# **MHAN Grand Rounds PPT Script**

# **Providing Compassionate Care for Pregnant or Parenting Patients with Substance Use Disorder: Reducing Stigma to Improve Outcomes ​**

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**SLIDE 1**

Welcome to [insert institution] grand rounds. The topic today is “Providing Compassionate Care for Pregnant and Parenting Patients with Substance Use Disorder: Reducing Stigma to Improve Outcomes.”​

***Note****: This slide is to be customized by the speaker/sponsoring organization.*

**SLIDE 2**

***Notes for presenter(s)****:​*

*1. This slide is to be customized by the speaker/sponsoring organization.​*

*2. Consider if you would like to share ground rules at the beginning of your presentation. These might include suggestions to use non-stigmatizing, person-first language when speaking about patients or others with substance use disorders or people who use drugs in the discussion.* Sample ground rules and language guidelines are on slides 4 and 5.

*3. There are slides later in the presentation that suggest that the presenter should offer examples from your clinical experience. This is a great opportunity to model the use of non-stigmatizing language.​*

**SLIDE 3**

*At the conclusion of this grand rounds, audience members can expect to understand the Health Stigma and Discrimination Framework; be able to describe how stigma and bias affect pregnant and parenting patients with substance use disorder (SUD); recognize the role of medication in SUD during pregnancy; and name specific actions clinicians and systems can take to decrease stigma for pregnant and parenting patients.​*

**SLIDE 4**

Here are some general ground rules we suggest for our time together today. Just as you do when you interact with patients, these same ideas can encourage the flow of our dialogue, and it’s also related to our conversation about reducing stigma. We ask everyone to think about coming from a non-judgmental place, using empathy, and being respectful. Also use patient-centered and inclusive language and be aware of your body language. I think it would be helpful if we practice these today, especially in our case study discussion and anything else pertaining to patient care. Does that work for everyone?

**SLIDE** **5**

***Note to Speaker:*** *The case of Ana R. will be used throughout the presentation to engage the audience and help them apply the information they are learning. ​*

***Introduce slide:*** *To frame our discussion, we are going to start with the case of Ana R. ​*

***Instructions****: Ask a participant to read the case. If that is not possible or no one volunteers, use the script below.​*

Ana is a 26-year-old Latina, carrying her first pregnancy with an estimated gestational age of 24 weeks, based on sure last menstrual period, who presents today for an initial prenatal visit. Her past medical history is significant for opioid use disorder (OUD) for 6 years and a motor vehicle collision 7 years ago. Her substance use began with opioid analgesics prescribed after the motor vehicle collision. When she could no longer get these, she began using heroin intranasally.

She has had no formal substance use disorder treatment, although she has made multiple attempts to stop on her own, including during this pregnancy. Her only medication is prenatal vitamins. ​

She is single and has an associate arts degree in hospitality. According to her record, she speaks Spanish at home but is comfortable communicating about her health care in English. Ana is weeping when you enter the room.​

**​SLIDE 6**

The word stigma comes from the Greek word meaning to mark with a pointed object. In the 16th century, it referred to a permanent physical mark, often a brand, used to show that a person had violated social norms or was otherwise undesirable.

​

Stigma today is a more complex and dynamic phenomenon. It is created by or emerges from often synergistic interactions between people and systems or structures where power is unequal. In short, stigma is more than individuals enacting their own specific biases.​

**SLIDE 7**

An international group of researchers developed the Health Stigma and Discrimination Framework in 2019. Its intent was to inform research, intervention design, evaluation, and policymaking for a range of conditions across settings and populations. Accounting for social, structural, and personal factors, it describes both how stigma manifests itself and its impacts on individuals and populations. ​

This model illustrates the dynamic and additive aspects of stigma and is helpful for identifying effective strategies to reduce it. It is also the model you are most likely to encounter in high-quality health outcomes research in today’s world. This is an illustration of the whole model with its three broad domains and, at the bottom, the impacts of stigma. We’re going to briefly unpack the model over the next few slides, and then we’ll look at the model as applied to pregnant and parenting patients with SUD. ​

**​**

**SLIDE 8**

The first domain can be thought of as the building blocks of stigma. Facilitators function at a structural or system level. Examples are behavioral norms based on cultural, social, gender, pregnancy-related or parenting expectations; structural or other pre-existing inequities; laws; and policies. Facilitators can make positive or negative contributions towards stigma. For example, gender norms can serve to either stigmatize or assign positive value to individual or group behaviors. ​

Drivers, however, are inherently negative, and tend to be more personal and subjective. They include things like fear of social judgement or harm, collective or individual lack of information or misunderstanding, stereotypes, and explicit or implicit biases or prejudices. We’ll go into more examples throughout the presentation.

​**​SLIDE 9**

Drivers and facilitators combine to “mark” (remember the original meaning of the word stigma) people or groups of people as stigmatized. Individual aspects of a person’s identity, social status, role, and health can be “marked” separately with stigma. Stigma is additive, so different conditions and inherent or socially constructed characteristics can add to how much stigma a group or person must live with. ​

**SLIDE 10**

The next domain of the model looks at the manifestations of stigma. Manifestations are a combination of practices and experiences. Practices are actions and behaviors demonstrated toward the stigmatized group or person. Stigma is what permits systems or people to enact prejudices, display negative attitudes, and actively discriminate. ​

Experiences, on the other hand, may be shared by many people, but are inherently personal. People who are stigmatized may have direct negative experiences or consequences when stigmatizing practices are enacted upon or applied to them.

Stigmatized people and groups may plan their behavior(s) because they anticipate negative experiences and seek to minimize being exposed to negative attitudes. They may also internalize negative judgements and apply these stereotypes and attitudes to themselves. ​

Finally, there is stigma by association, which may be experienced by family and community members or friends of persons experiencing stigma. ​

**​**

**SLIDE 11**

Stigma produces a range of increasingly predictable results for stigmatized groups and individuals. At the organization or society level, stigma may result in codification in the form of:​

* Laws or regulations​
* Decisions about what services are offered and where​
* What terminology or images can be used to communicate about people or groups who are stigmatized​
* Tolerance of these conditions​

Consequently, people and populations experience reduced access and acceptability of services, compounding negative consequences, impeding self-efficacy, decreasing resilience, and resulting in injustices that produce devaluation and isolation. ​

**SLIDE 12**

The model names the health and social impacts to which stigma can contribute, including increased incidence of disease, higher morbidity and mortality, worse quality of life, and social exclusion. We are going to turn our attention now to SUD in pregnant and parenting patients to look at the evidence for these outcomes. ​

**SLIDE 13**

***Note to presenter****: Use the exercise described here to engage the audience or use the script if the exercise is not feasible. ​*

***Introduce slide:*** *Let’s circle back to Ana for a moment and apply the model to her situation. ​*

***Instructions:*** *Ask a member of the audience to read the slide. If this is not possible or no one volunteers, use the script provided below. ​*

***Exercise****: Invite the audience to identify facilitators, drivers, and manifestations of stigma in the case.​*

* *Facilitator: Cultural, social, and gender expectations (i.e., Latina, unmarried, SUD)​*
* *Driver: Shame​*
* *Manifestation: Delay in seeking prenatal care​*

**Script**: Several circumstances and characteristics may be marked with stigma in our society and in health care. The most obvious source of stigma is her SUD, which is compounded by the fact that she is pregnant. She may be violating norms related to her marital status, as well as cultural and economic expectations. Ana also started herself on a prenatal vitamin, so chances are, she knows she should have begun prenatal care much earlier. With her circumstances in mind, let’s begin with the evidence.​

**Transition to next slide**: Thank you. Now that you understand the Health Stigma and Discrimination Framework, let’s look at what the evidence says about how stigma and bias affect pregnant and parenting patients with SUD. ​

**SLIDE 14**

***[Note to presenter: Please add personal experiences with how stigma has manifested where you practice. Examples might be the use of stigmatizing language in the medical record, which often continues despite health professionals learning to use less stigmatizing language when talking with people who use drugs. Another example might be colleagues expressing confusion or frustration about why a patient doesn’t “just stop.”]****​*

Many facilitators and drivers of stigma are associated with SUD. Many health professionals still widely use stigmatizing language, such as “addict” and “junkie.” SUD is still perceived as a moral failing or a choice that reflects personal weakness, which allows people with SUD to be blamed for their condition. This perpetuates the belief that they don’t need treatment and “just need to pull themselves together.” ​

These beliefs can be largely attributed to a lack of understanding of SUD as a condition with unmodifiable risk factors, such as genetics, early childhood experiences, and difficult-to-modify social and environmental factors. All of these factors may contribute to the changes in the brain structure and function underlying the disorder. ​

**SLIDE 15**

Criminalization is a major facilitator of SUD-associated stigma. It feeds the notion that people with SUD are inherently dangerous. Many of the negative social, economic, and employment consequences stem from this criminalization. Some people seek to avoid stigma by association with people with SUD. Employers, landlords, and others fear legal consequences and think it is necessary to reject people with SUD, even those in treatment or recovery, for risk management and reputation. Criminalization results in incarceration but also in arrest without charges. Being arrested and detained can result in the loss of employment, missed services and appointments, absence from caregiving roles, and separation from children–even if no crime has been committed. ​

**SLIDE 16**

***[Note to presenter: Please add personal experiences with how stigma has manifested where you practice. Examples might include a time when your team was surprised to discover that a patient they believed they knew well had long standing substance use or was receiving medication for OUD. ]****​*

This is how stigma manifests in people with SUD. Fear of encountering people with negative attitudes and of being treated unfairly deters people with SUD from seeking treatment and other medical care. It also makes them less likely to disclose substance use. As a result, they are not screened for preventable and treatable conditions associated with SUD, such as HIV, hepatitis, and comorbid mental health conditions. Consequently, they do not receive evidence-based care, such as overdose prevention, syringe services, or SUD treatment. ​For Black and Hispanic people, they are less likely than White people to receive this care or complete treatment for SUD.

Outdated beliefs within the treatment system continue to stigmatize the use of medication as an SUD treatment modality, such as a person with SUD is not really in recovery while being treated with medication or that medication is just substituting one drug for

another. Medication is the standard of care for OUD in general and during pregnancy. Medications for alcohol use disorder are also evidence-based and should be offered based on criteria similar to that of nicotine replacement therapies. ​

This slide illustrates the additive burden of stigma. First, the stigma associated with SUD reduces the likelihood that the conditions will be identified and addressed. Then the stigma associated with medication for SUD makes receipt of effective treatments less likely for those whose condition is recognized. These are added to separate stigma that is manifest towards members of minoritized groups that make those populations even less likely to receive effective treatment.

**SLIDE 17**

As you might expect, the impact of stigma is higher for pregnant patients with SUD. Pregnant people with SUD are even more likely to hide their substance use because of intense disapproval and consequences, such as the loss of parental rights. For pregnant people, it is true that being in substance use disorder treatment might make it more likely that CPS learns of their situation and their babies and other children would be taken away. This fact substantiates their fears and actions. In addition, negative attitudes from others about breastfeeding while taking medications for opioid use disorder can also discourage breastfeeding.

**​SLIDE 18**

***[Note to presenter: Please add personal experiences with how stigma has manifested where you practice. Examples might include hospital policies against admitting substance exposed infants to the nursery without medical indications because their parents are considered untrustworthy or discovering that a urine toxicology screen was obtained without patient consent.]***

It's crucial to understand the emotional impact that stigma can have on mothers with substance use disorders. When these mothers feel judged, it can significantly affect their actions and their relationship with their infants. For instance, they might **avoid visiting their infants in the hospital** due to the fear of being judged or scrutinized. This avoidance is often driven by the feeling of being **constantly watched** when they visit their babies.

By acknowledging these feelings and working to create a supportive, non-judgmental environment, we can help mothers feel more comfortable and supported. This, in turn, promotes better engagement with their infants and their own recovery journey. It's important to remember that empathy and respect can make a significant difference in these situations.

**SLIDE 19**

In the following quote, we can see how the use of judgmental and stigmatizing language used by a healthcare provider can affect a new mother with SUD. She said, “I overheard the nurses call my baby the NAS [neonatal abstinence syndrome] baby. They never used her name, and it was a stab in the heart, and I felt so embarrassed. It was very demeaning.”

End quote.

**​**

**SLIDE 20**

Some states specifically criminalize SUD in pregnancy. This criminalization is associated with a lower likelihood of receiving OUD treatment, timely prenatal or postpartum care, and a higher risk of giving birth to a baby that experiences NAS. ​

Pregnant people who do seek treatment are 17% less likely to receive an appointment with a healthcare provider than non-pregnant people because many treatment programs exclude this population. ​

**SLIDE 21**

***[Note to presenter: Please add personal experiences with how stigma has manifested where you practice. Examples might include a quality assurance project that reveals that Black or Hispanic patients are more likely to be asked about substance use than White patients when screening is not universal, or similar findings for urine toxicology screening in labor and delivery.]***

Stigma associated with personal characteristics or identity adds to the impact of stigma associated with SUD in pregnancy. Pregnant patients who are Black or Hispanic, live in rural communities, or whose first language is not English are less likely to receive medication for opioid use disorder than pregnant patients without those characteristics. ​

**SLIDE 22**

Overdose is one of the leading causes of pregnancy-related death in the US. Deaths from overdose have seen a dramatic rise in recent years. The constellation of facilitators and drivers, as well as the practices and behaviors they facilitate in the context of SUD among pregnant and parenting people, has individual- and population-level impacts on the maternal fetal dyad. Failure to treat OUD increases the risk of preterm delivery, low infant birth weight, and vertical transmission of HIV. While OUD receives the bulk of the public and research attention, it is important to remember that children are also affected by prenatal alcohol exposure; fetal alcohol spectrum disorder may be affecting 1 in 20 school children. ​

**SLIDE 23**

Let’s look at where we are with Ana. ​

**Exercise**: Ask an audience member to read the new information about Ana then ask the audience to identify any new facilitators, drivers, manifestations of stigma in this new information. ​

Facilitators ​

* Structural: criminalization of SUD behavior with additional penalties for pregnant people, inadequate treatment infrastructure​
* Driver: possible lack of awareness of how to seek SUD treatment or what to look for​

Manifestations​

* Practices: enacted stigma by staff person​
* Experiences: direct experience of stigma from staff person, anticipated stigma (previous attempts to access care)​

What is the impact of stigma for Ana? ​

* Delayed prenatal care​
* Limited access to needed treatment​

*Note: defer any discussion of MOUD until later in the presentation.​*

**SLIDE 24**

The pharmacology of the different medications and the specifics of behavioral interventions are beyond the scope of this presentation, but a familiarity with the evidence base for SUD treatment in pregnancy is necessary to effectively help Ana. ​

The principal thing to know about OUD treatment in pregnancy is that treatment with buprenorphine or methadone is the standard of care. Naltrexone can be used in pregnancy but is primarily limited to continuing it for women who were stable on the medication when they became pregnant. This is because naltrexone has not been well studied in pregnancy. MOUD with buprenorphine or methadone provides the following benefits to the maternal fetal dyad: ​

* Decreases substance use​
* Controls cravings and prevent withdrawal​
* Improves retention in treatment​
* Reduces mortality​
* Improves pregnancy outcomes; fewer preterm deliveries and low-weight infants for example.​

They are both also compatible with breastfeeding, which confers its own benefits for the newborn and mother. Pregnant women should be made aware of all psychosocial and behavioral interventions available. Their health care providers should offer, refer, or directly deliver an appropriate intervention based on the patient’s needs and preferences. Other treatment such as medication should not be contingent on participation in psychosocial or behavioral interventions.​

**SLIDE 25**

Quote "I wish that they [health care providers] would know that it’s not bad to breastfeed—that just because we’re on the medicine, it’s not bad for our child to get breast milk, you know. There’s facts. It’s not just your opinion—like, read about it. Be informed about it.” End quote.

This quote highlights the importance of evidence-based information and reducing stigma around breastfeeding while on medication.

**SLIDE 26**

Because of the lasting impact of prenatal alcohol exposure on the infant, it is important not to let stigma prevent effective care. Inpatient management of alcohol withdrawal is recommended for pregnant patients experiencing or at risk for moderate, severe, or complicated alcohol withdrawal. Abstaining from alcohol is the standard recommendation in pregnancy since no amount is known to be safe. Health professionals should advise abstinence for nondependent alcohol consumption but provide strategies to minimize alcohol consumption if abstinence is not possible during pregnancy and breast feeding. Medications for AUD may be used if benefits outweigh risks to the dyad. Little rigorous data exists on the effects or efficacy of acamprosate or naltrexone in pregnant patients. Behavioral and social support also should be provided to help achieve this. These should continue even if alcohol consumption resumes to minimize intake. ​

**SLIDE 27**

* Opioid and alcohol use disorders receive a lot of attention because of the extent of the harm associated with them, and the general underutilization of available treatments. But what do we do about other substance use? What do we do for people who do not chose to seek treatment or do not want abstinence?
* While the recommendation from a health professional must be for abstinence or minimization, we need to be prepared to promote the best possible outcome for all pregnant patients with SUD regardless of whether treatment is available or desired. In these circumstances, any positive change the patient wants to make should be supported with the available resources. Examples of changes that can improve outcomes—even if substance use is ongoing—include the following:
* Referring to a syringe services program so patients are using a sterile syringe for every injection, if this is not already the case, and changing from use by injection to use by another route.
* Recommending behavioral treatment like providing any available psychosocial services acceptable to the patient.
* Referring to peer recovery support and harm reduction services if they are available; otherwise, suggesting community behavioral health services.
* Connecting to social services so the patient can attend prenatal care, obtain stable housing, and address food insecurity.

**SLIDE 28**

Conceptually, four categories of interventions can reduce stigma: information, skills, exposure, and structural change. There are not specific evidence-based strategies for health professionals to gain exposure to people with SUD or in recovery from SUD, so we will focus on information, skills, and structural change as categories of intervention to reduce stigma in this presentation. Look for opportunities to learn about the needs and experiences of people with SUD when the person is not actively in need of healthcare or when you are not the direct provider of that service. This can happen while shadowing a substance use disorder treatment provider, meeting with peer recovery support specialists, or visiting a community agency that serves this population.

**SLIDE 29**

Learning about non-stigmatizing language provides a good foundation for practice change. Consistently using new vocabulary is a skill that requires more effort than knowledge acquisition. Using non-stigmatizing language in documentation, as well as with patients, is important not only because patients routinely access their records, but also because it can promote conversation and change across your team. Reviewing language guidance from the National Institute on Drug Abuse on terms to use and avoid when talking with pregnant patients who have SUD may be helpful. These guides are linked in the resources section of this presentation.​

In most circumstances, use person-first language to emphasize humanity. This helps differentiate the person from their medical condition. It’s important to note that people who use drugs may choose to refer to themselves or their peers as “addicts” or “junkies.” Ask patients their preferences for how they describe their behaviors and themselves, understanding that patients might use certain terms to refer to themselves or their peers that may not be appropriate for providers to use. Be sure to document these preferences in their record.

Avoid street terms for drugs except where it is necessary to connect a medical term with the street term more familiar to your patient. Remember to keep it medically accurate. For example, a baby cannot be born addicted because addiction is a behavioral disorder that we refer to as substance use disorder. Nor is the infant a “NAS baby” but, rather, a substance-exposed infant or a baby with NAS (neonatal abstinence syndrome) or NOWS (neonatal opioid withdrawal syndrome). ​

**SLIDE 30**

Knowledge acquisition is central to the health professions, so is likely the most familiar to us. Updating our fund of knowledge can help each of us become aware of where we might have been applying outdated information or allowing the outdated concepts to inform our patient care. Even if we don’t intend to manage patients with SUD, deepening our understanding of SUD and its treatment can help us be more confident in supporting their care and in assuring patient safety. Information can produce structural change if healthcare teams participate in the same training or read and discuss the same material.

This could happen on an institutional level, which would be even more powerful. Consider informing yourself and your teams about SUD in pregnant patients to:​

* Recognize and correct biased or outdated information to which you may have been exposed in the past​
* Improve responsiveness/readiness to meet patient needs​
* Normalize responsibility for an increasingly prevalent condition​
* Increase confidence to manage safety and risk with the current evidence base ​
* Uncover gaps in processes and resources to address before a patient encounters them​
* Incorporate professional/system level intervention if tied to policy and procedure updates ​

**​**

**SLIDE 31**

Brief motivational interviewing is typically a series of three or so appointments that focus on helping the patient clarify their motivations and priorities; positive behavior change is the overall goal. In addition to staff training on motivational interviewing (MI) techniques, accommodating brief MI in a way that is sustainable may necessitate minor workflow changes such as how the time for MI is billed, who provides it, and how it is coded in an electronic health record system.

 ​

MI is outside the scope of our discussion today, but some of its core techniques are using open-ended questions, affirming strength and positive behaviors, and reflective listening. Reflective listening is a strategy that communicates empathy and affirms understanding by restating the clinician's understanding of what the patient is saying. The OARS acronym—open-ended questions, affirmations, reflections, summaries—might be helpful when thinking about these steps. Stepping out of the roll of authority figure and educator is essential for genuine MI. This is sometimes the hardest skill for busy health professionals to master. ​

Clinicians can incorporate many of these techniques into patient visits in place of current patient-interviewing strategies. An MI approach to patient interactions is compatible with patient-centered care and harm reduction, well-studied in SUD health behavior change, and in support of stigma reduction. These smaller changes can be very beneficial for patients and foster the therapeutic relationship between the patient and health professional with minimal change to systems-of-care delivery. ​

**SLIDE 32**

A skill-based strategy for reducing the experience of stigma for your patients is to keep conversations and assessments strength-based. This approach communicates hope and respect and increases engagement. Active listening supports a strength-based approach and helps keep the interaction therapeutic. Focusing on strengths is also an effective way to keep from sliding into a task-focused mentality. Substance use disorder is a chronic condition; recovery from it is a process. A strengths-based approach:​

* Focuses on what the patient has going for them, starting with them showing up​
* Reduces tendency to pity/disempowerment​
* Communicates hope and respect​
* Increases engagement​
* Combines with active listening to elicit patient strengths and preferences​
* Recognizes substance use disorder is a chronic condition that requires long-term management (i.e., recovery from substance use disorder is a process, not a task)​

**SLIDE 33**

Quote “I found out that I was pregnant in the middle of a relapse, and I thought I could not keep the baby. I did not feel motivated to keep the baby. I also felt shame and mortified in trying to get prenatal or drug treatment help—I knew they would judge me. They would also judge me if I lost the pregnancy. There was no way out. The thought of walking into a hospital and saying I am using was terrifying.” End quote.

This quote reflects the deep fear and stigma that can prevent individuals from seeking necessary help and highlights the need for a supportive, non-stigmatizing approach like the strengths-based approach

**SLIDE 34**

Let’s go back to Ana and apply some of the approaches and information we have learned to what we know about her situation.​

**Exercise:**​

Ask the audience to identify Ana’s strengths. ​

What knowledge do you now have to offer Ana about her treatment?​

*Notes for speaker: ​*

*Ana’s strengths: she has overcome her fear to show up for prenatal care. She stayed, even though she felt judged by a staff person. She has abstained from other substances. She has taken steps to care for herself and her pregnancy by taking a prenatal vitamin and using the app. She has attempted to find treatment.​*

Ana’s treatment options: Based on what we learned about MOUD, we can tell her that buprenorphine and methadone are the recommended forms of MOUD in pregnancy. You can reinforce that she made the right choice by seeking that treatment. Either buprenorphine or methadone will improve her pregnancy outcomes, are compatible with breastfeeding, and reduce the risk of NOWS. Both medications will control cravings and withdrawal. ​

**SLIDE 35**

Here is the result of our discussion with Ana about her treatment options.​

**Exercise:** ​

Have a member of the audience read the slide then ask this question:​

* How does this interaction reduce stigma for Ana?​

*Notes for speaker:​*

*The clinician being knowledgeable about the standard of care and how to access treatment has normalized seeking help from her treating clinician for her SUD and reframed it as a medical condition.​*

*Ask for other ideas.​*

**​SLIDE 36**

Harm reduction is a set of principles that prioritizes autonomy, shared decision-making, and informed consent that can be applied in all categories of stigma-reduction activities. A good starting point can be for individual clinicians to visit nearby harm reduction programs and become acquainted with the services they provide. Harm reduction services typically include overdose education and naloxone and syringe services, but may also include wound clinics, Hepatitis testing, and test strips for drug checking. A growing body of evidence points to benefits from doula and other paraprofessional services using a harm reduction approach to support pregnant people with SUD. Doulas and other paraprofessionals increase health literacy and self-advocacy, promote effective parenting, and reduce maternal risk for their patients living with SUD.

**SLIDE 37**

The biology and pharmacology of SUD is essentially the same for all humans, but the experience and consequences of SUD and the perception of treatment has as many variations as there are people. Learning about the cultures in the populations served is a great first step for clinicians. Skills we’ve already discussed, such as active listening, strengths-based and patient-centered care, and MI techniques, can help create space for patients to process and problem solve within the context of their own culture and personal priorities. ​

At a systems level, having staff who share some of the same cultural heritage of local populations and, if possible, speak the same languages, could be very helpful. Even with bilingual staff, professional medical translation services are essential. ​

Changes to the environment can also make people of different cultures feel welcome, though it isn’t necessarily possible to tailor an office setting to every culture encountered. Demonstrating cultural awareness and willingness to invest time and effort into making your space welcoming to all people can be reassuring to patients, even if it does not fully represent their specific culture. ​

**SLIDE 38**

Reproductive healthcare is necessarily centered around biological sex but sensitive to the different ways people experience and express gender. It is important to consider gender in the context of reproductive health because of the additive effect of stigma associated with gender and SUD.

**SLIDE 39**

Meta-analysis of available research has found that transgender people are more likely to report current and lifetime substance use. The same meta-analysis found the prevalence of SUD to be the same for both cisgender and transgender groups. Substance use and substance use disorder among transgender pregnant people have not been well studied. Individual clinicians need information about the needs of transgender people, specifically in the reproductive healthcare setting. Education and anti-stigma training for staff, including labor and delivery, is an important systemic intervention. ​

**SLIDE 40**

It’s also important to factor in how trauma impacts the patient and how care is provided. Pregnant people with SUD have a higher prevalence of trauma. Trauma informed care is another care model that can reduce stigma when treating people with SUD.

Trauma informed care is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.

**SLIDE 41**

As we move through the approaches to care, a theme emerges around safety, agency, culture, and collaboration, which we also see here in the core principles and 4 R’s of trauma-informed care. Your patient population probably should inform which approach or approaches you choose and how you combine them. Few, if any, of us can expect to change our own practice or systems to accommodate all these strategies. ​

**SLIDE 42**

***Note to presenter****: Use the exercise described here to engage the audience or use the script if the exercise is not feasible. ​*

**Introduce slide:** Our case wraps up with follow up planning for Ana.​

**Exercise**: Ask a member of the audience to read the case, skipping over the resources. Ask the following question for a brief discussion: What approaches to care are reflected in this management plan?

***Note****: There is not a single right answer but there are elements of trauma-informed care being used (e.g., introducing Ana to your colleague in person because you will not be here) as well as harm reduction (e.g., use of a peer, emphasis on safety).​*

**SLIDE 43**

***Note to speaker:*** *Depending on the size and structure of the group, each question can be discussed one after the other as a large group, or participants could respond to all four questions at the same time. Encourage learners to write down the two changes they can make. Review the resources on the next slide before transitioning to general Q&A.​*

**​SLIDE 44**

***Note to speaker****: Please familiarize yourself with the resources to highlight the most relevant ones for the specific audience. Use the next slide to share local resources.​*

* The University of Texas at Austin Dell Medical School: Reducing Stigma Education Tools: [Reducing Stigma Education Tools (ReSET) – Dell-Medical-School](https://vbhc.dellmed.utexas.edu/courses/course-v1:ut+cn01+2020-21/about) (Free CME)​
  + The aim of these modules is to help health professionals confidently identify and address the stigma surrounding opioid use disorder to ensure the delivery of equitable and compassionate health care for all patients living with opioid use disorder. Creation of a free account at Dell Medical School is required.​
* [Your Words Matter – Language Showing Compassion and Care for Women, Infants, Families, and Communities Impacted by Substance Use Disorder | National Institute on Drug Abuse (NIDA) (nih.gov)](https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-language-showing-compassion-care-women-infants-families-communities-impacted-substance-use-disorder) (Free CME)​
  + This resource offers background information and tips for providers on how to use person-first language and which terms to avoid using to reduce stigma and negative bias when discussing addiction or substance use disorder with pregnant patients and mothers. ​
* [Stigma and Discrimination | NIDA (nih.gov)](https://nida.nih.gov/research-topics/stigma-discrimination#stigma)​
  + This webpage includes brief, plain language, evidence-based summaries of the impact of stigma on the health and wellbeing of people who use drugs. ​
* [Guidelines for the Identification and Management of Substance Use and Substance Use Disorders in Pregnancy - NCBI Bookshelf (nih.gov)](https://www.ncbi.nlm.nih.gov/books/NBK200701/) ​
  + These guidelines from the World Health Organization contain recommendations on the identification and management of substance use and substance use disorders for health care services, which assist pregnant people or people who have recently had a child who use alcohol or drugs or who have a substance use disorder. ​
* [Principles of Care for Pregnant and Parenting People With Substance Use Disorder: The Obstetrician Gynecologist Perspective - *Frontiers in Pediatrics* (nih.gov)](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10246753/)​
  + This article presents the principles of care for pregnant and postpartum people from the obstetrician-gynecologist perspective. It includes information about care for the mother-baby dyad, person-centered language, and current medical terminology. It discusses SUD during the birthing hospitalization, and the risk of mortality in the postpartum period.​
* [Care for Pregnant and Postpartum People with Substance Use Disorder Patient Safety Bundle](https://saferbirth.org/wp-content/uploads/U2-FINAL_AIM_Bundle_CPPPSUD.pdf) (saferbirth.org)​
  + This resource comprises a set of practices to improve the quality of care provided during delivery and the postpartum period.​
* [Find Harm Reduction Resources Near You | National Harm Reduction Coalition](https://harmreduction.org/resource-center/harm-reduction-near-you/)​
  + This resource identifies syringe service programs and overdose prevention programs by location. ​
* [Preparing for Your Baby: Information for Pregnant People with Substance Use Disorders](https://ncsacw.acf.hhs.gov/files/preparing-for-your-baby-tipsheet.pdf)​
  + This webpage includes patient education resources for pregnant people with SUD.​
* [Healthy Pregnancy Healthy Baby Fact Sheets](https://store.samhsa.gov/product/healthy-pregnancy-healthy-baby-fact-sheets/sma18-5071)​
  + This is a set of factsheets for pregnant people with OUD.​
* [Staying Connected Is Important: Virtual Recovery Resources](https://www.samhsa.gov/sites/default/files/virtual-recovery-resources.pdf)​
  + This factsheet includes descriptions and links to various mutual aid recovery groups including virtual meetings. ​

**SLIDE 45**

*Note: This slide is to be customized with local resources.​*

**SLIDE 46**

*Note: This slide is to be customized with contact information.​*

**SLIDE 47 - 50:**

And these are our references for this presentation.