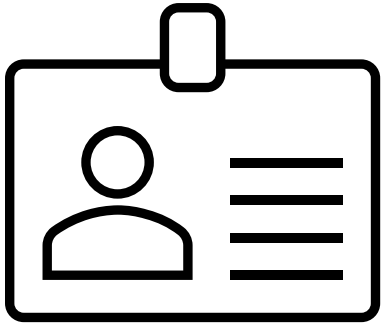


Transforming Care for People with Substance Use Disorder in Pregnancy and Postpartum

Bias and Stigma Training – Nov 3rd, 2026

Welcome & Introductions



- Diana Smith, CNM, MPH – OPC Perinatal SUD Clinical Lead
- Laurel Durham, MPH, RN--OPC Director of Quality Improvement
- Pilot developed in 2025 by a multi-disciplinary group of experts in perinatal SUD from across Oregon with support from the CDC Foundation
- 2-part training
    1. 1 hour didactic + Q&A
    2. Case study work encouraged with your local team

Objectives

1. Increase understanding of **bias and stigma and how they can impact care**
2. Provide **strategies to reduce bias and stigma** to ensure safe and effective care
3. Promote **interdisciplinary learning, teamwork, and effective communication** related to perinatal SUD
4. Increase **understanding of lived experience of perinatal SUD and the role of peers and doulas** in supporting patients and care teams

Grounding

Compassionate Care:

Hospitals throughout Oregon are shifting from a culture of surveillance of families with SUD to a culture of support, transparency, and respect.



Harm Reduction:

Perinatal SUD is a **public health concern and treatable health condition**, not a moral failing.

- Shifting from a punitive framework to a framework grounded in **evidence-based practice, including harm reduction**, allows for a therapeutic and person-centered approach to care.

Bias and Stigma in Care for Birthing People with SUDs

High Level Definitions:
Implicit Bias & Health Related Stigma

Implicit Bias:

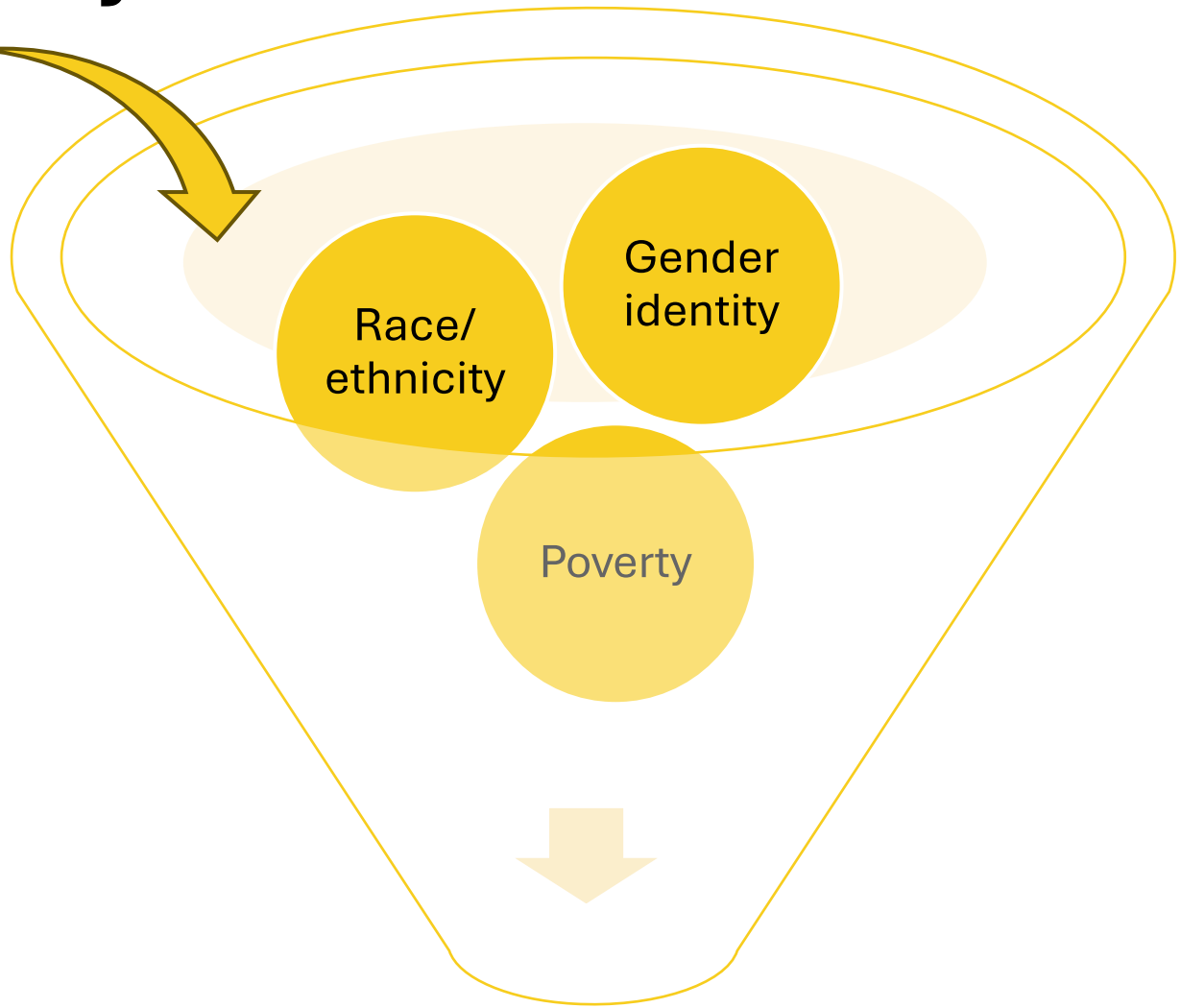
Unconscious collection of stereotypes and attitudes that are ***developed*** towards certain groups of people or situations that affect understanding, actions and decision making.

Health Related Stigma:

Attitudes, stereotypes, and beliefs that lead to devaluation of individuals and groups of people who live with certain health conditions.

Implicit Bias & Health Related Stigma: Intersectionality Matters

Stigma and bias of substance use during pregnancy



Result= Inequity.

Stigma and bias affect some individuals and groups more than others.

Cumulative Bias and Stigma Load

Implicit Bias & Health Related Stigma: The Impact of Racism



Themes from qualitative review

- Increased scrutiny, mistrust, and expectations from clinicians and treatment programs
- Greater self-advocacy required of participants during and after their pregnancy, including presenting themselves in ways to counteract racial and ethnic stereotypes and addiction stigma
- SUD history and pregnancy status intersect with racism and gender bias to heighten and form unique experiences of discrimination

Schiff, DM et al. (2024). Multiple marginalized identities: A qualitative exploration of intersectional perinatal experiences of birthing people of color with substance use disorder in Massachusetts. Journal of Substance

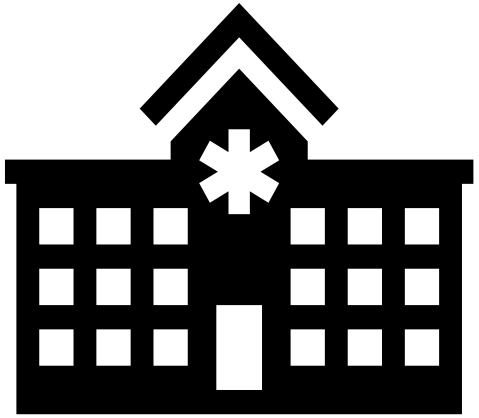
What are Bias and Stigma?

"People were talking about me and my baby like we weren't even there."

"It was hard to believe in myself, when no one else believed in me."

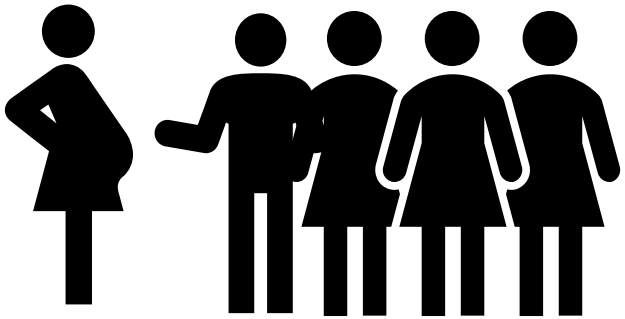
Florida Perinatal Quality Collaborative video: From Judgement to Healing

stigma remain against mothers and pregnant women with mental health needs. Providing judgment-free and respectful, compassionate care will support the open dialogue of mental health and illness – *Photo by Janko Ferlič on Unsplash*

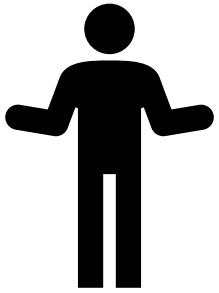


Institutional/
Organizational

Types of Stigma



Interpersonal



Internalized/
Individual

[Stigma of Addiction: Reducing and Breaking Stereotypes]

Individual/Internalized Stigma



Example:	When someone feels	The result can be
Self Blame and Shame	like they don't deserve care. Like they have already messed up too much to be helped.	They may delay or avoid care/ treatment due to fear of judgment or belief they don't deserve help.

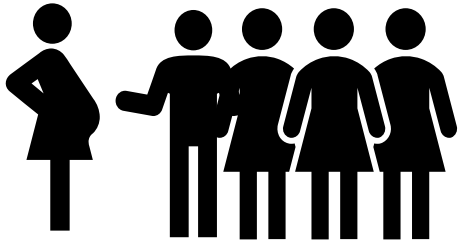
(about care in hospital after taking baby to NICU for withdrawal) "I felt really small. Because even though things weren't being said, the looks… the treatment. . . solidified what I already knew in my mind: that I was a useless drug addict that couldn't raise a child." --Monique

Individual/Internalized Stigma



How have you seen individual/internalized stigma manifest for patients you care for?

Interpersonal Stigma



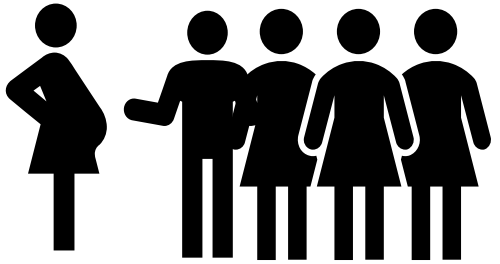
Example

A patient hears her provider say "I can't believe she is still drinking" when they think she cannot hear.

Result: At the next visit, patient tells the provider she has stopped. She also stops speaking up with questions/concerns about pregnancy.

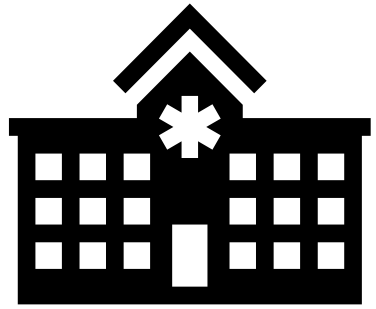
(after a miscarriage) "I was told in the most callous, cold way that I was not pregnant. And if I didn't use drugs, I probably wouldn't have lost the baby." --Monique

Interpersonal Stigma



Can you think of an example of interpersonal stigma in your workplace?

Institutional/Organizational Stigma



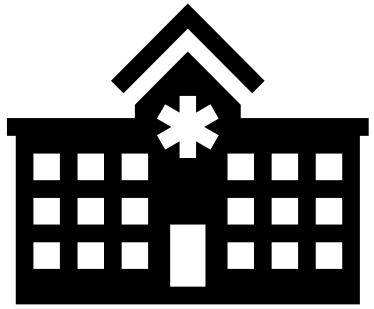
Example

Patient has a urine drug screen sent per policy without consent or discussion.

Result: Loss of trust, leading to withholding of important information out of fear of punitive consequences.

"They took (the baby) while I was asleep. And they put him in the NICU. And I woke up and didn't know where he was. And then they told me I couldn't see him and they didn't tell me why. " --Syrrita

Institutional/Organizational Stigma



How do you see organizational policies or practices contributing to stigma in care for birthing people with SUD?

Strategies to Reduce Stigma

Strategy #1: Trauma Informed Approach to Care

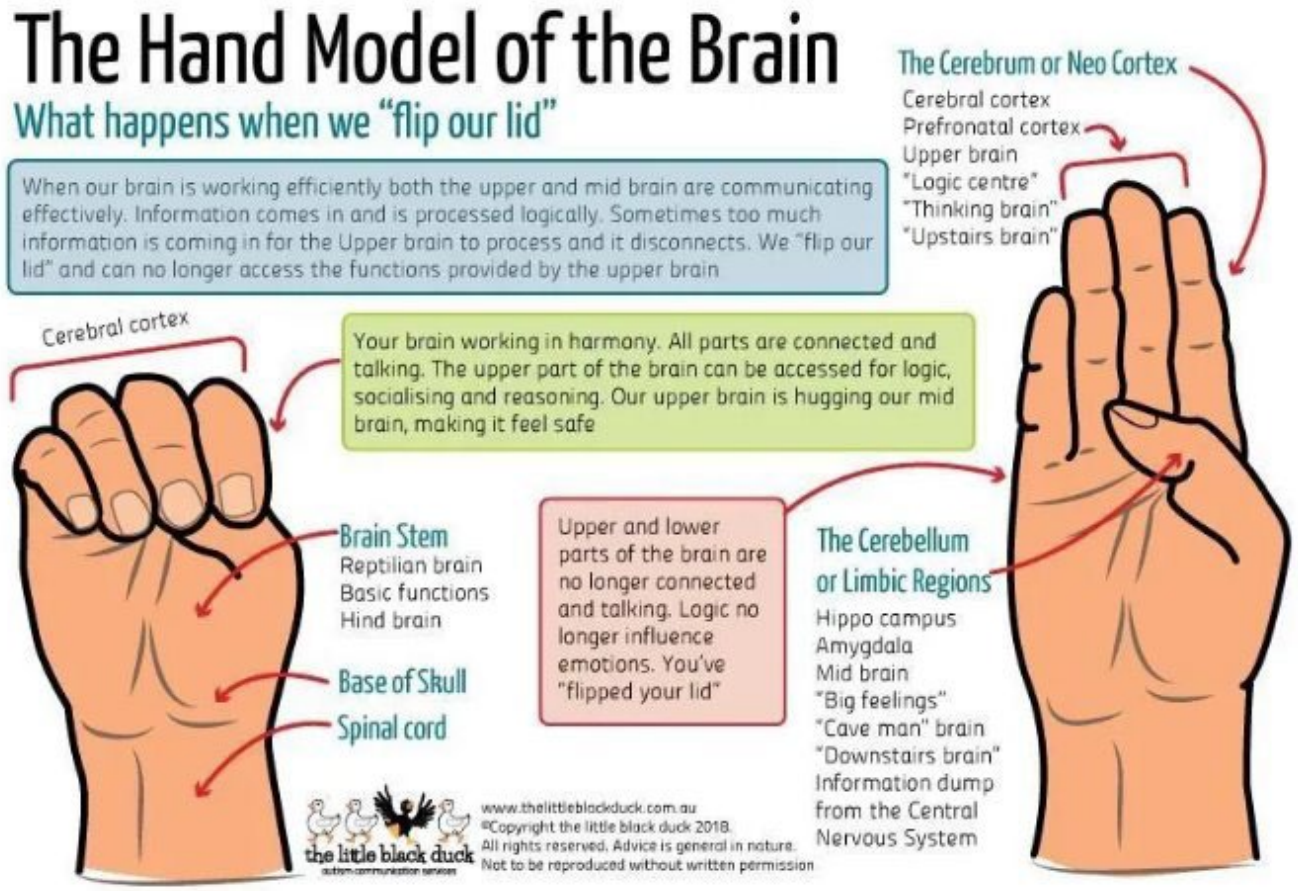
- Correlation between SUD and traumatic life experiences, including adverse childhood experiences
- People who have experienced trauma may
  - Feel unsafe, betrayed, and have difficulty trusting others
  - Shut down and be less receptive to information/ learning
  - Experience heightened emotions like anger/ aggression, shame, numbing, isolation when trauma is triggered
- Trauma-informed practices and policies can be incorporated at the organizational level

Assume and acknowledge openly that people have experienced past trauma, including with medical care

Aim to not trigger, repeat, or cause additional trauma

What is Trauma? - Trauma-Informed Care Implementation Resource Center (chcs.org) July 13, 2026.

Strategy #1: Trauma Informed Approach to Care



Regulate, relate, reason

Regulate first!

- Support physical comfort – do they need food, water, warmth, medication?
- Sit at their level or below them
- Go slow, allow time
- Take a break
- Include a support person

Image source: 1-brain-pathways-of-dopamine-and-serotonin-gwen-shockey.jpg (900×665) (fineartamerica.com)

Strategy #1: Trauma Informed Approach to Care

- Sit down, slow down
- Build rapport – introduce yourself, make eye contact, smile
- Provide context for your questions and care
- Ask permission – again, and again, and again
- Give the person agency and choice
- Thank them for disclosures

Regulate, relate, reason

The care you provide is a therapeutic intervention

Strategy #1: Trauma Informed Care Approach to Care
Example: Provide Context for Care



“Our hospital is working to improve the care we provide to pregnant people and families affected by substance use. We ask every person that comes to give birth the same questions so we can connect them to support, treatment, and other resources they may need. Would it be ok to ask you some questions about substance use?”

Strategy #2: Correct and Compassionate Word Choice

Avoid	Instead say
Addict, abuser, junkie	Person who uses (insert substance) Person with (insert substance) use disorder
Clean	In remission, no longer using, interrupted use, free from substances
Addicted baby Born addicted	Infant with prenatal (insert substance) exposure Neonatal opioid withdrawal (NOW)
Medication assisted therapy	Medication for (insert substance) use disorder
Relapse	Return to use/ use
Clean or dirty drug test	Negative or positive for (insert substance)
Drug seeking	In pain, exhibiting signs of a possible use disorder, experiencing withdrawal symptoms

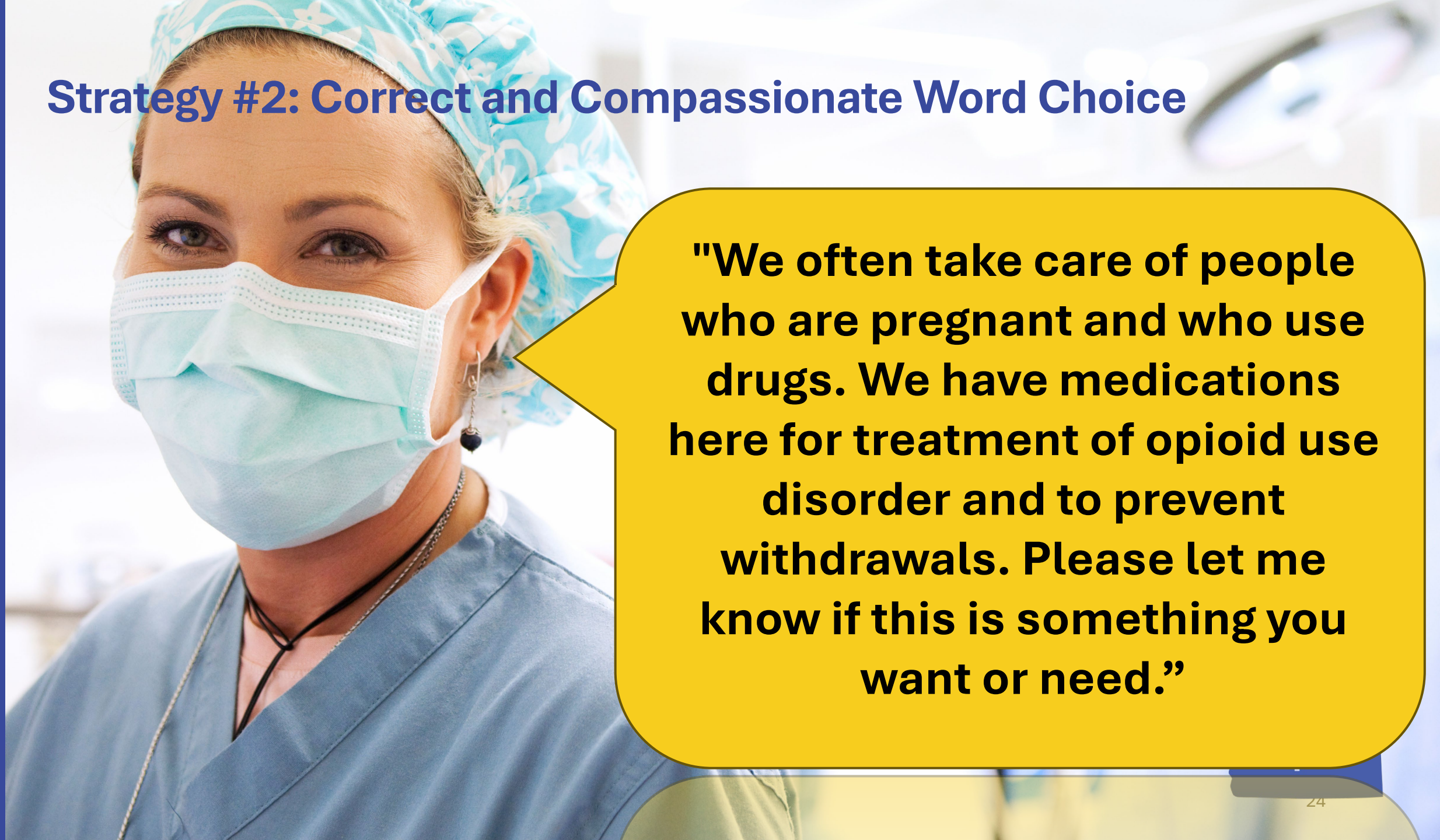
Strategy #2: Correct and Compassionate Word Choice

It is ok to make mistakes. We are all learning.

- Use person first language
- Use value neutral and precise language

Note: When talking about their own substance use, people will choose the language that feels right to them. No need to correct them. Our focus is on our own word choice and ensuring we are not using stigmatizing terms or labels.

Strategy #2: Correct and Compassionate Word Choice



"We often take care of people who are pregnant and who use drugs. We have medications here for treatment of opioid use disorder and to prevent withdrawals. Please let me know if this is something you want or need."

Strategy #3: Strength-based Care

What is strength-based care?

- Highlight real and meaningful positives for a person who may not see them for themselves
- Treat people with unconditional positive regard

Why focus on strengths?

- Shifts the focus to what is working in patient's favor
- Increases engagement and motivation
- Communicates genuine hope and respect
- Reduces pity and disempowerment
- Demonstrates your professional skills in caring for people with SUD

Strategy #3: Strength-based Care



“You made it in for your buprenorphine induction. That’s great. I know it can be difficult to schedule, get your stuff together, find childcare and a ride—all to come do something you aren’t looking forward to. I’m glad you are here and I’m here to support you through this process.”

Strategy #3: Strength-based Care
The Power of Unconditional Positive Regard

“Where my road to recovery came from was my primary doctor. She just put it in my head, like, ‘You can do this. I know you can do this!’ Like so motivational. She was there. She was a person I could talk to…” -- Ashlee

stigma remain against mothers and pregnant women with mental health needs. Providing judgment-free and respectful, compassionate care will support the open dialogue of mental health and illness – *Photo by Janko Ferlič on Unsplash*



Strategy #3: Strength-based Care
Strength-based Charting

<u>Chart Note Example</u>:

Patient showing engagement and self-advocacy, requesting medication for symptom management amidst challenges of buprenorphine induction. Provided words of encouragement, warm blanket, and hydration to patient and we reviewed available medications to support comfort and coping.

Strategy #4: Harm Reduction



- Grounded in the belief that very person deserves respect and health care, including people who use drugs
- A way to build rapport and show understanding of the day-to-day challenges and reality of life with a SUD
- Centers options and interventions proven to improve health
- Requires creation and implementation of supportive policies that protect patient choice
  - Lack of choice = loss of autonomy
  - Feeling trapped can lead to people directing their own discharge from the hospital
  - Consider where we can provide choices and compromise



Strategy #4: Harm Reduction

Hospital Examples

- Plan for an arrival window rather than a strict appointment time for an admission to the hospital
- Allow a smoke/ mental health break and support the patient to go outside
- Teach harm reduction (next slide)
- See Harm Reduction Resources in the OPC Substance Use in Pregnancy and Postpartum Toolkit



Strategy #4: Harm Reduction

Safer use practice

- Prevention of injection site infections – provide alcohol wipes, access to clean needles, syringe exchange services
- Talk about a change of route: could they switch from IV use to smoking?

Harm Reduction Saves Lives

Overdose prevention

- Never use alone
- Have naloxone out and ready
- Drug testing supplies
- Test dose – use a smaller amount when you first use a new supply or product, or if you have not been using for a while (like if in treatment, jail, or at the hospital)

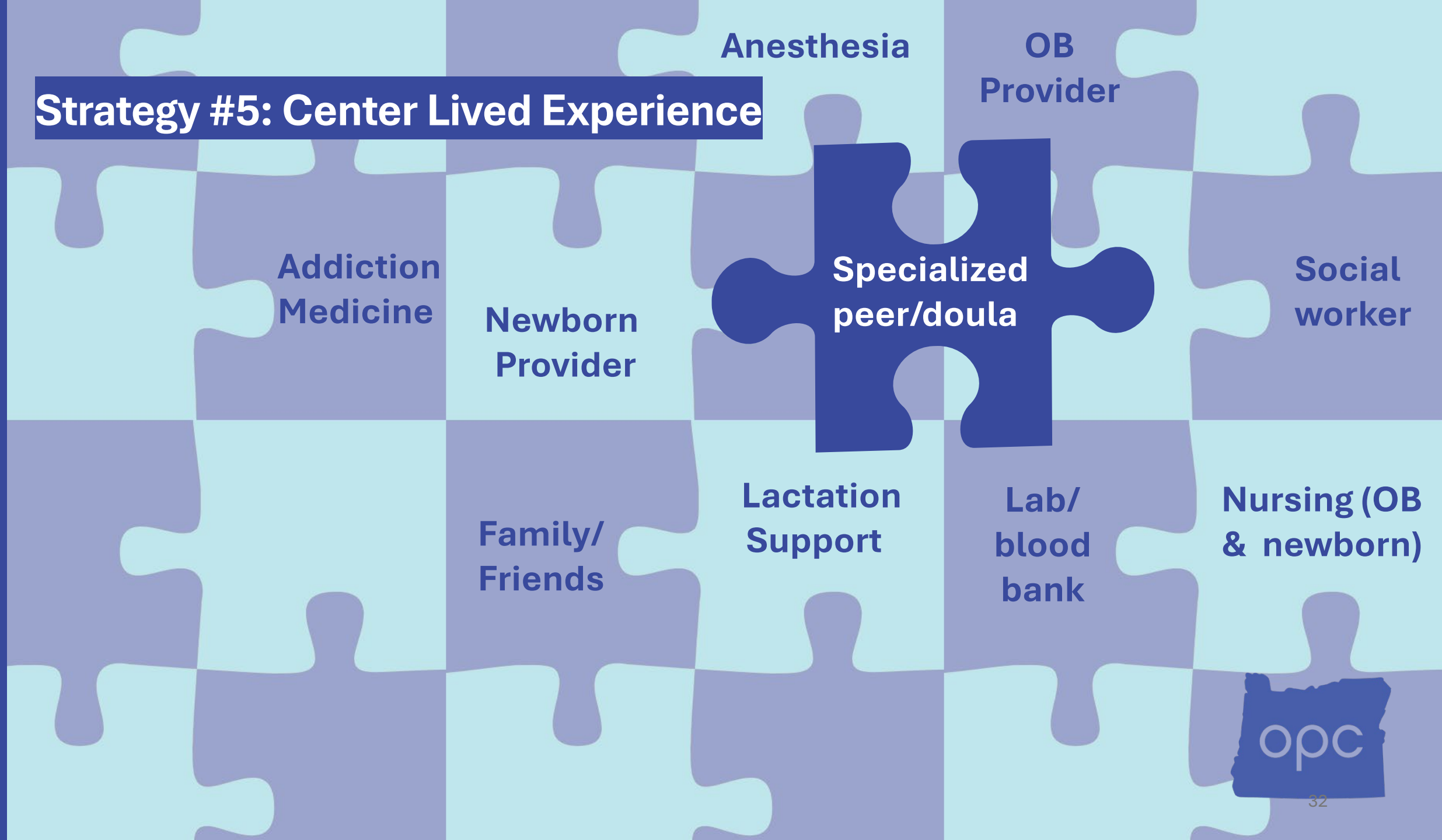


Health care

- Start where they are
- Connect/provide perinatal care
- Start or continue treatment medications, even if still using
- Provide STI prevention, screening, and treatment
- Offer vaccination and preventative healthcare at the hospital

opc

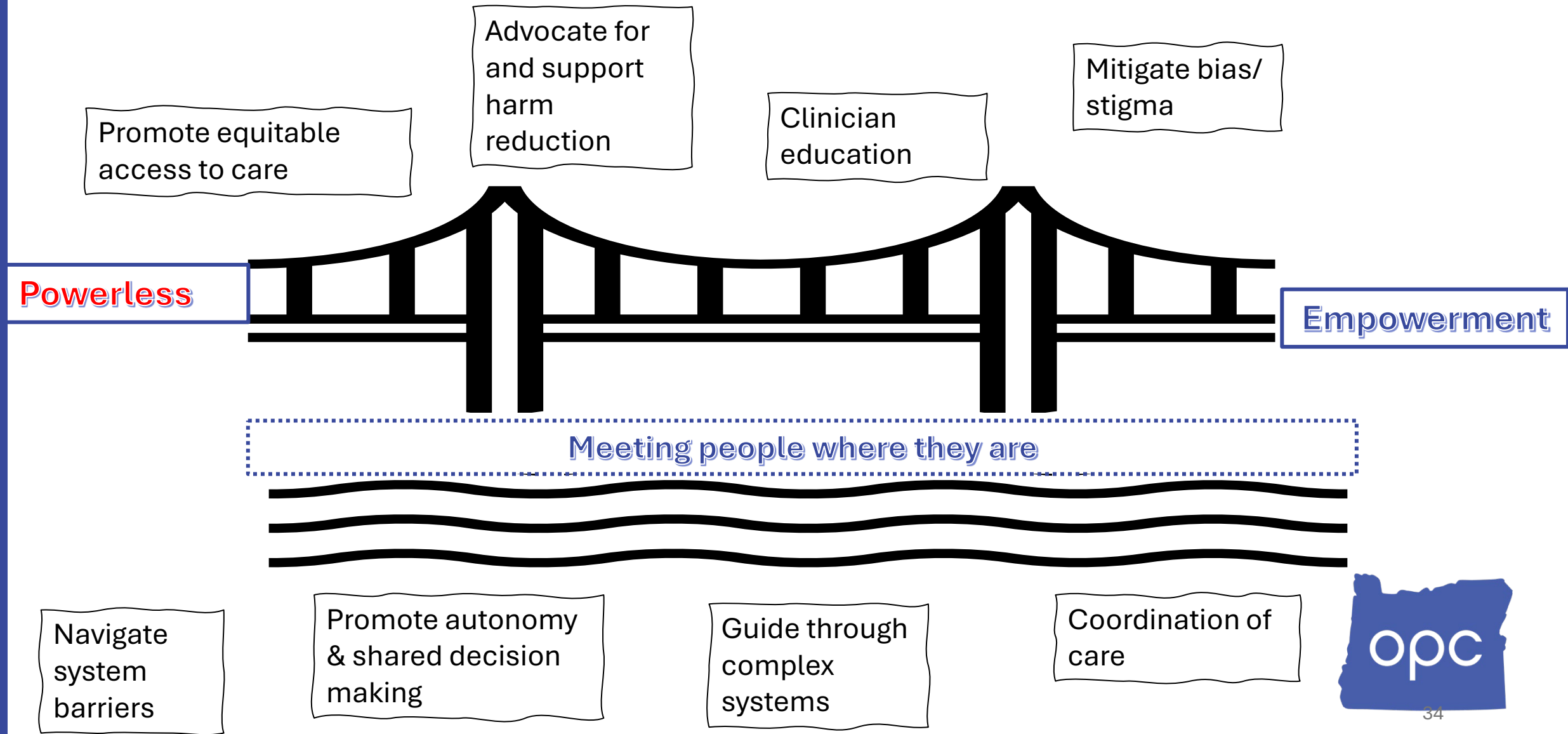
Strategy #5: Center Lived Experience



Strategy #5: Center Lived Experience

- Watch and listen to Brooke's Story
- Oregon Health Authority : THW Home : Equity and Inclusion Division : State of Oregon
- Project Nurture — Health Share of Oregon Partners
- Nurture Oregon — Peer Support Oregon

Strategy #5: Center Lived Experience
Peer Support/ Doulas: Bridging the Gap to Empower Patients



Strategy #6: Build Interdisciplinary Teams

- **Formalize physical-behavioral health partnerships**
- **Add people with lived experience to the team**
- **Implement interdisciplinary huddles and decision making for**
  - Care planning and care transitions
  - Patient support in hospital
  - Family Care Plans
  - Collaborative decisions re child welfare
  - Responding when challenging situations arise like in-hospital substance use or intoxication; pregnancy loss; child removal



Strategy #7: Update Hospital Policies and Practices

Create a more accepting environment and align with evidence-based care

- Incorporate a harm reduction model
  - Ensure patient autonomy and respect for choices
- Coordinated support from the whole team (RN, provider, social work, security, peer/doula, all staff)
- Consult with Addiction Medicine
- Technical Assistance available from OPC and OHSU Impact Team

Are policies at your hospital creating barriers to care? Are they positively or negatively impacting outcomes, including patient and staff experience?

Strategy #7: Update Hospital Policies and Practices

1. Universal screening
2. Drug testing
3. Security/bag/ property search
4. Response to in hospital use/intoxication
5. Naloxone on discharge
6. Medications for opioid use disorder
7. Leaving and returning to the unit/ smoke breaks
8. Visitors
9. Charting/documentation guidelines
10. Family Care Plans
11. Lactation/Breastfeeding
12. Child welfare reporting

Align policies with evidence, trauma-informed care, and harm reduction.

A Call to Action

Together, we can transform care

1. Embrace and model a trauma informed approach to care
2. Consistently use correct and compassionate words
3. Provide strength-based care
4. Learn and incorporate harm reduction strategies throughout care/ education
5. Center lived experience
6. Build interdisciplinary teams and implement huddles as a tool for interdisciplinary decision making
7. Review and update or create policies & practices to support evidence based, trauma informed care

Final words of wisdom and a question for you

"Treat them with respect and dignity. How you treat them *really* matters. The trajectory of where their recovery goes, where their child's life goes and where their life goes, depends in part on how you treat them at that time, [around the birth]" -- Sarah

"People often ask me what my metric for success is, and it's that people come back to care, regardless of whether they are using drugs or not, and know I will care for them and advocate for them." –Dr. Kristin Prewitt

What is one thing you can do by next Tuesday to start or continue this work to improve care at your site?

Acknowledgements & Gratitude

To everyone who poured their passion, expertise, and experience into developing this training:

- Julie Bennette
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- Diana Smith

To the CDC Foundation for funding the development of the pilot training

And to:

- Peers working to improve the lives of families impacted by SUD everyday
- Patients and families who have preserved, despite stigma and bias in healthcare
- The OPC and Comagine teams for responding to the need for QI work related to perinatal SUD.
- Trauma Informed Oregon
- The Anti-Stigma Institute
- So many other professionals and organizations working each day to eliminate stigma and bias in healthcare