged in the many aspects of prevention work.

Prescription Opioids After Injury or Surgery

There are myriad ways in which people come into contact with and interact with opioids.

For the purpose of the research, however, we identified the use of doctor-prescribed opioids for acute pain after injury or surgery as an important focus in prevention efforts, recognizing this as a critical way in which people can and do develop dependency on opioids.

Our Audience

Communications is not one-size-fits-all, and developing effective messaging requires that we clearly identify the audience we aim to reach.

The focus of our research and our work in this project is on the following communities who have experienced disparities in health and health care, and who have been disproportionately affected by the opioid crisis:

- American Indian/Alaska Native
- African American
- Latino/a
- People living in rural communities

While our findings and message recommendations are focused on the above audiences, it should be noted that we were surprised by how much commonality we found in our research. That is, when it comes to how general (non-medical, non-expert) audiences think and talk about pain and pain management, people of diverse backgrounds share many of the same concerns. We also found that messaging performed similarly well across all of the target audiences, as long as it was tailored in the ways we will discuss in this guide.

WHY NOT CHRONIC PAIN?

In our work as behavior change communicators, we are careful to draw clear distinctions between issues that can be addressed through education and awareness, and those that require deeper intervention and support.

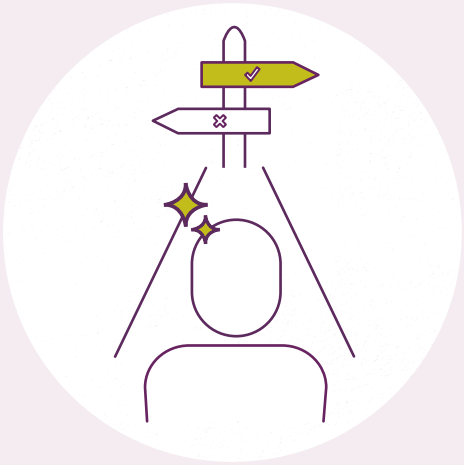
There is a significant difference between helping someone make the choice not to start a new opioid prescription for acute pain after an injury or surgery, and supporting someone who has been using doctor-prescribed opioids for months or even years to manage chronic pain. While the former is achievable through prevention-based communications, the latter requires not only information and education, but also medical and social support.

While we believe that the findings of our research are in many ways relevant to chronic pain patients, it is important to be clear that a consumer-facing communications campaign alone cannot—and should not—be considered an appropriate way to support people who have been using doctor-prescribed opioids to manage chronic pain on a long-term basis. This will require additional intervention and resources at the individual, system and policy levels.

Humans Are Heartwired

In 2017, with support from the David and Lucile Packard Foundation, Goodwin Simon Strategic Research and Wonder: Strategies for Good released a strategy guide called Heartwired that outlined a new, integrated approach to audience research, storytelling and persuasion communication. We used this approach in conducting the research for this project.

In short, this research approach is based on the fact that human decision-making is influenced by how people are "heartwired"—the mind circuits and connections that tie together their emotions, identity, values, beliefs and lived experiences.

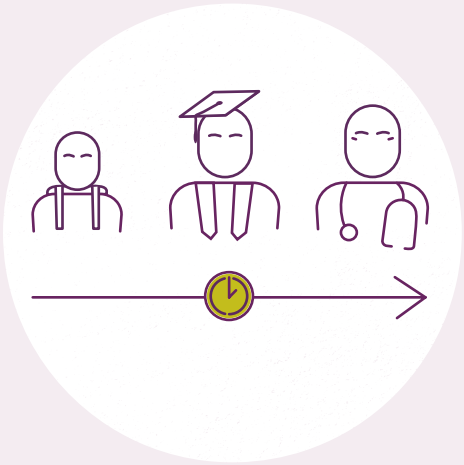


Heartwired Factor #1: EMOTIONS

The feelings that human beings have in response to the stimuli within and around us are complex. Our emotions typically drive our behavior and lead us to prioritize certain concerns. Because of how we are neurobiologically wired, we tend to make decisions based on emotions and back them up with logic, especially when we feel urgency and need to make a split-second decision, and this all happens on a largely unconscious level.

Heartwired Factor #2: IDENTITY

Self-identity is how people see themselves in relation to the world around them. We are all driven to make decisions that align with our sense of self, and when we don't, we experience uncomfortable cognitive dissonance. Every individual's identity incorporates many facets (e.g. gender, race, faith) and traits (e.g. being hard-working, fair-minded, educated). Internal conflict related to behavior change on certain topics is often the result of a tug-of-war between different facets of a person's identity.



Heartwired Factor #3:
LIVED EXPERIENCES

The events and relationships people experience in their lives combine with the meaning they assign to those experiences to shape their response. The way we interpret and remember events—the narrative we construct around them—is just as important as what actually happened. Exploring and understanding those lived experiences is key to effective messaging strategies that drive behavior change.

Heartwired Factor #4:
VALUES

Values are ideals that individuals hold about what is good or bad, right or wrong, important or unimportant, appropriate or inappropriate. Values influence emotional reactions, attitudes, beliefs and behaviors and are often shared broadly within a culture or community. A person's values help them make meaning in their lives. If those values are contradicted, people experience a sense of dissonance and incongruence, which interferes with their capacity to change attitudes and behaviors.

Heartwired Factor #5:
BELIEFS

Beliefs are ideas that people hold to be true. When we have significant experience with something, our beliefs are deeper and more nuanced. When we have little to no experience, we tend to fill in the knowledge gaps. Whether we have deep or scant knowledge, our beliefs are further shaped by our identity, our lived experience and our values. In other words, facts alone do not shape beliefs.

Research Findings: The Audience Mindset

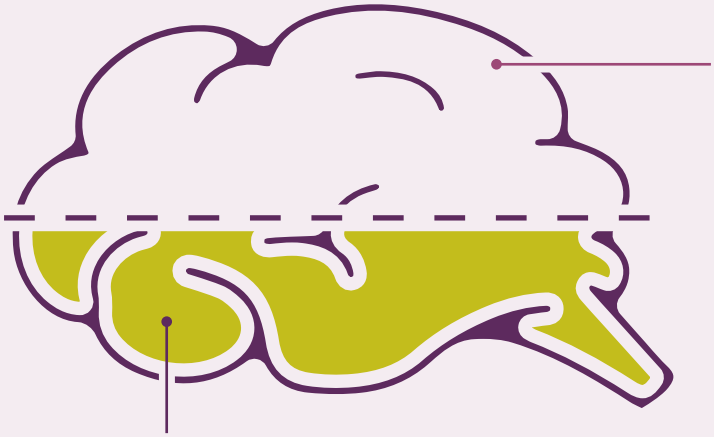
When presented with new information, people filter and respond to what they hear and see through their lived experiences, emotions, identities, values and beliefs.

Imagine someone who grew up in a coal-mining town in northeastern Wyoming. For as long as they can remember, their family and their friend's families have worked in coal mining, their community's history is built around coal—in fact, their town's very existence is tied to its export. As a result, they may hear calls for cleaner energy solutions and a reduction in our nation's coal usage very differently than others across the country because of the many ways it deeply connects to their identity, sense of autonomy, history and lived experiences.

Communication through connection

The way people hear guidance around opioids and pain management is just as complex. When we understand where our audiences are coming from—and identify where our values overlap with theirs—we are able to communicate from a place of connection rather than distance. In doing so, we can help create trust and resonance that becomes the opening for positive change.

Key Concept: Calming the Downstairs Brain with Empathy



UPSTAIRS BRAIN

When human beings feel relaxed and comfortable, we tend to rely on our "Upstairs Brain"—the part of the brain that is responsible for our higher order thinking, reflection and empathy.

DOWNSTAIRS BRAIN

When something is unfamiliar or uncomfortable for us, the amygdala—sometimes called the "Downstairs Brain"—kicks into high gear. This is the part of our brain that regulates big negative emotions like fear, anxiety and anger. Those emotions are like noise that can shut down our ability to hear thoughts from our thinking brain. As long as the amygdala is overly triggered, the brain is unable to process the messages we want our audiences to consider, which interferes with their ability to reflect, reconsider, and ultimately to change behavior. The audience remains emotionally stuck and conflicted.

EMPATHY

To enable change, we have to meet audiences where they are. Empathy—the capacity to understand and be sensitive to another's experience—is critical to our efforts to create behavior change. Our communications need to convey empathy to help meet the emotional needs of audiences and help to manage negative emotions and feelings that interfere with behavior change.

It is important to recognize that the information that is most compelling to us as advocates and health professionals may not connect with our audiences—and if it does not feel relevant, it will not lead them to change. When we focus on what our audiences need to hear in order to help them be open to persuasion, it can sometimes feel as though we are not making as strong a case for our point of view or the information we find most important. Our research shows, however, that meeting the audience's emotional needs and providing the information that matters most to them (rather than the information that matters most to us) is critical for opening the pathway to change. *(Source: Heartwired Guide)*

Findings

FINDING 1: Pain is shaped by identity.

While pain is experienced by an individual, how people think about pain and their options for pain management is social, cultural, and familial—in other words, deeply connected to their identity. This includes both personal pain experiences and community-level pain experiences (including the pain of discrimination, oppression, violence and poverty).

Messengers reflecting identities

People's identities are multifaceted. Across genders, as workers, parents, spouses, athletes, members of cultural and ethnic groups, and in other facets of their lives, aspects of identity influence how people think about and respond to their pain and the pain of loved ones. Communications or messengers that do not reflect these dimensions of people's identity—or worse, conflict with them—tend to fall flat. People need to see and hear from others like themselves to connect emotionally and for the message to have genuine impact.

> *"The level of pain you're feeling is so personal. What's unbearable for one person can feel very different for the other."*
>
> **Latina, Portland Metro**

FINDING 2: People want to have agency (control) over their own health.

Identity is about more than demographics and family structures; it also includes the personality attributes people see as core to who they are. Across the board, the people we talked to expressed the desire to be self-sufficient, informed and proactive when it comes to their health and pain management. Many prided themselves on having a "high pain tolerance" and valued being able to soldier through pain and discomfort to focus on what was most important to them in their daily lives.

> *"I'd rather be responsible for my own actions than have somebody else tell me I need to have this."*
>
> **Native American male, Warm Springs**

Self-perception

Having the ability to survive, endure, "just deal with it," adapt, keep trying, not give up, and find a way to live with pain—even if it cannot be eliminated—was important for many. Most did not see themselves as living with or "suffering" from pain (even when they may be experiencing serious pain). In other words, while everyone experiences pain, most did not want to see themselves as defined by it or stuck in it when it happens. They also did not want to be seen that way by others in their lives, including health care providers.

Agency

In addition, many expressed the desire to educate themselves, have options and information, and to be able to manage and care for their pain directly. They wanted and often preferred home remedies, home-treatment, self-treatment or "natural" remedies that didn't make them feel out of control or disconnected, which is how many described opioids make them feel.

FINDING 3: Lived experiences influence how people understand pain.

Everyone has personal lived experiences that they bring to their beliefs about pain and their perceptions of how they (and others) deal with pain. Pain is seen as something that is an inevitable part of life. Yet, pain is also seen as personal and individual. Many acknowledged that different people experience and deal with pain differently—even for the same injury, surgery or condition—and that the same person may deal with pain differently at different times in their lives, depending on what else they may be experiencing at the time.

Generally speaking, people thought of pain as an acute and temporary condition, unless they were living with frequent, persistent or chronic pain.

Pain as a guide

Depending on their past experiences, some saw pain as playing a valuable role in the body's "alarm system" to warn that something is wrong and needs attention. They also believed that pain can serve as a guide to help a person understand their limits after an injury or surgery to avoid doing more harm.

"Well, some pain is good. You need to know what your limits are, what you can and can't do."

Latina, Portland Metro

Fear of the unknown

Even as they acknowledged some helpful aspects of pain, however, most saw pain as an overwhelmingly negative experience to be avoided. Many expressed fear that pain might become unbearable, and said they would preemptively request or take a prescription opioid in order to prevent the possibility of unmanageable pain before it happens.

The connection between physical and emotional pain

Many people also understood that pain is both a physical sensation and an emotional experience. They noted that these were distinct kinds of pain and that they were connected. That is, emotional pain can make the experience of physical pain worse or manifest physically in the body, and physical pain can lead to and exacerbate emotional pain, depression and anxiety.

"For people who have anxiety and pain, the pain will be worse."

Native American female, Warm Springs

FINDING 4: People do not know what we mean when we talk about "opioids" and have little understanding of the risks.

We found that the term "opioids" was, overall, not clearly understood. When people heard campaign information about opioids, they often believed we were talking about heroin or fentanyl, rather than prescription opioids. Many were surprised to learn that Codeine, Vicodin and Percocet were opioids. Most used words like "painkillers," "pain pills" and "pain medicine" to describe the class of drugs we categorized as opioids.

Inadequate dialogue

Few people reported having conversations with health providers about the risks of prescription opioids. Those who had talked with their health providers reported that these conversations focused on side effects like nausea, constipation or feeling foggy, rather than addiction, dependence or other more serious concerns. Despite the relatively low information level among our research audience, many people initially felt as though they knew more than they did and felt confident about their ability to take these drugs safely if needed.

"I don't think that I would become dependent on opioids because first of all I've had surgeries—I've taken them."

African-American female, Portland Metro

FINDING 5: Unless they have direct lived experience with addiction, most do not believe they can become addicted to prescription opioids.

Many participants in our research did not see themselves as potential "addicts" or at risk for opioid dependence or abuse, reporting with some pride that they did not have an "addictive personality" and stating confidently that as long as they followed doctor's orders, they would not become addicted.

"I was able to medicate myself and wean myself off of it, because I'm strong-willed and not anything like the addicts in my family."

White female, Albany

Ignoring messaging

As a result, they tended to see messaging related to the dangers of opioid use, addiction and overdose as irrelevant to their own lives. Participants in focus groups, for example, often talked about information or resources related to opioids as being helpful for "other people" who they saw as being less informed, taking less personal responsibility and/or being less in control of themselves. This is an example of a flawed mental template—one that it is important to disrupt in our communications about prescription opioids (see sidebar).

Alert to the dangers

This was not true for those who had direct lived experience with addiction, either personally or in their family or community. For these audiences, the dangers of opioids were clear and top-of-mind, and they expressed frustration that providers sometimes prescribed medications without alerting their patients that these medications were opioids.

"I've got a family who was addicted to drugs and alcohol. So it can happen... it's in most of my family. I can be addicted because it's going to modify my brain."

Latino, Portland Metro

RESEARCH FINDINGS

Physical dependence

While many people quickly dismissed the risks of addiction and overdose, our research found that discussing how the body can become dependent on opioids—leading people to need higher doses for the same effect or to become sick when they stop taking them—sidesteps the flawed mental template people have around addiction as somehow optional. Out of all of our tested language, this statement had the strongest response:

> *"Your body can become dependent on prescription opioids in as few as three days."*

Many research participants and survey respondents noted that this information gave them serious pause; even if they thought they may consider using opioids in the future, they reported that they would do so much more cautiously, for a shorter period of time, and at a lower dose.

> *"I am definitely a lot more skeptical taking opioids...it made me more cautious."*
>
> **African-American female, Portland Metro**

> *"It's like a last resort and I'll approach it with caution and like, all right, I need to take this amount, so I'll do it once and see if it helps, and if not, then I'll just continue with like the ibuprofen and acetaminophen."*
>
> **Native American male, Warm Springs**

KEY CONCEPT: MENTAL TEMPLATES

A mental template is a set of images and associations that people have with something—or someone—they encounter out in the world. The idea was developed by Dr. Phyllis Watts, a social and clinical psychologist who advises change-makers on the psychological dynamics that prevent progress on tough social issues.

It is important to understand that these mental templates are not always fair or accurate. According to Dr. Watts, people develop flawed mental templates when they are not deeply familiar with something or someone—when they lack the information or experiences to fully understand and are therefore forced to "connect the dots" themselves. In our work, this means that people who don't have firsthand experience with prescription opioid addiction are likely to develop a flawed mental template about who this issue impacts and who is at risk—something that will unconsciously impact their views of and emotional reactions to our communications.

For example, many participants talked about those who experienced opioid dependence or addiction as "junkies," people who were homeless or living on the fringe of society, people who were emotionally troubled, irresponsible or using prescription opioid medicine not recommended by doctors. In other words, people unlike them. So, for our communications to be effective, we will need to understand the key components of these flawed mental templates in order to disrupt and replace them with associations and images that are neutral to positive and that connect with our audience's self-identity and lived experiences.

(Source: Heartwired Guide)

FINDING 6: Pain and pain management are not top of mind.

For most, the issue of pain management was not top of mind—many actively avoided thinking about it until they were actually experiencing pain. Most had not given consideration to how they would respond if they someday faced severe pain and had done little or no information-gathering around their options for pain management.

Planning is empowering

Many also reported that when they were actually experiencing pain, it was difficult to think clearly about any goal other than making the pain stop. Therefore, having the opportunity to consider the breadth of pain-management options in advance—in a way that was empowering and didn't provoke fear or anxiety—created more receptivity toward non-opioid options in the future.

FINDING 7: Many have had positive experiences with using doctor-prescribed opioids for pain management in the past and do not want their future options to be limited.

Many of our research participants reported previous, positive experiences with using prescription opioids to manage pain after an injury or surgery, either personally or with someone in their family. Most believed that opioids should only be used in rare instances or when in extreme pain, yet they tended to view the times they themselves used them as falling into the "appropriate use" category.

False sense of safety

This previous "non-problematic" use of opioids led many to feel as though they knew the risks, and that their past ability to take opioids without becoming dependent or addicted meant that opioids were safe for them in perpetuity. Participants expressed these beliefs even when their previous prescription opioid use took place

KEY CONCEPT: REASONING CHAINS

A reasoning chain is the way people's associations and connections lead them to develop premises and assumptions that take them to a particular conclusion.

When people have limited information about a topic, they can draw false, flawed or incomplete conclusions that interfere with their ability to change—such as the belief that taking prescription opioids as prescribed by a doctor means one cannot become physically dependent on them, or that all opioids at all doses are "safe" because they've taken opioids with no problems in the past. To support behavior change, we need to fill in the broken links in our audience's reasoning chains—the information or understanding that can help lead them to the conclusions that support the behavior change we seek.

(Source: Heartwired Guide)

years ago or was for a very different injury or condition than one they may have in the future. Most participants also made no distinctions between different types of opioids or the potency of different doses. Therefore, they felt as equipped to safely take Vicodin® or other lower-dose opioids as they did something far more potent.

Fast relief

A majority of people participating in our focus groups also believed opioids were the most effective—and often the only credible—tool for quickly and fully relieving serious pain. Many reported that they only seek medical care for pain once all of their own home-based efforts have failed and when the pain has become unbearable or significantly interferes with their life activities. Therefore, when in serious pain and seeking medical care for that pain, they want an effective tool for relieving the pain—and they want the pain relief now. Many said they were not necessarily seeking opioids and were open to other pain relief options, yet they also believed that opioids fit the bill in ways that other pain management options, like ice or over-the-counter medication, do not or have not.

> *"Opioids are the best pain reliever that there are."*
>
> **White male, Albany**

Important for healing

Notably, opioids were seen as important for more than pain relief. They were also seen as playing a vital and unrivaled role in aiding with sleep, recovery, healing and day-to-day function after an injury or surgery. So, pain management options that did not address these other perceived benefits and needs were not viewed as credible alternatives.

> *"When I am in severe pain I want to go to sleep and opioids help me go to sleep."*
>
> **African-American female, Portland Metro**

All options open

Audiences wanted to have all options available to them and had overwhelmingly negative reactions to prohibition-based messaging. If we suggested that opioids should never be used for pain management, people perceive us as unsympathetic to their pain and/or as having an "agenda"—and they largely rejected the rest of our information as not credible or relevant to their lives.

FINDING 8: Many feel ill-equipped or afraid to have conversations with their doctor about pain and pain management.

The degree to which people felt empowered and able to ask questions of their provider varied greatly and was tied to how they saw themselves as well as how they saw the provider.

Perceived power imbalances

Some, particularly audiences with lower incomes and Latino/a, Native American and Black audiences, expressed a perceived power imbalance between themselves and the health care provider that increased their reluctance to ask questions. Research participants noted concern about being uninformed or fear that the provider might be offended or angry—which could negatively impact the quality of their subsequent health care. Some felt that the provider simply knows best and there is no need to question their expertise. Others believed providers have little time to address their questions or concerns, so there was no point in asking. Some also did not realize that as patients, it was okay—and in fact important—to ask certain questions of medical professionals when they were prescribing certain courses of treatment.

> *"Talking to a physician or anyone that's in a position of authority is really uncomfortable for a lot of people."*
>
> **Latino, Portland Metro**

Past experiences with health care

A number of participants of color and participants with lower incomes pointed to negative past experiences with health care providers, expressing anger, frustration and sadness about the idea that they "have to" speak up for themselves in order to get good care. They felt that they were being failed by a health care system that was not prioritizing their needs. Research participants who had positive, long-term relationships with their health care providers and access to quality health care overall felt more equipped to have discussions with their providers and to advocate for themselves with regard to pain management. At the same time, many expressed frustration about experiences where they felt that medical professionals only treated the symptoms of their pain and did not spend enough time investigating, diagnosing and treating its source.

> *"Low income communities or black or people of color and women, I feel, are not given the same amount of quality of care in the medical health system, especially when it comes to alternative healing methods."*
>
> **African-American female, Portland**

Varying experiences

Notably, there were varied experiences related to how available or readily prescribed opioids really are. Some—particularly those with more education and access to quality medical care—reported a sense that opioids were "pushed" on them even when they did not ask for or want them. Others, particularly Native American, Latino/a and Black participants, described their perception that doctors were more withholding or reluctant to prescribe opioids for their pain.

Yet, across all participants, a significant portion did not initially believe that providers or dentists would prescribe opioids unless the drugs were really necessary. Many also questioned why, if the dangers of opioids are so serious and well-known, providers would continue to prescribe them. Communications that included this topic elevated distrust of medical professionals in a way that felt discouraging and disempowering for many.

"There have been studies that prove that black women in particular have been given less options for pain management or treatments because we are supposed to withstand more pain."

African-American female, Portland

Advocating for a family member

Interestingly, many research participants who said they were unlikely to advocate for or ask questions regarding their own pain said they were much more willing to do so on behalf of a loved one such as a child, spouse, parent or sibling who they felt needed support. This suggests that activating people's self-identity around caregiving is a significant pathway for helping people feel more positive and confident around the idea of asking questions of a provider.

"A doctor is not going to give it to you unless you really need it. That's how I feel."

Latina, Portland

FINDING 9: People are genuinely interested in non-opioid options—but concerned about access, affordability and effectiveness.

As noted above, when it comes to managing pain, many people value self-sufficiency and see themselves as being proactive and not willing to wallow or indulge in self-pity. Many want to be able to manage pain on their own—a desire intensified by anxiety about their interactions with providers.

"Nobody wants to keep going back to the doctor. Nobody wants to keep going back to the pharmacy. You want something that you can do at home, possibly for free, that works for you."

White male, Lincoln City

Questions about effectiveness

Interest in other options was tempered by skepticism and the fear that non-opioid alternatives wouldn't be able to match opioids' strong and immediate pain relief and ability to aid with rest and healing after an injury or surgery. People had very low awareness of non-opioid options for severe pain—including non-opioid prescription pain relievers or sleep aids, mechanical aids such as cryo-therapy or TENS units, topical or other over-the-counter therapies, or anesthetic/medical options such as Botox® or nerve blocks that can significantly relieve or eliminate acute pain.

Experiences of dismissal

Furthermore, some audiences heard suggestions to use alternatives like ice or over-the-counter pain relievers as dismissal or mockery of their pain. This was particularly true for women or people of color who had lived experiences with health care providers ignoring, minimizing or dismissing their pain. Some felt as though these options, when offered instead of opioids, implicitly suggested that they were exaggerating or faking symptoms or that the provider believed they were "drug-seeking."

> *"I have had family members really suffer with pain and talking about how the doctor was just like, 'put ice on it."*
>
> **African-American female, Portland**

Previous negative or ineffective experiences with certain non-opioid alternatives can also lead participants to dismiss them as options for current or future pain—even if the current or future injury or surgery causing the pain is quite different. Notably, many people also expressed more concern about the fear of liver damage resulting from over-the-counter painkillers than about the side effects or overdose risk of prescription opioids.

Access and affordability

When non-opioid options were mentioned, many participants initially raised concerns about access and affordability. The belief—and sometimes the reality—was that prescription opioids were less expensive and more likely to be covered by insurance than other options. Overall, participants were interested and excited to learn more about, and to have the option to consider, non-opioid pain management options. Yet, they also wanted to preserve the option to take opioids for "serious" pain or injury if needed.

> *"If you can't pay for it, well, then that really limits your options."*
>
> **Native American male, Warm Springs**

Recommendations: Putting The Findings To Work

Applying what we've learned about how people think about pain and opioids to our communications work—whether as marketers, public health professionals or providers—starts with a consideration of the "frame" through which we present our information.

The Power of Framing

Framing is the "information around the information"—the imagery, metaphors, stories, messengers and tone that all provide subconscious cues about how the information should be interpreted.

FRAMING

The way issues and problems are framed influences the choices we make about what we do with the information. This is clearly evident in political campaigns; for example, the frame "energy exploration" evokes a very different understanding of motivations and consequences than the frame "drilling for oil." Similarly, the way in which we frame terms such as "pain," "pain management" and "opioids" influences how people respond and the options they consider for their own lives.

MOTIVATION-BASED FRAMING

We have a much better chance of engaging people in behavior change when we appeal to their motivations rather than their fears. Indeed, numerous psychological and neurological studies show that people are far more likely to take action in order to achieve a desired reward than to avoid a perceived risk. In the realm of pain management, rather than telling people to avoid the negative threat of addiction, it is more effective to choose frames that activate people's positive desire for agency. This provides reassurance that they will be able to successfully and safely manage pain, rest and heal.

HARM-BASED FRAMING

Many opioid campaigns to-date have centered a harm-based frame that "anyone can become addicted to opioids." However, our research shows that a large percentage of our target audience does not believe they are at risk for addiction—likely leading them to disregard information framed through this lens as irrelevant to their lives.

Recommendations

KEY RECOMMENDATION 1: Build connection.

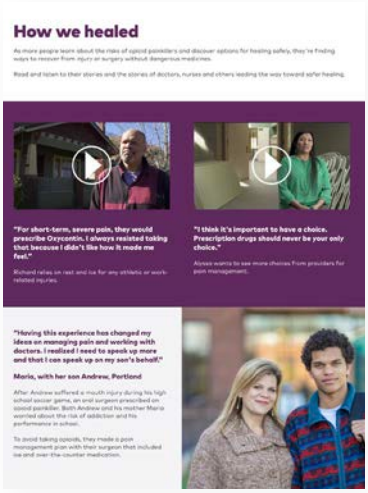
Openness to persuasion, and ultimately attitude and behavior change, comes through connection. People need to see and hear from people like themselves to build connection emotionally—to believe that they, and their pain, matter.

Mirroring experiences of pain

Many people expressed concern that they were treated "like a number" rather than an individual, or have had experiences where they felt like their pain was being minimized. By validating people's realities and mirroring their experiences of pain, we calm the "downstairs brain" and enable them to receive information about pain management without feeling judged or dismissed.

Key words, phrases and statements to use:

- *Pain is real.*
- *Pain is personal.*
- *Pain is part of life.*
- *Pain is both a physical and emotional experience.*
- *No two people experience pain the same way.*
- *Everyone deserves to have a plan to help them rest, recover and heal.*
- *It can be difficult to talk about pain management and ask questions when you are in serious pain.*



The Heal Safely website shares personal stories about pain and pain management.

"Most of these doctors I go to—five minutes at a time, they are rushing through their papers, scribbling like this. They sign a prescription, send you out the door."

White male, Lincoln City

KEY RECOMMENDATION 2: Define acute pain and frame the goals of pain management.

Pain means many things in the minds of our audience, as does managing it. Defining terms and goals is crucial to empowering people to understand their health care experiences.

"Serious" pain after injury or surgery

Our research shows that when we don't help audiences situate the kind of pain we are talking about—for these purposes, serious pain from injury or surgery—we can talk past them and miss an opportunity to connect effectively.

It is important to be clear that we are not talking about emotional, chronic or persistent pain. The word "serious" matters as well—conveying that we are not talking about non-opioid approaches for relatively minor pain that can easily be managed with other methods.

We also want to make evident that we are not talking about certain kinds of very severe pain, such as terminal cancer, for which a different pain management approach may be needed. It's equally important to be aware of using jargon like "acute" pain or other medical phrasing that is not readily understood by the audience.

Begin by situating the conversation in specific terminology, using phrases such as:

- *Pain after an injury or surgery*
- *Short-term pain due to a serious injury*
- *Treating pain*
- *Aiding in recovery*

SOCIAL MODELING

Behavioral and cognitive psychology tell us that there are two basic ways people learn new things: first, through trial and error (doing something and learning through first-hand experience what happens as a result) and second, through social modeling (watching others' actions and drawing conclusions by observation).

Social modeling is an important way that cultural norms and expectations are learned. It is more than mimicry of others' actions; instead, people develop subconscious "rules" for behavior based on what they see. And the more people identify with the person they are observing, the more likely they are to change their own behavior as a result.

Emphasizing pain management rather than elimination

Using specific language can also help redefine goals, shifting the expectation away from being "pain-free" to "addressing pain," "managing pain," and "aiding in recovery and healing." Language should be focused around:

- *Pain management (not pain cure)*
- *Pain management is a process*
- *Making pain manageable, tolerable*

Further, talking about pain as "one of the ways your body helps you know your limits as you are healing," helps build on people's belief that pain can serve a productive and important purpose—one that opioids can mask.

Defining the goal

Defining the goal around "healing" further mirrors people's desire to be empowered in their journey to recovery—treating the source of the pain and not just the symptoms:

- *Effective pain management after an injury or surgery can help you heal, reducing the chances of complications and serious side effects from medications.*
- *Effective pain management can reduce or eliminate serious risks.*
- *Effective pain management can prevent short-term pain from becoming chronic pain that keeps pain signals firing for weeks, months, or even years after an injury has healed.*

KEY RECOMMENDATION 3:
Define "opioids."

As noted above, awareness and understanding of the term "opioids"—as well as their risks, who takes them and who may become addicted or dependent on them—is limited and often incomplete or flawed.

To avoid confusion, it is necessary to clearly define the term "opioids" as "prescription pain medication," distinguishing them from recreational or "street drugs." Using brand names with which people are more familiar can be helpful in creating association.

A last resort

Explaining that opioids or prescription pain killers are a powerful class of drugs designed to manage the most severe pain helps recategorize them as potent and potentially risky and reserved for only certain cases or as a last resort. This is important for helping people understand that there are other options available and to be open to using non-opioid or low-opioid pain management options:

- *Opioids, or prescription pain killers, are a powerful class of drugs designed to manage the most severe pain and should be a last resort for most short-term pain after injury or surgery.*

Using familiar language

When describing and defining opioids, using terms that are more familiar along with plain language helps reduce confusion:

- *Prescription painkillers*
- *Prescription pain medicine*
- *Prescription pain pills*
- *Opioid pain medicine*
- *Opioid painkillers*
- *Prescription opioids*

It is important to situate opioids within the context of prescription medication:

- *Healthcare providers sometimes prescribe strong pain medicines called opioids for management of severe pain.*
- *Vicodin ®, Norco®, OxyContin®, Codeine, Morphine, Percocet® and Oxycontin® are just some of the many types of opioid prescription pain medicines.*

Heal Safely provides a list of commonly prescribed opioids for patients.

KEY RECOMMENDATION 4: Emphasize the risk of physical dependence and serious side effects rather than addiction and overdose.

We know that many people discount warnings about overdose and addiction. However, as mentioned above in Finding 5, one of the single most effective statements we found in our research is:

> *Your body can become dependent on prescription opioids in as few as three days.*

Research participants expressed that this statement gave them serious pause, leading them to feel more cautious about opioid use in the future. People also reported that this information made them more likely to ask for a lower dose or shorter prescription in the future.

The three action steps on the Heal Safely website start with introducing the risk of physical dependence.

Unpleasant experiences

Even people who expressed that they found prescription opioids to be helpful during past injuries or surgeries acknowledged that the tradeoff for pain relief were often unpleasant side effects that interfered with their daily lives: dizziness, nausea, lethargy, feeling "out of it," inability to drive, inability to care for kids. Leading with these side effects in our communications helps people relate to the experiential reasons they may choose to avoid opioids.

"I just didn't like how it made me feel. I felt very irritated; my stomach was upset. I threw up. . ."

African-American male, Portland Metro

When discussing the risks and side effects of opioids, it's important to use clear, concise language that is validated by research:

- *Recent studies have shown that prescription painkillers can actually slow down the body's healing process by disrupting sleep and making other pain management options less effective.*[1]
- *Prescription opioids can hide the signals your body is sending you, leading you to move too much before you are physically ready and risk reinjuring yourself.*[2]
- *Prescription painkillers mask pain, but don't reduce or treat the source of the pain, such as swelling, inflammation and overactive pain signals.*[2]
- *While prescription opioids may be necessary in cases of extreme pain for many kinds of injury and surgery pain, recent studies have shown they can be less effective at addressing pain and aiding healing than lower-risk non-opioid options.*[3]

"You feel like a zombie afterwards."

Latina, Portland Metro

Unexpected risks and side effects

Because many people do not believe they are at risk of addiction or overdose, talking about these risks as "unexpected" and characterizing overdose as "accidental" helps introduce the idea that these things could inadvertently happen to them, despite their best intentions.

1. Shanmugam VK, Couch KS, McNish S, Amdur RL. Relationship between Opioid Treatment and Rate of Healing in Chronic Wounds. Wound repair and regeneration: official publication of the Wound Healing Society [and] the European Tissue Repair Society.2017;25(1):120-130. doi:10.1111/ wrr.12496.
2.National Institute of Neurological Disorders and Stroke (2014) Pain: hope through research. Retrieved from https: //www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Hope-Through-Research/Pain-Hope-Through-Research
3. Ilyas, A.M. , Miller, A.J., Martin, D., Matzon, J. L. (2018) Fighting the Opioid Epidemic: A Prospective Randomized Controlled Double-Blinded Trial Comparing Acetaminophen, Ibuprofen, and Oxycodone after Hand Surgery. Retrieved from http://aaos-annualmeeting-presskit.org/2018/research-news/opioid/

In addition, while people were familiar with the common side effects of nausea, constipation and dizziness, many were less aware of opioids' more serious potential risks such as slowed respiration and heartbeat. Characterizing side effects as more than just "unpleasant" but also "serious and potentially risky"—and providing specific examples—helped give participants reason to rethink whether the benefits are worth the risks.

- *Many people are surprised to learn that taking prescribed pain medicine after common surgeries and injuries are some of the main ways that people unexpectedly find themselves physically dependent on prescription painkillers.*
- *After taking opioids for just a few days, your body can start becoming dependent—even if you have taken prescription painkillers with no issues in the past.*
- *Prescription painkillers have many serious side effects and risks, including slowed breathing, trouble thinking, physical dependence and accidental death by overdose.*

"I hadn't considered the side effects and their seriousness. I assumed it was a normal effect of taking the medications, and didn't realize how serious some of those side effects actually can be."

White female, Portland Metro

KEY RECOMMENDATION 5: Raise awareness about non-opioid options that credibly meet people's needs for rest and healing.

We have found that terminology is also a key component in framing non-opioid pain management options. When hearing the word "alternatives," many people reported associations with medicines that are untested, experimental or "woo-woo."

People responded more positively to the word "options," not only because it avoids the negative associations of "alternatives" but also because it conveys agency and emphasizes personal choice.

Modeling the journey from skeptical to informed

Messengers should model a journey from being unaware or skeptical to exploring other options, becoming more informed and using non-opioid or significantly reduced opioid approaches for pain management:

Billboards for the Heal Safely campaign emphasize the need to ask questions.

RECOMMENDATIONS

- *Like a lot of people, I always assumed that prescription pain medicine was necessary or the best option for dealing with pain after a serious injury. I never thought to ask questions about it or talk with my doctor about other options.*
- *I never imagined that I could become dependent on opioid medication. I always took it as directed, hadn't had problems in the past and didn't have an addictive personality. I was shocked to find that it was so easy for your body to become dependent so quickly and that was a wake-up call.*
- *To be honest, I was skeptical that anything could really work as well as the prescription pain medicine I'd had in the past, but I was surprised to find that wasn't the case.*
- *I was afraid of the pain and afraid that other options wouldn't work as well as prescription pain killers.*
- *As a doctor, I find that many people are afraid they won't be able to handle the pain and feel that opioids are their only option.*
- *Sometimes patients have tried something before with no success so they come to believe that it can't work for them. They hear us say they can take Advil® or use ice and think that means we don't take their pain seriously. The key is knowing what is right for them and how to use these options effectively.*

Offering concrete options

Introducing concrete examples is highly effective in motivating audiences to investigate, explore and consider other approaches, as is listing options in a comprehensive but not overwhelming way. Explaining how each works not just to relieve pain, but also to aid in rest and healing—such as reducing swelling—helps audiences connect to the information.

It's important to include not just medical options, but home remedies such as over-the-counter or topical treatments such as plant or hemp-based products prescribed by a naturopath physician that people can do on their own:

- *Research shows that, for most people, taking a few weeks of prescription strength ibuprofen or acetaminophen for pain relief has far fewer health risks than even a few days of prescription opioid use.*

- *For rest and sleep, over-the-counter sleep aids such as melatonin or Tylenol® PM can be as or more effective than prescription pain killers.*

Again, mirroring possible feelings of skepticism is important in establishing trust and reliability:

- *Sometimes people may hear about these options and feel as though they aren't real solutions for serious pain and healing, but that's not the case. They can be very effective when taken properly and at the right doses.*

It can be helpful to make reference to "prescription strength" or "prescription doses" to minimize skepticism for people who have taken these medications previously and found them to be ineffective. They need to be cued that taking them differently or at a different potency could lead to better outcomes—even for surgeries causing serious pain, such as C-sections and heart surgeries—and that their provider can help them plan the right approach.

Explaining how each option works

It isn't enough to say that someone can recover from an injury without opioids or that there are many other ways to treat pain, or even to list different options. Audiences need to hear basic explanations of how other options work to address pain.

Particularly when discussing less familiar options, it's helpful to include more detail and, whenever possible, to draw parallels to familiar terms:

- *Many people are surprised to learn that there are new non-medication treatments or tools for immediate relief of serious injury pain or surgery—like nerve blocks, which temporarily numb the nerves causing pain.*
- *An epidural is one common form of nerve block, but there are others that don't require hospitalization and can still allow you to function pain free.*

While many people were open to non-opioid approaches, concerns about accessibility and affordability led some to dismiss these options for managing serious pain. By addressing these concerns, we can help them consider other options they might otherwise assume are out of reach:

- *Many people are surprised to learn that there are new and affordable non-medication treatments for serious pain relief that are covered by most insurance companies, including Oregon Health Plan.*

Treating pain at the source

Some research participants expressed frustration that their providers only treated their symptoms, not the source of pain. Highlighting that other options actually treat the underlying cause of the pain (swelling, muscle contractions, etc.) reinforces the importance of healing and serves to make these options more appealing than opioids, which only mask pain.

- *Instead of masking the pain, these options can reduce inflammation and swelling that cause the pain—treating the source, not just the symptoms.*

Contextualizing options

We found that there is an important balance to strike in sharing information with audiences about non-opioid options. Too little detail risks causing audiences to think we are not taking their pain seriously; too much feels overwhelming and leads them to stop reading and to reject the information as too complicated. The Heal Safely campaign website (www.healsafely.org) that we developed as a result of this research includes simple, high-level information in list format, designed to be easily digestible.

SEVEN OPTIONS FOR SAFE HEALING

1. Over-the-counter medicines: Ibuprofen and acetaminophen (Advil (R) and Tylenol (R)) can actually reduce pain just as well as prescription opioids—without the side effects. And because ibuprofen reduces swelling, it can help you heal faster. Your doctor can prescribe the right prescription-strength doses and a custom schedule for you.

Friedman, B.W., Dym, A.A., Davitt, M, et al. (2015). Naproxen with cyclobenzaprine, oxycodone/acetaminophen, or placebo for treating acute low back pain: a randomized clinical trial. JAMA, 314(15): 1572-80.

2. Ice and heat: Ice and heat reduce swelling and inflammation, easing pain. They are powerful options when combined with other safe treatments.

Qaseem, A., Wilt, T.J., McLean, R.M., Forciea, M.A. (2017). Noninvasive treatments for acute, subacute, and chronic low back pain: a clinical practice guideline from the American College of Physicians. Annals of Internal Medicine, 166:514–530.

3. Help with sleep: For rest and sleep, your doctor can recommend adjustments to your sleep schedule, positioning, timing of medications and other helpful ways to help you get the rest your body needs to heal—without the risks and side effects that come with opioid painkillers.

Whibley, D., AlKandari, N., Kristensen, K., Barnish, M., Rzewuska, M., Druce, K., & Tang, N. (2019). Sleep and pain. The Clinical Journal of Pain, 35(6), 544-558.

4. Acupuncture: Acupuncture uses very thin needles to stimulate nerves, muscles and connective tissue, reducing pain and helping you heal.

Cho, Y. , Kim, C. , Heo, K. , Lee, M. S., Ha, I. , Son, D. W., Choi, B. K., Song, G. and Shin, B. (2015). Acupuncture for acute postoperative pain after back surgery: a systematic review and meta-analysis of randomized controlled trials. Pain Practice, 15: 279-291.

5. Physical therapy: Physical therapy involves a combination of exercises, massage and other treatments to ease pain and help you move better.

Liu, X., Hanney, W., Masaracchio, M., Kolber, M., Zhao, M., Spaulding, A., & Gabriel, M. (2018). Immediate physical therapy initiation in patients with acute low back pain is associated with a reduction in downstream health care utilization and costs. Physical Therapy, 98(5), 336-347.

6. Nerve blocks: A nerve block is injected during your surgery and temporarily numbs the nerves that cause pain, providing relief during the first 24 hours of recovery.

Altıparmak, B., Toker, M.K., Uysal, A.I., Turan, M., Demirbilek, S.G. (2019). Comparison of the effects of modified pectoral nerve block and erector spinae plane block on postoperative opioid consumption and pain scores of patients after radical mastectomy surgery: A prospective, randomized, controlled trial. Journal of Clinical Anesthesia, 54: 61-65.

7. Topical medicines: Your doctor can recommend topical medicines–such as salves and creams that you rub on your skin—that have been shown to be effective in treating pain and inflammation.

Derry, S., Wiffen, P.J., Kalso, E.A., Bell, R.F., Aldington, D., Phillips, T., Gaskell, H., Moore, R.A. (2017). Topical analgesics for acute and chronic pain in adults - an overview of Cochrane Reviews. Cochrane Database of Systematic Reviews, 5. Addressing accessibility.

KEY RECOMMENDATION 6:
Calm skepticism and concerns.

When people feel like their concerns are understood, they become more open to hearing messages that contradict their pre-existing beliefs about opioids.

Expanding understanding

As noted above, prohibition messages ("no opioids") lead people to feel we are taking something away from them and to distrust our motives. When we instead focus on expanding people's understanding of—and confidence in seeking out options for—better pain management and healing, they are more willing to come to the conclusion themselves that opioids are not their first choice. Seeing non-opioid options as having fewer side effects, speeding up healing and aiding in sleep broadens the conversation and addresses the breadth of people's concerns.

Evolving knowledge

Acknowledging that until recently, prescription opioids were seen as the best way to handle pain across medical industries helps people understand that science and medical practice are constantly evolving. Research participants viewed this as a good reminder that certain established practices and understandings are changing, without elevating mistrust of their provider:

- *Until recently, prescription painkillers were seen by many patients and health care professionals as the best way to manage serious pain after an injury or surgery. We now know they can do more harm than good, come with serious side effects and risks and should be avoided unless you and your doctor decide they are necessary.*
- *New pain management options are constantly emerging that make opioids less necessary.*

The right dose and approach for the kind of pain

It is important to communicate that non-opioid approaches need to be used correctly and matched to the injury or type of pain, and that even if something hasn't worked in the past, that doesn't mean it won't work in the future. It should be explained that the key difference between what a person might have experienced as an ineffective pain management approach in the past and what they can expect now is the counsel and support of a medical professional who will work with them to find the right approach for this unique kind of pain, and provide guidance on how to maximize effectiveness:

- *The key to using over-the-counter options is taking the right doses at the right time. Even if you have tried these before, your provider can help guide you to use them more effectively.*

Again, mirroring people's initial skepticism can be helpful in reinforcing the message:

- *Sometimes patients have tried something before with no success so they come to believe that it can't work for them. They hear us say they can take Advil or use ice*

and think that means we don't take their pain seriously. The key is knowing what is right for them and how to use these options effectively.

- *Sometimes people may hear about these options and feel as though they aren't real solutions for serious pain and healing, but that's not the case. They can be very effective when taken properly and at the right doses.*

KEY RECOMMENDATION 7: Equip and empower people to develop a plan.

Having a plan before people experience pain from a surgery or injury offers them practical guidance. When people are in the middle of a crisis and experiencing pain, they may have difficulty remembering what to ask. A plan gives them something tangible to bring with them to a medical appointment or to take home after leaving their appointment.

Tools for conversation

Providing people with tools to prepare for effective conversations with health care professionals when they or a loved one are experiencing pain reduces their anxiety and concern over pain. Many times, patients don't know what questions to ask. The idea of preparing in advance is positive for many people and they report that the prompt to prepare questions before their next appointment is practical, helpful and empowering. It is also a cue that taking responsibility for their own health means planning ahead:

- *It can be tough to know what to ask your doctor. Asking a few simple questions can make a big difference in your healing.*

It's not enough to tell people they can ask questions of their providers or to prepare in advance for their appointment. It's important to model what this looks like, providing concrete examples of the kinds of questions and interactions people can have with their providers. Knowing what questions to ask lets people know that it is okay to ask and helps make them feel less concerned that their doctor will think they are asking inappropriate questions.

> *"If you have a plan you have something to go by if you feel helpless—and you usually do if you're in pain."*
>
> **Latina, Portland Metro**

> *"Unfortunately, a lot of people don't have the wherewithal to think of things they should be asking. . .a lot of people don't know to ask, or they don't know they can ask and they just go, "Oh yes, okay."*
>
> **White male, Lincoln City**

Heal Safely provided a downloadable or printable plan for patients to take to doctor appointments.

KEY RECOMMENDATION 8: Position providers as partners.

At the end of the day, a person's positive ongoing relationship with their provider is the key to paving the way for long term health. They need to see their providers as partners, and while the goal of a campaign is to help people think more broadly about their options and change their intent, ultimately, they have to work with their provider. It is, therefore, important to pave the way for a positive relationship and successful experience, and our communications can help do that.

Modeling permission to ask questions

As discussed in the previous section, encouraging people to develop a plan and prepare questions for their providers promotes the collaborative nature of health care and is essential to the success of opioid behavior change. And giving people explicit permission to ask questions helps them feel empowered:

- *Your provider can help you create the right plan for you.*
- *Even if you have tried these other options before, your provider can help guide you to use them more effectively.*
- *You can always call or email your doctor if you have questions after your appointment.*

Heal Safely featured doctors and nurses as messengers encouraging patients to ask questions.

A wide range of providers

Including references to doctors, dentists, oral surgeons, surgeons, nurses, nurse practitioners and other kinds of providers is important, given the wide range of professionals our audience may see and interact with around opioids. They may also have had different experiences with different kinds of providers—some more positive than others.

Putting It All Together: The Heal Safely Campaign

Building on our research and messaging findings, we developed an audience-centered campaign that aims to empower Oregonians to choose a non-opioid option for managing acute pain after injury or surgery.

The key goals of the campaign are:

- Define opioids so people know we are talking about prescription painkillers.
- Raise concerns about the effectiveness and safety of prescription painkillers (opioids) for managing short-term pain after injury or surgery.
- Increase confidence in non-opioid pain management options and comfort in talking with their doctors about pain.

The campaign is story-driven, using photos, videos and first-person narrative from diverse Oregonians throughout the state. Under the name "Heal Safely," the campaign centers the positive goals of safe healing rather than the negative threat of opioids.

My Pain. My Plan.

The centerpiece of the campaign is a simple "My Plan. My Plan." toolkit that provides research-tested information about pain, prescription opioids and pain management options, as well as questions for people to ask their doctor and a planning worksheet. Research participants reported that it made them much more likely to request a non-opioid option in the future and feel more confident about asking questions of their doctor. Many said they intended to share it with friends and family.

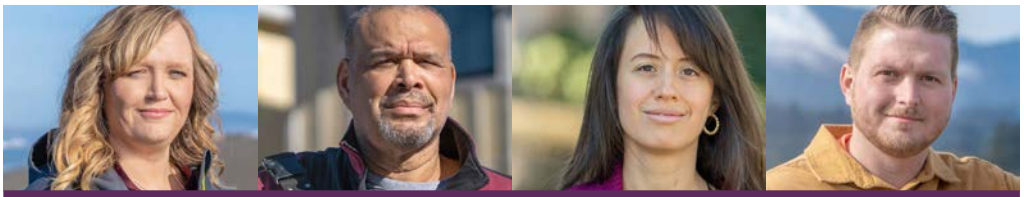
First person statement, emphasizing that pain is personal and reinforcing agency in developing a plan. Positive, natural imagery.

Intentional resilience-based sequencing: introducing positive goals first (resting and healing) and then introducing the key fact about physical dependence. "Everyone" framing reinforces that pain is a part of life, and the idea that people "deserve" a safe, effective plan centers the patient's experience.

Focus on "serious risks and side effects" rather than addiction and overdose.

List of common brand names to define opioids.

Campaign description defines the kind of pain we are talking about: pain after injury or surgery.



Get the best pain management options for you.

Step 1: Prepare for your doctor visit

1. Is there a friend or family member who can come with you to your appointment to help you get the information you need?
2. Do you have concerns about taking pain medication? Have you had a negative reaction to it in the past?
3. What are you currently doing to reduce pain?

Step 2: Ask your doctor key questions

1. Are there over-the-counter options or non-opioid medications to manage pain and help with healing?
2. What about managing swelling or difficulty sleeping?
3. Are there things you can do to get back to your regular routine?

Don't be afraid to keep asking questions until you clearly understand your doctor's instructions. And don't hesitate to call or email them after your appointment if you need more information.

Step 3: Questions to ask if you are prescribed pain medicine

1. Can I try a non-opioid medication?
2. Can I start with the lowest dose and fewest pills?
3. Can I stop taking it in three days or less?
4. How can I safely get rid of any leftover medication?

SOURCES:

1. Bemben, Nina M. "CDC recommends limiting duration of opioid therapy for acute pain." *Pharmacy Today,* 22.09 (2016): 46.
2. Shanmugam VK, Couch KS, McNish S, Amdur RL. "Relationship between Opioid Treatment and Rate of Healing in Chronic Wounds." *Wound Repair and Regeneration: Official Publication of the Wound Healing Society [and] the European Tissue Society* 25.01(2017):120-130.

heal SAFELY

A campaign to empower people to heal safely after injury or surgery. **Learn more at HealSafely.org**

In partnership with: Oregon Health Authority | OHEA Oregon Health Equity Alliance

Call to action is positive: Get the best options for you. Intentional use of "options" rather than "alternatives."

Simple questions broken into three categories, centering the patient's experience.

Encouragement to ask more questions and follow up, emphasizing agency.

Research citations to emphasize recent, science-based information about pain management.

My Plan:

Many people are surprised to learn how many safe, effective and affordable options there are for managing serious pain. Insurance companies, including the Oregon Health Plan, cover a variety of options. The key is to ask.

Use this chart with your doctor to map out the right combination of treatments for rest and healing:

MY PLAN	Prescription medicine (dose & time)	Over-the-counter medicine (dose & time)	Rest / activity changes	Other treatments (ice, heat, exercises, etc.)
DAY 1				
DAY 2				
DAY 3				
DAY 4				
DAY 5				
DAY 6				
DAY 7				

heal SAFELY

A campaign to empower people to heal safely after injury or surgery. **Learn more at HealSafely.org**

In partnership with: Oregon Health Authority | OHEA Oregon Health Equity Alliance

"Many people are surprised" models the journey of learning new information & emphasizes that more options are available than people may realize.

Columns cue that there are more than just prescription approaches for pain management, and mention of "dose and time" communicates the importance of a specific plan to maximize the effectiveness of the selected approach.

Grid visually shows that a plan may include multiple approaches, and may evolve over time.

Narratives with Impact

Storytelling is a powerful tool for change. Yet all stories are not created equal.

Our research reveals that people find first-person stories from people "like them" sharing how they navigated their own experience and successfully managed pain without opioids to be compelling, credible and influential. The findings also show that including the following components matter a great deal to whether a story has transformative power or falls flat:

> *"[I saw] someone similar to me, a regular construction worker who was expected to be back and ready immediately after pain."*
>
> **White male, Central Oregon**

Situate the messenger in family and community.
As discussed above, people bring multiple identities to the way they think about pain. Personalizing the messenger as much as possible is helpful for creating identification and emotional connection along attributes including:

- Ethnic/racial (e.g. "a member of The Confederated Tribes of the Umatilla Indian Reservation)
- Geographic (e.g. "from a small town on the Oregon coast)
- Occupational (e.g. "a construction worker who counts on being healthy to get a paycheck")
- Family (e.g. "a father to teenaged sons")
- Caregiving (e.g. "helping my husband prepare for his surgery")

In general, our messaging should not lead with addiction. However, our research shows that in rural communities and Native communities, it is helpful to acknowledge the community-wide impacts of opioid addiction, highlighting the strong desire to keep prescription opioids out of the hands of young people as a key motivator to avoid them.

Acknowledge the seriousness of pain and the fears and concerns people have about being able to manage pain.

Our research shows that people have a great deal of anxiety about pain and some may request or take prescription opioids preemptively in order to avoid pain becoming unmanageable (rather than waiting until they are in severe pain to do so). Validating the severity of people's pain and modeling that it is reasonable and normal to have fears about pain helps calm the "downstairs brain." Discussing ways that providers can help them make contingency plans in case the pain gets worse can further calm people's fears.

Give voice to the needs and values people are weighing in their decisions.

People are not managing pain in a vacuum and their decisions about how best to do so are often influenced by other pressures, responsibilities and needs and values. Giving voice to these influences—getting back to work, caring for kids, not being stuck in bed, being resilient and self-reliant—can help to elevate similar values and aspirations in our audience and support them in contextualizing "what's at stake" in a way that goes beyond a list of risks and side effects.

Explicitly describe the methods people used to manage pain without opioids and, if applicable, provide information about how these methods helped people heal or caused fewer side effects than opioids.

Because of people's lack of familiarity with non-opioid pain management options and their skepticism that they will work, it is important to provide concrete information about non-opioid options and how they help people rest and heal. This offers a solution ("here's how other people have managed pain without opioids") rather than simply raising a problem ("opioids can be addictive and should be avoided").

People will be skeptical of stories that overstate or oversimplify the effectiveness of non-opioid pain management options—and may feel that we are minimizing or diminishing the severity of their pain if we do so. This means it is important to be realistic about how people are able to manage ongoing pain. We also know from our research that people find the negative side effects of opioids to be more motivating and relatable than the risk of addiction or overdose as a reason to avoid them. So, it is helpful to emphasize how non-opioid options do not cause the physical side effects of opioids (dizziness, lethargy, disrupted sleep, constipation, nausea, etc.).

"I loved how [the messenger] said she and her doctor worked together. We are the ones living in our bodies, therefore we're the experts, but we also need to recognize, and appreciate our doctors' medical expertise, and work together with them."

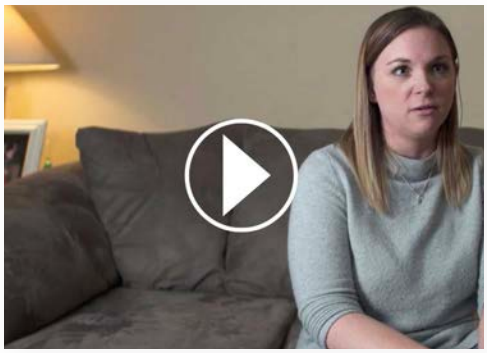
White female, Oregon Coast

Model asking questions, making a plan with a doctor and being able to heal safely.

Our research shows that regardless of the reason, most people have some level of anxiety or hesitation around asking doctors questions about pain and pain management. By modeling both the experience of asking questions and the specific questions people asked (as well as the positive results they gained in their healing), we help give people permission and encouragement to do so. By communicating how people worked with their provider to make a personal plan for pain management that met their goals and needs, we help more people feel confident in doing the same.

Sample Narrative #1: Kathy

In the story below—a transcript of one of the Heal Safely web videos—Kathy situates herself immediately within her family and community, and elevates her hopes around being able to take care of her children as the reason she did not want to use opioids longer than necessary after her serious surgery. She acknowledges her fears about being able to manage pain without opioids and describes developing a plan with her doctor. She also talks about the contrast between her experience with opioid and non-opioid pain management approaches and concludes by expressing concern for the community impact of prescription opioids.



A few years ago, my doctor told me that I needed to have a hysterectomy. I'm a single parent so I don't have a lot of help, and my kids are super dependent on me. I was really concerned with how quickly I could get back to driving my kids to school, to being present in their daily life.	*Kathy starts by placing herself in her family and talks about her priorities for healing: driving her children to school and caring for them on a daily basis.*
I was going to drive my son to school Monday morning. My surgery had been on Friday, so the last time I took an opioid was Sunday morning. I was in a lot of pain and very concerned, wondering, "Could I do this? Could I really stop taking the opioids?"	*Kathy acknowledges the severity of her pain and expresses her fears about being able to manage pain without opioids.*
I used heat—heat was the miracle of all things. Lots of rest. I felt Ibuprofen was just as effective. I was still in pain. There was still pain there, and that goes with it—it was a major surgery.	*Kathy describes the specific way she managed her pain without suggesting that the pain was completely eliminated.*
I think I felt worse on the opioids than I did when I was just taking Ibuprofen because I was foggy and fuzzy. And actually, the fourth day I got a really bad migraine, and called my doctor and she had said that it was from the opioids that I had been taking. So, I was happy to know that taking Ibuprofen, using heat and getting rest was a better alternative in every aspect than taking opioids.	*Kathy describes ongoing conversations with her doctor and models that the non-opioid options provided fewer side effects than opioids.*
Roseburg is a small town. Opioid dependency is pretty prevalent. You can see it on the street, you can see it in our schools, you can see it all over our community. When I chose not to take it, it made me have leftovers, and it's scary to have that in your house—to be available to your kids, to be available to someone else's kids, so being able to dispose of prescription pain medicine properly is really important.	*Kathy connects her personal experience to the community experience of opioid addiction and names her desire to avoid having leftover opioids that could end up in young people's hands.*
I learned that you have to take care of yourself, that you have to advocate for yourself, and you're the only one that can control your future.	*Kathy concludes with a statement of empowerment and agency.*

Sample Narrative #2: Dr. Madrigal

In the story below—a transcript of one of the Heal Safely web videos—Dr. Madrigal speaks in an empathetic, conversational tone about his personal experiences with pain and how they inform his approach as a doctor helping his patients. Throughout, he emphasizes that pain is personal and patients know their bodies best. He describes working with patients to develop the right plan with them, and to continue working with them if the pain persists. He closes with an explicit encouragement that patients should ask their doctors questions.

When I was young, my mother worked really hard. She used to clean houses and used her hands a lot. She ended up getting arthritis very early in life, so, I got to see kind of firsthand how pain could affect someone.	*Dr. Madrigal starts by telling his own personal/family story about pain, creating an empathetic connection with the viewer.*
When I think about a patient with pain, it is something that's very personal to them. I need to let the patient tell me their story, and how they're managing with the pain from day to day. I need to know where it is, what type of pain it is so I can help them come up with a good treatment plan.	*Dr. Madrigal acknowledges that pain is personal and describes talking with the patient and working closely with them to come up with the best plan for them.*
Since I finished residency and my training, what I've seen with prescription painkillers is kind of a full 180. Most healthcare organizations are really, um, taking a strong stance on not prescribing these medications.	*Dr. Madrigal models changing medical science and practices around pain management, helping diffuse potential mistrust of doctors' past prescribing of opioids.*
Long-term use of them can lead to things like problems with constipation, problems with memory, thinking clearly, being able to make good decisions.	*Dr. Madrigal emphasizes serious side effects rather than the risks of addiction or death.*
Some of your other options besides the typical prescription drug medications are going back and forth between ice and heat. If the pain persists, then I start suggesting things like massage, acupuncture, chiropractic depending on the type of injury, and using a combination of things to get their pain under control.	*Dr. Madrigal describes several other options, using "options" rather than "alternatives" and models working with patients over time to respond to changing needs.*
I believe that it's important for a patient to ask questions, especially in the realm of pain management. Only a patient knows their own body, and I'm just here as a guide to try to help patients make the most informed decisions.	*Dr. Madrigal explicitly encourages patients to ask questions of their doctor, and ends with an empowering statement that patients know their own bodies best.*

While many people were open to non-opioid approaches, concerns about accessibility and affordability led some to dismiss these options for managing serious pain. By addressing these concerns, we can help them consider other options they might otherwise assume are out of reach:

- *Many people are surprised to learn that there are new and affordable non-medication treatments for serious pain relief that are covered by most insurance companies, including Oregon Health Plan.*

Treating pain at the source

Some research participants expressed frustration that their providers only treated their symptoms, not the source of pain. Highlighting that other options actually treat the underlying cause of the pain (swelling, muscle contractions, etc.) reinforces the importance of healing and serves to make these options more appealing than opioids, which only mask pain.

- *Instead of masking the pain, these options can reduce inflammation and swelling that cause the pain—treating the source, not just the symptoms.*

> *"I'm on the Oregon Health Plan, so there's some things that they don't cover. Some of the options that [my doctor] came up with like ice, going to the gym, that's not always necessarily easily accessible to someone who is struggling economically."*
>
> **White female, Albany**

Appendix A: Research Methodology

These findings and recommendations are drawn from extensive qualitative and quantitative research conducted between October 2017 and February 2019. Each research phase shaped and informed the subsequent research, building on what was learned to deepen our understanding of the landscape, audience mindset and effective approaches to persuasion.

This research included:

- A media landscape and social listening audit of news coverage on opioid-related topics in Oregon between November 2016 and November 2017
- A review of professional medical and health journals to examine coverage of opioids and pain management in the professional sphere between January 2016 and January 2018
- Qualitative research including 12 in-depth interviews, six dyads (pairs of people), 12 in-person focus groups, and one online focus group conducted among white, Black, Latino/a, and Native American Oregonians between June 2018 and October 2018
- An online dial-testing and message testing survey of 806 Oregon adults conducted in February 2019

Appendix B: Community Driven Campaign Development

Building a strong sense of cultural humility and equity into the DNA of the campaign was important as we considered the deeply embedded experiences of our audiences, specifically rural people with low-incomes, people of color and tribal communities.

We undertook this campaign in close partnership with Se-ah-dom Edmo, Executive Director of the MRG Foundation (formerly a Movement Builder at Western States Center) whose training and consultation was vital in centering health equity, racial justice and tribal sovereignty at every stage of the project. Through our work together, Heal Safely was developed within the broader context of holistic efforts to effect systemic change that benefits marginalized communities.

From the start to the final development of the campaign, we were informed by community leaders and direct service providers and leveraged their expertise in reaching our audiences.

Leveraging expertise through community engagement

At the outset of the project, Brink assembled a Change Advisory Team (CAT): a core group of experts and members of the community already working in health promotion, prevention, treatment and recovery. Many CAT members were from or representative of the target audience for the campaign, including people of color, rural Oregonians and tribal members. This partnership ensured that we were building on existing knowledge and relying on their input to help shape the campaign early-on. Heal Safely's CAT was assembled in February 2018. This included:

- Healthcare providers
- People working in prevention, addiction and recovery (including several with lived experience)
- Professionals working within health promotion and equity relating to communities of color
- Behavioral health specialists
- County health professionals

The CAT provided input and strategic direction on our research approach, including two key recommendations for learning how best to situate our upstream prevention approach:

- Deep listening sessions
- Interactive engagement activities with key community groups and organizations from across the state

In addition, two members of the CAT provided additional consultation on the project—Zeenia Junkier, Executive Director of the Oregon Health Equity Alliance whose role was to help facilitate and build connections with key community groups

from across the state, and Asa Wright, an artist, designer and educator who worked closely with Brink on tribal outreach and engagement throughout the campaign.

Broadening collaboration and support across communities

Guided by direction from the CAT, the project team explored how the campaign could be responsive to community needs and barriers and support current health promotion efforts related to opioid prevention.

As we moved forward in our research, we scheduled community forums at key intervals to gather input:

- Oregon Community Forum: We invited 30 community organizations from across the state to Portland to preview our initial research findings, make time for deep listening and to solicit feedback about our approach for a potential call-to-action strategy.
- Oregon Health Equity Alliance (OHEA) Forum: Here we presented findings from online message tests and focus groups and unveiled initial drafts of campaign materials, tools and messenger videos. We received important feedback on creating accessible and digestible communication assets for our audiences.
- Spanish/Latino/a Messaging Workshop: This workshop, held in Spanish, was an effort to solicit feedback on materials developed for our Spanish-speaking audiences. We gained valuable insight around developing a culturally-responsive communications strategy for this audience.

Supporting communications within tribal communities

In collaboration with the Oregon Health Authority's Tribal Affairs team, we developed a technical assistance program for the nine federally recognized tribes in order to maximize the reach of the campaign and support existing efforts on the ground throughout Indian Country:

- The Tribal Technical Assistance Programs funded individual technical assistance for each tribe, including a local photoshoot and assistance with creation of customized campaign assets for use in tribal newsletters and newspapers.
- The program also funded a local Facebook advertising buy to market custom campaign assets through tribes' pages/online communities.

Appendix C: Acknowledgements

This guide is the product of essential partnerships and deep community engagement. We wish to thank our Change Advisory Team (CAT) for playing a key role in shaping the research approach.

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ABOUT THE HEAL SAFELY CAMPAIGN

Heal Safely is a campaign to empower people to heal safely after injury or surgery. We believe everyone deserves safe, effective options that will help them rest, recover and get back to daily life.

Learn more at healsafely.org

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